NASOGASTRIC (NG) & NASOJEJUNAL (NJ) FEEDING TUBES – POLICY FOR INSERTION AND MANAGEMENT IN ADULT PATIENTS (EXCLUDES PAEDIATRICS AND NEONATES)

<table>
<thead>
<tr>
<th>Reference</th>
<th>CPG/TW/NG</th>
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<tbody>
<tr>
<td>Approving Body</td>
<td>Nursing, Midwifery and AHP Board</td>
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</tbody>
</table>
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v1.1, September 2019 |
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• v1.1, minor amendment on advice from Regional Chief Medical Officer |
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• All Divisional Heads of Nursing |
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| Review Date | April 2021 |
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| Author (Position & Name) | • Nutritional Specialist Nurse, Hazel Saddlington  
• Nurse Advisor to Patient Safety Programme, Sarah Addlesee |
| Lead Division/ Directorate | Corporate |
| Lead Specialty/ Service/ Department | Nursing – Nutrition Team |
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| Associated Documents/ Information | Date Associated Documents/ Information was reviewed |
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• Naso-gastric tube placement monitoring chart (Adults)  
• Enteral Tube Feed Monitoring Chart (Adults)  
• Guideline for glycaemic control in patients with diabetes taking enteral nutrition  
• SOP for imaging of nasogastric tubes in adults, children and infants |
|  | March/ April 2018 via Nutrition Steering Group and Nursing & Midwifery Board |
# CONTENTS

<table>
<thead>
<tr>
<th>Item</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>KEY MESSAGES</td>
<td>3</td>
</tr>
<tr>
<td>1.0</td>
<td>INTRODUCTION</td>
<td>4</td>
</tr>
<tr>
<td>2.0</td>
<td>POLICY STATEMENT</td>
<td>4</td>
</tr>
<tr>
<td>3.0</td>
<td>DEFINITIONS/ ABBREVIATIONS</td>
<td>5</td>
</tr>
<tr>
<td>4.0</td>
<td>ROLES AND RESPONSIBILITIES</td>
<td>5</td>
</tr>
<tr>
<td>5.0</td>
<td>APPROVAL</td>
<td>6</td>
</tr>
<tr>
<td>6.0</td>
<td>DOCUMENT REQUIREMENTS</td>
<td>6-15</td>
</tr>
<tr>
<td>6.1</td>
<td>OVERVIEW</td>
<td>6</td>
</tr>
<tr>
<td>6.2</td>
<td>CONTRAINDICATIONS</td>
<td>6</td>
</tr>
<tr>
<td>6.3</td>
<td>COMPLICATIONS</td>
<td>7</td>
</tr>
<tr>
<td>6.4</td>
<td>CONSIDERATIONS REGARDING THE DECISION TO INSERT AN NG FEEDING TUBE</td>
<td>7</td>
</tr>
<tr>
<td>6.5</td>
<td>TYPE OF TUBE</td>
<td>8</td>
</tr>
<tr>
<td>6.6</td>
<td>SYRINGES</td>
<td>9</td>
</tr>
<tr>
<td>6.7</td>
<td>INSERTION</td>
<td>9</td>
</tr>
<tr>
<td>6.8</td>
<td>SAFE METHODS FOR TESTING CORRECT POSITION</td>
<td>10</td>
</tr>
<tr>
<td>6.9</td>
<td>ONGOING CHECKS OF NG TUBE POSITION</td>
<td>13</td>
</tr>
<tr>
<td>6.10</td>
<td>NASOJEJUNAL (NJ) TUBES</td>
<td>14</td>
</tr>
<tr>
<td>6.11</td>
<td>NASAL BRIDLE</td>
<td>15</td>
</tr>
<tr>
<td>6.12</td>
<td>DISCHARGE TO COMMUNITY CARE</td>
<td>15</td>
</tr>
<tr>
<td>6.13</td>
<td>LEARNING FROM PATIENT SAFETY INCIDENTS</td>
<td>15</td>
</tr>
<tr>
<td>7.0</td>
<td>MONITORING COMPLIANCE AND EFFECTIVENESS</td>
<td>16</td>
</tr>
<tr>
<td>8.0</td>
<td>TRAINING AND IMPLEMENTATION</td>
<td>17</td>
</tr>
<tr>
<td>9.0</td>
<td>IMPACT ASSESSMENTS</td>
<td>17</td>
</tr>
<tr>
<td>10.0</td>
<td>EVIDENCE BASE (RELEVANT LEGISLATION/ NATIONAL GUIDANCE) AND RELATED SFHFT DOCUMENTS</td>
<td>17</td>
</tr>
<tr>
<td>11.0</td>
<td>APPENDICES (LIST)</td>
<td>18</td>
</tr>
</tbody>
</table>

