

Special Diets

Liberal Bland Diet:

This diet is indicated for any medical condition requiring treatment for the reduction of gastric secretion, such as gastric or duodenal ulcers, gastritis, esophagitis or hiatus hernia. The diet consists of any variety of regular foods and beverages, which are prepared or consumed without black pepper, chilli powder or chilli pepper. Chocolate, coffee, tea, caffeine-containing products and decaffeinated coffee are not included in the diet. The diet should be as liberal as possible and individualized to meet the needs of the patient. Foods, which cause the patient discomfort, should be avoided. Small, frequent feedings may be prescribed to lower the acidity of the gastric content and for the physical comfort of the patient.

Low Fat Diet : Fat restricted diets may be indicated in diseases of the liver, gallbladder or pancreas in which disturbances of the digestion and absorption of fat may occur (pancreatitis, post gastrointestinal surgery, cholelithiasis and cystic fibrosis). Fats are digested with the help of bile. In diseases affecting the liver, bile is not produced in sufficient quantity. Also in gall bladder disease the bile may not reach the duodenum. Therefore, in liver and gall bladder diseases, a low fat or fat free diet may be ordered. Skimmed milk is allowed. Glucose, sugar or jaggery, rice, bread, dal, green vegetables and fruits are allowed, provided that no fat is used in cooking.

High Protein Diet: This is ordered for patients with burns, protein deficiency disease, pre eclampsia, anemia and in chronic kidney disease. About one litre of milk should be taken each day and extra protein can be supplied by adding skimmed milk powder or egg to the milk. Mixed protein rich foods like groundnuts, grams and dal may be ground and cooked with the stable cereal. Non vegetarians may have fish and meat.

Low Protein Diet: This is ordered for patients with acute nephritis. It is continued as long as there is too much urea in the blood. Easily digested carbohydrate foods with a little ghee or butter and boiled sweets may be allowed. At first the diet may be only fruit juice with glucose. A little milk may be allowed later.

Low Residual Diet: This is a diet without roughage or anything that stimulates the bowel. This is ordered in cases such as colitis, colostomy and may be ordered for a few days after perineal suturing. Arrowroot, milk and eggs, tea, toast, strained fruit juice is allowed. Vegetables and fruits are softened and filtered through a sieve. Avoid rough cereals, green vegetables, dal, peas and beans.

Sodium Restricted Diet: The purpose of the sodium restricted diet is to promote loss of body fluids for patients who are unable to excrete the element normally because of a pathological condition. The diet is indicated for the prevention, control and elimination of edema in congestive heart failure; cirrhosis of the liver with ascites; renal disease complicated by either edema or hypertension; when administration of adrenocorticotrophic hormone (ACTH) or steroids are prescribed, for certain endocrine disorders such as Cushing's disease and hypothyroidism. The sodium-restricted diets provide a specific sodium level or a range of sodium. The diet order must indicate the specific sodium level or range desired either in milligrams (mg) or milli equivalent (mEq). Terms such as "salt free" and "low sodium" are not sufficient.

Responsibilities of the Nurse in Relation To Diet Therapy

1. The nurse should be familiar with the diet prescription and its therapeutic purpose.
2. Although individual trays are carefully checked before leaving the Nutrition Care Division, mistakes can happen.
3. Examine each tray with the patient's specific diet in mind.
4. Be able to explain the general principles of the diet to the patient and obtain the patient's cooperation.
 - a. For example, teach a diabetic patient the relationship between his insulin and the amount of food consumed.
 - b. Observe the patient's reaction to the diet. If the patient understands the relationship between his condition and his diet is shown that he can to enjoy most of his favorite foods, he is more to remain on the diet.

THERAPEUTIC DIET

Therapeutic diet is used for the therapeutic purposes in form of dietary supplements. It is a diet that is formulated usually by nutritionists, dietitians and medical doctors to aid in the healing of the body from certain types of injuries and diseases.

Advantages of Therapeutic Diet

Nutritional support is fundamental, whether the patient has an acute illness or faces chronic disease and its treatment. Frequently, it is the primary therapy in itself. The registered dietitian, along with the physician, carries the major responsibility for the patient's nutritional care. The nurse and other primary care practitioners provide essential support. Valid nutritional care must be planned on identified personal needs and goals of the individual patient. We should not lose sight of the reasons for therapeutic diets.

- To Maintain or Improve Nutritional Status
- To Improve Nutritional Deficiencies
- To Maintain, Increase or Decrease Body Weight
- To Eliminate Food Substances to the which the Patient may be Allergic

FEEDING HELPLESS PATIENT ORALLY

Preparing the Patient for Meals

1. Provide for elimination by offering the bedpan or urinal or assisting the patient to the bathroom.
2. Assist the patient to wash hands and face as needed.
3. Create an attractive and pleasant environment for eating
4. Remove distracting articles such as an emesis basin or a urinal and use a deodorizer to remove unpleasant odors in the room.
5. See that the room is well lighted and at a comfortable temperature.