**Appendix A** – Representational Copy of: ‘Pathway of Care for Patients undergoing maintenance of feed via Nasogastric Tube’ – usable copies are accessible via the trust’s forms management system using ref FKin030372

**Appendix B** – Flow Chart for insertion of Nasogastric tube.

**Appendix C** – Safe Practice for the Insertion and Management of a Nasal Bridle (NB) in adults to secure a NGT

**Appendix D** – Alert Links

**Appendix E** – Equality Impact Assessment
KEY MESSAGES

- Nasogastric (NG) tube feeding is the choice for patients who require short term enteral feeding i.e. 4-6 weeks and who have a functioning gastrointestinal tract.
- The insertion of the tube will be completed by a competent practitioner, and details of insertion documented on the Pathway of Care for Patients undergoing maintenance of feed via Nasogastric Tube.
- A maximum of 3 attempts at inserting the tube should be made at any one time to prevent trauma to the nasal/oesophageal mucosa, and if difficulty in inserting the tube this should be escalated accordingly via the medical team to ensure adequate attempts are made to secure a safe enteral route for nutrition/fluid/medication.
- The position of a NG tube on initial placement will be confirmed by pH of 5 or below as first line test, with x-ray only being used when no aspirate could be obtained or pH indicator paper has failed to confirm the location of the NG and all the recommended steps to gain an aspirate as documented on the NPSA decision tree have been followed.
- **Following insertion of the tube the guidewire must be removed immediately. The NG tubes at SFHFT are radiopaque and NPSA compliant. Guidewires should never be reinserted under any circumstances.**
- Nasogastric tubes must not be flushed or any liquid/feed introduced through the tube following initial placement, until the tube tip is confirmed by pH testing or x-ray to be in the stomach.
- The position of the NG tube will be checked and confirmed prior to any feed, medication or fluids being administered via the tube, and the result documented on the NG bedside check and x-ray interpretation document.
- **Whoosh tests, acid/alkaline test using litmus paper, the absence of respiratory distress or interpretation of the appearance of aspirate are NEVER to be used to confirm nasogastric tube position as these are not reliable.**
1.0 INTRODUCTION
NG feeding tubes are tubes passed into the stomach via the naso-pharynx for the purpose of providing nutrition. NG tubes are commonly used across the Trust, in a wide range of clinical settings. Nasogastric feeding is an active nutritional support commonly used to maintain or improve the nutritional status of patients who are unable to take sufficient nutrition orally (Stroud et al 2003). It is the commonest way of providing artificial nutritional support to patients in hospitals.

A Patient Safety Alert issued in 2016 Nasogastric tube misplacement: continuing risk of death and severe harm states that the use of misplaced nasogastric and orogastric tubes were first recognised as a patient safety issue by the National Patient Safety Agency (NPSA) in 2005 and three further alerts were issued by the NPSA and NHS England between 2011 and 2013. Introducing fluids or medication into the respiratory tract or pleura via a misplaced nasogastric or orogastric tube is a Never Event. Never Events are considered ‘wholly preventable where guidance or safety recommendations that provide strong systemic protective barrier are available at a national level, and should have been implemented by all healthcare providers’

Between September 2011 and March 2016, 95 incidents were reported to the National Reporting and Learning System (NRLS) and/or the Strategic Executive Information System (StEIS) where fluids or medication were introduced into the respiratory tract or pleura via a misplaced nasogastric or orogastric tube. While this should be considered in the context of over 3 million nasogastric or orogastric tubes being used in the NHS in that period, these incidents show that risks to patient safety persist. Checking tube placement before use via pH testing of aspirate and, when necessary, x-ray imaging, is essential in preventing harm.

Nasojejunal (NJ) tubes should be placed either radiologically or endoscopically. Please refer to these separate departments should they be required.

The Trust is committed to reducing the incidence of incorrectly placed NG and NJ tubes and this policy sets out the trust standards which must be followed in practice.

2.0 POLICY STATEMENT
The scope of this policy is to provide guidance to all healthcare professionals who care for patients with an NG tube for feeding. This policy is aimed at standardising the care of patients with NG feeding tubes to ensure that insertion and ongoing management is safe, effective and comfortable for the patient. The policy includes principles for the safe insertion of NG tubes. The policy also includes safe methods for checking the position of NG feeding tubes and advises on unsafe methods, which should not be used. It is applicable to adults only. Children and neonates guidance can be sought via the current Nasogastric Tube Feeding in Children Guideline.
3.0 DEFINITIONS/ ABBREVIATIONS

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enteral Feeding</td>
<td>Feeding into the gastro intestinal tract</td>
</tr>
<tr>
<td>Nasal Bridle</td>
<td>A tube retaining device which is placed around the septum to secure the nasogastric/nasojejunal tube</td>
</tr>
<tr>
<td>Naso gastric feeding tube</td>
<td>A fine bore feeding tube where the tips sits within the stomach lumen</td>
</tr>
<tr>
<td>Naso jejunal feeding tube</td>
<td>A fine bore feeding tube which is longer than 110cm where the tip sits within the first part of the small bowel some are weighted or have modified ends to aid passage into the small bowel.</td>
</tr>
<tr>
<td>NEX Measurement</td>
<td>The NEX measurement is estimated as follows :place exit port of the NG tube at tip of nose ,extend the tube to the earlobe and then to the xiphisternum</td>
</tr>
<tr>
<td>KMH</td>
<td>King’s Mill Hospital</td>
</tr>
<tr>
<td>MCH</td>
<td>Mansfield Community Hospital</td>
</tr>
<tr>
<td>NH</td>
<td>Newark Hospital</td>
</tr>
<tr>
<td>PEG</td>
<td>Percutaneous Endoscopic Gastrostomy</td>
</tr>
<tr>
<td>RIG</td>
<td>Radiologically Inserted Gastrostomy</td>
</tr>
<tr>
<td>PEG-J</td>
<td>Percutaneous Endoscopic Jejunostomy</td>
</tr>
<tr>
<td>RIG-J</td>
<td>Radiologically Inserted Jejunostomy</td>
</tr>
<tr>
<td>ED</td>
<td>Emergency Department</td>
</tr>
</tbody>
</table>

4.0 ROLES AND RESPONSIBILITIES

Responsibly for ensuring the application of this policy lies with the Clinical Chair, Head of Nursing, Divisional Manager and Matron of each division.

Nutrition and Hydration Steering Group
- The Nutrition and Hydration Steering Group is accountable to the Trust Board via the Patient Safety and Quality Group and will send activity reports to Nursing, Midwifery and AHP Board.

Medical Staff
- Medical staff are responsible for ensuring the dissemination and implementation of this policy within Divisions and for demonstrating compliance of staff competency through audit.

Dietitian
- The Dietitian is responsible for completing a nutritional assessment of the patient and designing an appropriate feeding regimen, taking account of any risks.

Matrons/ Sister/Charge Nurses
- Matrons/ Sister/Charge Nurses are responsible for ensuring the dissemination and implementation of this policy within their clinical ward areas and for demonstrating compliance of staff competency through audit.

Registered Nursing Staff
- Registered nursing staff are responsible for ensuring their own compliance with this policy.
5.0 APPROVAL

- Nutrition and Hydration Steering Group
- Nursing, Midwifery and AHP Board

6.0 DOCUMENT REQUIREMENTS

6.1 OVERVIEW
Insertion of NG feeding tubes should be carried out in accordance with procedures outlined in the Royal Marsden Manual procedure ‘NG intubation with tube using an introducer’ Management of patients thereafter should be carried out in conjunction with this Trust Policy.

Management of patients thereafter should be carried out in conjunction with this Trust Policy. All information pertaining to the insertion and ongoing management of NG tubes should be recorded in the ‘Pathway of Care for Patients undergoing maintenance of feed via Nasogastric Tube’ (see Appendix A for representational copy).