6. Position the patient for the meal. If allowed, elevate the head of the bed or assist the patient to sit up in a chair.
7. Clear the over bed table to make room for the diet tray.
8. Avoid treatments such as enemas, dressings and injections immediately before and after meals.
9. Meals should be accurately prepared, according to the requirements of the individual, patient and his disease.
10. Great care should be taken and be kept away from the patient to avoid spilling.
11. Meals should be attractively served. The plate should be clean on both surfaces. A nicely prepared, well cooked food improves appetite.

Articles Required

1. Mackintosh and towel
2. Feeding cup or straw
3. A glass of water
4. Full plate, quarter plate
5. Cup and saucer
6. Jug
7. Spoon, fork, knife
8. Napkin
9. Kidney tray

Procedure

1. Wash hands.
- 2 Sit by the bedside.
3. The position should be convenient for the nurse and patient.

4. A towel must be placed around his neck so that it gives maximum protection to the patient and bedclothes.
5. Feed the patient slowly in small amounts, allowing him to chew the food and swallow it adequately.
6. Place the spoon properly in patient's mouth.
7. Give dry foods in patient's hands to hold and eat
8. Give the foods in order in which they are normally eaten by the patient.
9. Do not force the food.
10. Encourage the patient to take all types of foods.
11. When the patient has stopped eating, offer a glass of water.

Feeding helpless patient

Spoon Feeding

1. This is often used for the feeding of children and patients who cannot feed themselves. The spoon should be of suitable size and time should be allowed for the mastication.
2. The nurse should appear unhurried. It is usual for the nurse to stand on the right side of the patient.
3. Help the patient to take their feeds who are unable to feed themselves and everything possible must be done to alleviate the feeling of helplessness.
4. Children with cleft lip and cleft palate are mostly spoon fed; sometimes a special spoon is used and after operation, a sterile spoon is used.
5. The child should be well supported and the spoon placed well to the back of the mouth. After operation for cleft lip or cleft palate, great care should be taken to prevent the spoon from touching the suture lines.

Feeding with a Feeding Cup

1. The feeder (feeding cup) must be perfectly clean, especially the spout and under the Overhanging half-lid, should be placed on a saucer with a spoon and carried to the bedside on a tray which is covered with a tray cloth.
2. Spread a towel around the patient's neck. The feed should not be too hot. The nurse's left arm should be placed under the pillow to raise the patient's head and the spout of the feeder placed between his lips.
3. The patient should be taught to place his tongue over the spout tip when requiring a rest or to make a sign to the nurse.
4. In some instances, feeding is made more easy if a piece of rubber tubing is attached to the spout of the feeder, this should be carefully washed and boiled at least once daily.
5. In some cases, both feeder and rubber spout are boiled before and after each feed. A special brush is provided for the cleaning of spouted feeders.
6. At the end of the meal, the patient's mouth should be dried, in some cases the mouth may require cleaning before and after the meal.

After Care

- Help the patient to wash his mouth, face and hands
- Dry the face and hands.
- Make the patient comfortable.
- Tidy up the bed.
- Take all articles to the utility room. Discard the w
- Wash hands.
- Record the amount and type of food taken.

NASOGASTRIC INTUBATION

Definition

Nasogastric intubation refers to the process of placing a soft plastic nasogastric (NG) tube through a patient's nostril, pass the pharynx and down the esophagus into a patient's stomach.

Purposes

1. To remove fluid and gas from gastrointestinal tract (decompression).
2. Prevent or relieve nausea and vomiting after surgery.
3. To treat patients with mechanical obstruction and bleeding of the upper gastrointestinal tract.
4. To obtain a specimen of gastric contents for laboratory studies.
5. Administer medications and feeding directly into gastro-intestinal tract.

General Instructions

1. Do not use force when inserting an NG tube. If resistance occurs, rotate and retract the tube slightly and try again. Forcing the tube can cause traumatic injury to the tissue of the nose, throat or esophagus.
2. Always check the tube positioning before giving feed. If the tube is out of place, the patient may aspirate the feeding solution into the lungs.
3. Keep the patient in an upright or semi upright sitting position when delivering a tube feeding to enhance peristalsis and avoid regurgitation of the feeding.
4. Cap or clamp off the NG tube when not in use to prevent backflow of stomach contents or accumulation of air in the stomach
5. If a patient has severe sinus conditions, nasal obstruction or has had facial surgery, it may be necessary to place an oral gastric tube to avoid further nasal trauma.

6. If the amount of gastric aspirate is large prior to a bolus or intermittent feeding, notify the physician. The feeding size may need to be decreased if the patient is not digesting it.

7. NG tube placement is meant to be a short term solution for feeding problems.

8. Long-term NG tube usage can cause nasal erosion, sinusitis, esophagitis, gastric ulceration, esophageal tracheal fistula formation, oral infections and respiratory infections.

9. Keep the head of the bed elevated 30 degrees at all times to decrease gastric reflux. Place the head of the bed 30-45 degrees during tube feedings and for 30-60 minutes after intermittent tube feedings if the patient can tolerate this position.