All patients starting NG feeding should be referred to a dietitian. High risk patients, should be referred to a specialist with expert knowledge of NG tube insertion and management.

The bedside checklist within the pathway of care for patients undergoing maintenance of feed via Nasogastric Tube should be completed for all patients requiring nasogastric tube placement, on insertion and on all subsequent insertions, before administration of artificial nutrition or medication via the nasogastric tube.

Any additional information should be recorded in the patient’s medical or nursing notes as appropriate.

6.2 CONTRAINDICATIONS
These contraindications are not absolute, but in these patient groups the insertion of a nasogastric tube must be discussed with the medical team in charge of the patient’s care and specialist advice sought where appropriate. The decision and plan of care should be documented in the patient’s medical notes. Such patients may require NG tube insertion under fluoroscopic control.

- Anatomical deformities
- Non-functioning GI tract e.g. ileus.
- Large gastric aspirate and/or high risk of aspiration.
- Intractable vomiting not resolved by anti-emetics.
- Maxillo-facial surgery/trauma/disease
- Oral, nasal or oesophageal tumours/surgery
- Basal skull fractures as the tube may enter the brain if incorrectly positioned (oro-gastric positioning may be appropriate).
- Severe gastro oesophageal reflux disease
- Mucositis
- Allergies – to NG tube or securing material
- Oesophageal varices
- Vomiting responding to anti-emetics
- Recent radiotherapy to head and neck
- Advanced neurological impairment
- Obstructive pathology in oropharynx or oesophagus preventing passage of the tube e.g. stricture, tumour, pharyngeal pouch. Procedure may need to be done under endoscopic or fluoroscopic control. Specialist input advised.

6.3 COMPLICATIONS
There are some potential complications to NG tube insertion that practitioners should be aware of in order to recognise and appropriately respond to these if and when they may occur.

Fine bore NG feeding tubes are preferred for gastric feeding as large bore tubes (Ryles-type) NG tubes are harder to tolerate by patients and can cause rhinitis, oesophageal reflux and strictures. Wide bore NG tubes are therefore only recommended for gastric decompression or very short term feeding in Critical Care Unit.

The use of fine bore NG feeding tubes however carries risk as some patients may tolerate accidental intubation of the trachea and bronchi without any obvious signs of distress. If a misplaced tube is not spotted and feeding commenced, the consequences can be serious. Such complications include:
- Pneumothorax
- Severe pneumonia
- Emphysema
- Pulmonary haemorrhage
- Death – depending on the response to any of the above.

6.4 CONSIDERATIONS REGARDING THE DECISION TO INSERT AN NG FEEDING TUBE

6.4.1. CONSIDER: IS NG TUBE FEEDING THE RIGHT DECISION FOR THIS PATIENT?
For most people, eating is an enjoyable and social experience as well as a physiological necessity. A patient who is tube fed may no longer be able to eat and drink orally and enjoy his/her food. If this is so, nurses have a responsibility to help the patient come to terms with this situation and endeavour to help the patient not feel isolated.

Routine mouth care is vitally important for the patient unable to eat or drink; mouthwashes and oral mouth care should be offered.

The decision to start NG tube feeding should be made following a risk assessment. Where possible this will include a Nutrition Nurse Specialist or Dietician. A senior doctor responsible for the patients care, a senior ward nurse familiar with the patient and if appropriate the patient themselves should be involved in the decision to insert an NG tube for feeding. A decision must be made that balances the risks of feeding with the need to feed. The rationale for inserting a nasogastric tube should be recorded in the patient’s medical notes.
The following patient groups are at higher risk of placement error or tube migration:

- Patients with a reduced level of consciousness.
- Patients who are agitated or confused.
- Patients with swallowing dysfunction.
- Patients who are retching, vomiting or coughing.

Patients receiving medication which has an antacid effect are more likely to have stomach aspirate pH levels of 5 or above, making identification of an incorrectly placed tube more difficult.

6.4.2. CONSIDER: IS THIS THE RIGHT TIME TO PLACE THE NG TUBE FOR FEEDING?
Where possible, elective placement of NG tubes should not occur at night, unless there is sufficiently competent senior medical cover available to accurately confirm placement if an x-ray is needed.

When a decision is made to insert or reinsert an NG tube out of hours, the rationale for the decision must be documented in the patient’s medical notes. It is anticipated that these patients will be being cared for in areas where sufficient senior support is available at all times of night and day.

6.4.3. CONSIDER: IS THERE SUFFICIENT KNOWLEDGE / CAPACITY TO TEST FOR SAFE PLACEMENT OF THE NG TUBE?
All staff involved in the insertion of NG tubes and/or position checks must have undergone training. They must be certified as competent to carry out this procedure and ongoing care.

6.4.4. CONSENT
Where possible informed verbal consent should be obtained from the patient prior to the insertion of a NG tube. If capacity is in doubt, complete a TWO STAGE TEST. If the patient lacks capacity, follow this by completing the BEST INTERESTS check list. This should be clearly documented in the patient’s medical notes and indicated on the “Pathway of Care for Patients undergoing maintenance of feed via Nasogastric Tube’ (Appendix A, representational copy). Staff should follow guidance according to the SFH Policy For Consent to Examination, Treatment and Care

6.5. TYPE OF TUBE
National Patient Safety Alert (NPSA 2016 and resource pack) Reducing the harm caused by misplaced nasogastric feeding tubes in adults, children and infants.

- The tubes should be fully radio-opaque with externally visible markings to enable accurate measurement, identification and documentation of their position (NPSA 2016).

Feeding tubes must comply with:

- Must have an integrated ENFIT or Enfit adaptor attached. Enteral feeding systems should not contain ports that can be connected to intravenous syringes, or that have end connectors that can be connected to intravenous or other parenteral lines.
- Enteral feeding systems should be labelled to indicate the route of administration.
- Recommended tube size for adults –10 refer to Appendix B – Flow Chart for insertion of Nasogastric tube.

6.6. SYRINGES
All syringes used to access nasogastric tubes and to administer feeds, medications or to aspirate should be purple enteral EnFit syringes and in hospital are single use only.

6.7. INSERTION
It is the responsibility of the person inserting the NG tube to complete the insertion record section of the ‘Pathway of Care for Patients undergoing maintenance of feed via Nasogastric Tube’. All qualified healthcare professionals must ensure that the insertion record shows a signed and printed confirmation of correct NG tube position before using the NG tube.

Prior to insertion, the tube length should be estimated for each patient by measuring from the xiphisternum to the ear lobe, and then to the tip of the nose (NEX measurement – see Appendix B). Inserting the tube at the correct length for each patient increases the chances of successful tube aspiration. Aspiration of the tube allows for the pH to be checked on initial insertion and also thereafter if there is any cause for concern about tube position.

NG tube insertion is a clean procedure and health care professionals should adhere to universal infection control precautions throughout.

The NG tube should not be flushed or lubricated with water prior to insertion as this may give a falsely low pH reading, indicating correct placement when the tube is in fact incorrectly placed. A small amount of lubricating jelly can be used to assist insertion and increase patient comfort. Care must also be taken when obtaining subsequent aspirates to check pH if there is a concern over tube position. If water has been used to flush the tube following completion of an earlier feed, then approximately 5mls of fluid will need to be aspirated from the NG tube and discarded before obtaining a further aspirate sample to confirm gastric pH.

If the patient has an intact swallow they should be encouraged to drink sips of water during insertion of the NG tube enabling the inserter to progress the tube safely and comfortably with each swallow (whilst considering the risk of false pH readings as described). For patients who do not have a safe swallow, mouth care swabs can be used to moisten the mouth which will make it easier for the patient to swallow as the tube is inserted. The tube should be removed immediately if the patient shows any signs of respiratory distress and, if possible, another attempt at insertion made.

If the tube meets resistance and cannot be advanced further the procedure should be abandoned, the patient reassured and a referral made to a more experienced practitioner.
Once the tube is safely inserted and the guidewire has been removed, the pH of the aspirate should be checked and the internal tube length documented on the 'Pathway of Care for Patients undergoing maintenance of feed via Nasogastric Tube' form.

It is possible for the tip of the tube to displace upwards into the oesophagus, particularly with retching, coughing or vomiting, increasing the risk of aspiration, even if the external length appears unchanged (NNNG 2004). If suspected, additional checks as per initial insertion are necessary to confirm gastric placement. Removal and replacement of the tube may be necessary if this is suspected and if additional checks do not confirm gastric placement.