Articales Required

A tray containing:

1. Mackintosh with drawsheet to protect bed and garments

2 Feeding cup or drinking tubes or pipes to give fluid to patient.

3 A glass of water to offer at the end of meal.

4 Full plate, quarter plate, cup saucer, jugs, etc. to serve the food.

5. Spoon, fork, knife, etc. to feed the patient.

6. Feeding cup with water and kidney tray to wash the mouth before and after the feeding.

Procedure

1. Assess patient for the need for enteral tube feeding. NPO or insufficient intake for more than 5 days, functional GI tract, unable to ingest sufficient nutrients.

2. Assess patient for appropriate route of administration. Evaluate nares for patency.

a . Close each nostril alternately and ask patient to breathe.

b. Assess for gag reflex.

- c. Inspect nares for any irritation or obstruction.
- d. Review patient's medical history for nasal problems and risk of aspiration. Nurse may seek physician's order to change route of nutritional support or to place tube that pass through stomach into the intestine with increase risk of aspiration.
3. Review physician's order for type of tube and enteral feeding schedule.
4. Perform hand hygiene.
5. explain procedure to the patient
6. Stand on same side of bed as nare for insertion and assist patient to high fowler's position unless contraindicated.

Place bath towel over chest. Keep facial tissues within reach insertion of tube may produce tearing

8. Determine length of tube to be inserted and mark with tape Traditional method, measures distance from tip of nose to earlobe to xiphoid prooess of sternum. Length approximates distance from nose to stomach in 98% patients. For duodenal or jejunal placement, an additional 20 to 30 cm is required.
9. Prepare nasogastric or nasointestinal tube for intubation
10. Cut tape 10 cm long.
11. Put on sterile gloves.
12. Dip tube with surface lubricant into glass of water. Activates lubricant to facilitate passage of tube from nares to GI tract.
13. Insert tube through nostril to back of throat (posterior nasopharynx). Aim back and down toward ear. Natural contours facilitate passage of tube into GI tract.
14. Flex patient's head toward chest after tube has passed through nasopharynx.
15. Emphasis need to mouth breathe and swallow during the procedure
16. Insert tube each time patient swallows until desired length has been passed. Do not force tube. If resistance is met or patient starts to cough, shock or become cyanotic, stop advancing the tube and pull tube back.

17. Check for position of tube in back throat with penlight and tongue blade
18. Perform measures to verify placement of tube.
 - Inject 30 ml of air into the tube and aspirate GI contents with a syringe. gastric contents are usually cloudy and grassy or tan to off white in contrast. Intestinal fluid is usually deep golden yellow and is more clear than gastric fluid.
 - Measure pH of aspirated GI contents. Fasting gastric pH is 1 to 4 only infrequently is it greater than 6.
19. Apply tincture of benzoin or other skin adhesive on tip of patient's nose and tube. Allow to dry. Helps tube adhere better.
20. Remove gloves and secure tube with tape, avoiding pressure on nares.
 - a. Split one end of tape lengthwise 5 cm (2 inches). Place the intact end of tape over bridge of patient's nose. Wrap each of the 5 cm strips around tube as it exits nose securing tape to nares prevents tissue necrosis.
 - b. Fasten end of nasogastric tube to patient's gown by looping rubber band around tube in slip knot. Pin rubber band to gown. Reduce traction on the nares if tube moves.
21. For intestinal placement, position patient on right side when possible until radiological confirmation of correct placement has been verified. Otherwise, assist patient to a comfortable position.
22. Apply gloves and administer oral hygiene. Cleanse tubing at nostril.
23. Remove gloves, dispose of equipment and wash hands.
24. Inspect nares and oropharynx for any difficulty in breathing or gagging

Contraindications

1. Esophageal varices
2. Esophageal surgery

3. GI bleeding
4. Facial fractures
5. Epistaxis
6. Nose and throat surgery
7. Sinusitis
8. Severe coagulopathies

Complications of NG Tubing

1. Pulmonary aspiration due to:

- a. Feeding tube displacement.
- b. Patient in supine position.
- c. Deficient gag reflex.
- d. Gastro-esophageal reflex disease.
- e. Delayed gastric emptying.

2. Diarrhea due to:

- a. Hyperosmolar formula or medications.
- b. Antibiotic therapy.
- c. Bacterial contamination.
- d. Malnutrition/hypoalbuminemia.
- e. Malabsorption.

3. Tube Occlusion due to:

- a. Insufficient tube irrigation.
- b. Reaction of incompatible medication or formula.

Constipation due to:

- a. Medications.
- b. Lack of free water.
- c. Inactivity.
- d. Lack of fiber.

5. Abdominal cramping/nausea/vomiting due to:

- a. Lactose intolerance.
- b. Delayed gastric emptying.
- c. Intestinal obstruction.
- d. Rapid increase in rate/volume.

6. Tube displacement due to:

- a. Not taped securely.
- b. Coughing, vomiting.

7. Delayed gastric emptying due to:

- a. Serious illnesses.
- b. Diabetic gastroparesis.
- c. inactivity.
- d. Prematurity.

8. Increased respiratory quotient:

Overfeeding of carbohydrate:

9. Serum electrolyte imbalance due to:

- a. Renal insufficiency
- b. Diabetes mellitus