Refer to Flowchart for insertion of Nasogastric tube (Appendix B)

6.8. SAFE METHODS FOR TESTING CORRECT POSITION

6.8.1. POSITION OF A NASOGASTRIC FEEDING TUBE ON INITIAL PLACEMENT

This will only be confirmed by:
- First line test method: pH paper
- Second line method: X-ray appearances

Safe methods for testing correct position following initial insertion and on subsequent testing; the position of a Nasogastric Feeding tube will only be confirmed by testing the pH of a nasogastric aspirate and X-ray appearances. Skin Dressings should be changed regularly and their security checked each shift, taking note of any skin sensitivity.

Nasal care Where possible nostrils should be swapped each time the tube is replaced to prevent nasal erosion and discomfort. Observe nostril daily for signs of discomfort and pressure damage.

6.8.2 PH TESTING

pH testing is the first line test method of checking NG tube position. The pH of an aspirate from the NG tube can be tested effectively using pH indicator strips CE marked for use in human gastric aspirate (NHS Improvement Resource Pack). A pH aspirate reading of between 1 and 5 confirms correct gastric placement and feeding through the NG feeding tube can be commenced as soon as the insertion record has been completed.

Statement regarding pH range

Following a review of guidance Sherwood Forest Hospitals have made the decision to set the acceptable limit for pH aspirate to 5 as the recommended safe pH to deliver a feed.

Although NPSA guidance does say a pH of 5.5 is acceptable there is also an additional safety notice to say that we cannot be confident the tube is positioned correctly, therefore by working to a pH of 5 we are increasing patient safety and the confidence of those checking the position of a tube that it is safely placed.
Brands of pH testing strips that make it difficult to see any colour change between readings so again by setting 5 as our acceptable pH level we remove the need for a clinical judgement and can have greater confidence that at a pH 5 our NG tube is in the correct place and it is safe to feed.

6.8.3. PROBLEMS OBTAINING AN ASPIRATE
Aspirating fluid from NG tubes can be problematic. Some useful advice is as follows:

- Ensure that correct length of tube is established on initial insertion using NEX measurement (see Appendix B) to ensure aspirate can be obtained.
- Use the correct sized, purple-coloured oral/enteral polyurethane syringe as advised by the NG tube manufacturer
- **On initial placement only** Instill air into the NG tube prior to aspiration. This will clear any debris from the end of the tube and dislodge the tip of the NG tube if it is imbedded in the gastric mucosa. The patient’s medical condition should be taken into account prior to instilling air down the NG tube, and if there is any doubt as to whether this is appropriate air should not be injected. This method must not be used for subsequent checks once the tube has been used for feeding and medications
- If safe to do so, ask the patient to drink a small amount of water then try again to aspirate.
- Change the position of the patient in order to move the fluid level in the stomach e.g. if sitting up, turn the patient onto the left side which will allow the tip of the tube to enter the gastric pool.
- If possible advance the tube (10-20cm in an adult, 1-2cm in infants and children). This may allow the NG tube to pass into the stomach if it has been in the oesophagus.

**IMPORTANT**

If unable to obtain an aspirate or the aspirate is higher than 5.0 an X-ray MUST be obtained to confirm position.

6.8.4. IF THE PH IS ABOVE 5
The aspirate obtained may have a pH above 5 because the NG tube has been misplaced into the lungs on initial insertion or become displaced at a later stage either into the intestine or the lung.

There are some limitations to the testing for gastric pH. Gastric pH can also be affected by medications, particularly proton pump inhibitors (e.g. Omeprazole, Lansoprazole, Pantoprazole) and H2 receptor antagonists (e.g. Cimetidine, Ranitidine, Nizatidine). Consideration should be given to changing the timing of medication administration or aspiration to enable correct pH readings to be carried out.

The most likely reason for an elevated pH is the dilution of gastric acid by feed. Feeding being stopped for up to an hour will allow time for the stomach to partially empty and the pH to reduce. If there is any doubt about the position of the tube and/or the pH of the aspirate then feeding should not be commenced. A risk assessment should be carried out and medical advice sought from the responsible team.
IMPORTANT

If unable to obtain an aspirate or the aspirate is higher than 5.0 on initial insertion, an X-ray MUST be obtained to confirm position.

6.8.5. X-RAY, refer to:
- [SOP for Imaging of Nasogastric tubes in adults, children and infants](#)

Chest x-rays are only used as a second line test where aspiration has been unsuccessful or the pH indicator paper has failed to confirm correct placement. Although the use of x-ray is advocated in patients who are at risk of inadvertent placement into the respiratory tract, it should not be used 'routinely' to check tube position (NHS Improvement 2016, NPSA 2005, Metheny 1990, Stroud 2003).

X-ray is an accurate and reliable method for confirming tube position however there have been multiple reports of x-rays being misinterpreted (NHS Improvement 2016, NPSA 2005, 2011). Other limitations to the use of x-ray include exposure to radiation, loss of feeding time and increased patient movement (Metheny 1990). It must also be remembered that an x-ray only confirms tube position at the time the x-ray was taken. The NG tube can become displaced at any time.

When requesting an x-ray for the purpose of checking NG tube position, the reason for the request must be included on the request form. It is the responsibility of the radiographer to ensure the NG tube can be clearly seen on the x-ray.

**Care must be taken when interpreting x-rays and this should only be undertaken by a qualified trained and competent healthcare professional.**

If an NG tube is inserted in the operating theatre during laparotomy, surgical confirmation of intra-gastric or post-gastric positioning, either manually or by direct vision, this will be sufficient to allow immediate use without further assessment. NG tubes that are inserted under direct vision by specialist practitioners using endoscopy and fluoroscopy may also be used without the need for pH testing or X-ray. Where tube position has been confirmed in this manner, a free text note to this effect should be made on the ‘Pathway of Care for Patients undergoing maintenance of feed via Nasogastric Tube’.

Subsequent use of the tube will be subject to the checks detailed in this policy.
IMPORTANT

Nasogastric tubes must not be flushed with water, nor should any feed be introduced prior to confirmation of gastric placement.

This is important because:

- Any flush could cause an aspiration pneumonia if the tube is placed in the lungs
- pH testing for gastric placement relies on collecting aspirate via the tube; anything introduced down the tube will contaminate this aspirate, potentially leading to false positive pH readings.

6.9 ONGOING CHECKS OF NG TUBE POSITION

The position of the NG tube should be checked by pH and if required x-ray imaging in the following circumstances:

- Before restarting feed after a rest period.
- Daily in the case of continuous feeding.
- Before administering medication.
- If there are any concerns that the tube may have become displaced (e.g. loose tape, episodes of retching or coughing, excessive sneezing, any change in external length).

This check consists of checking the internal length of the tube by noting the length markings at the nostril, and also ensuring that the tube is securely taped or fastened. This check should be documented on ‘The Pathway of Care for Patients undergoing maintenance of feed via Nasogastric Tube’ (Appendix A, representational copy).

6.9.1 WHEN NOT TO FEED

In the following circumstances, patients should NOT have feed started unless a pH of between 1 and 5 has been obtained and documented OR correct tube placement has been confirmed by a competent person through x-ray and documented:

- following initial insertion;
- following episodes of vomiting, retching or coughing spasms (note that the absence of coughing does not rule out misplacement or migration);
- when there is suggestion of tube displacement (for example, loose tape or portion of visible tube appears longer);
- in the presence of any new or unexplained respiratory symptoms or reduction in oxygen saturation.

These checks should be recorded on the ‘Pathway of Care for Patients undergoing maintenance of feed via Nasogastric Tube’ form and in the medical or nursing notes.
6.10 NASOJEJUNAL (NJ) TUBES
Nasojejunal tubes are fine bore feeding tubes that are longer than 110cm. The tip of an NJ tube sits within the first part of the small bowel some are weighted or have modified ends to aid passage into the small bowel.

Indications:
- Post pyloric feeding required
- Gastric reflux/ gastroparesis
- Therapeutic requirement to bypass duodenum eg pancreatitis
- Upper gastro-intestinal obstruction/ fistula
- Peri-operative feeding

Absolute Contraindications:
- Basal skull fracture
- Trachea-oesophageal fistula

Relative Contraindications:
- Frequent nosebleeds
- Nasal polyps/ injuries
- Upper GI obstruction
- Coagulation disorder
- Oesophageal stricture
- Oesophageal pouch

The make and size of NJ tube should be documented in the nursing and medical records. Patients who have a Nasojejunal tube should have their pre and post procedure and ongoing care documented in their nursing and medical records. The length of tube clearly documented in the nursing notes so that any movement of the tube is easily identified.

Post placement care:
As this method bypasses the gastric acid, it is important to ensure sterile procedures during feed preparation. The feeding regimen must be followed carefully as the rate must be gradually increased to prevent nausea and diarrhoea as there is no stomach reservoir to hold large amounts of feed. The patient is likely to be fed over 24 hours initially as there is no reservoir to hold large feed volumes. NJ tubes must be flushed a minimum of 8 hourly using sterile water and a push/pause technique. As these tubes easily block it is recommended that drugs are not administered via the NJ tube. Suitable alternatives should be discussed with Pharmacy. It is possible for NJ tubes to migrate back into the stomach. Feed noticed in vomit, gastric aspirate or an increase in pain in patients should be notified to the medical staff and dietitian.

Care of a jejunostomy tube
Ensure that the jejunal tube is flushed with sterile water whenever the feed is interrupted. Otherwise the feed should be administered as directed by dietician If the jejunal tube is not in use ensure that the tube is flushed at least every 8 hours with sterile water using a 50ml oral/enteral syringe.
Drug administration via Nasojejunal tubes
Ensure that the clinical pharmacist is aware that the tube is jejunal rather than gastric.
In all cases patients should be monitored for clinical signs. To establish that the drug is being sufficiently absorbed to give therapeutic levels.
When liquid preparations are administered it is important to be aware that they are hypertonic and will not be diluted with gastric contents as with intragastric administration. The hyperosmolar solution creates a gradient across the intestinal mucosa that inhibits water absorption and can cause osmotic diarrhoea.

Radiologically/endoscopically placed N.J. tubes
When the patient arrives back on the ward, make a note of the centimetre markings at the nose ensure this is the same as immediately post procedure.
The position of the tube should be checked pre and post using and at least once each shift handover
If vomiting occurs or the nurse is in any doubt that the tube is in the correct position, ascertain tube position with X-ray.

6.11. NASAL BRIDLE
Nasal Bridle – insertion and management in adults to secure a nasogastric or nasojejunal tube. See Appendix C

Bridles are loops which go through each nostril around the posterior aspect of the nasal septum and are then secured to the feeding tube in front of the nose. They are intended as a method of securing feeding tubes so that they are not easily displaced. They should be used only when at least 3 feeding tubes have become dislodged.

If a patient is assessed as requiring a nasal bridle and capacity is in doubt, complete a TWO STAGE TEST. If the patient lacks capacity, follow this by completing the BEST INTERESTS check list. This should be clearly documented in the patient’s medical notes and indicated on the ‘Pathway of Care for Patients undergoing maintenance of feed via Nasogastric Tube’

The patient must have Deprivation of Liberty completed, refer to the trusts Deprivation of Liberty Safeguards Policy (For Adults 18 years and over). Further advice can be sought from the Trusts Safeguarding Team.

6.12. DISCHARGE TO COMMUNITY CARE
Discharging a patient from acute to community services with an enteral feeding tube in place requires careful planning. A multidisciplinary risk assessment should be performed and documented (NHS Improvement 2016, NPSA 2011). Guidance and support can be provided by contacting the Nutrition Nurse Specialist.

6.13. LEARNING FROM PATIENT SAFETY INCIDENTS
Feeding into the lung as the result of a misplaced NG tube was designated a ‘Never Event’ in England by the NPSA in 2009. ‘Never Events’ are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. In the interest of patient safety and in order to learn from any mistakes made within our Trust, all misplacement incidents must be reported to your immediate line manager, the Trust Governance Support Unit and recorded as an incident on Datix.
## 7.0 MONITORING COMPLIANCE AND EFFECTIVENESS

Compliance with this policy will be monitored by the Nutrition and Hydration Group, who will monitor the number and type of incidents. Audit of NG insertion practice and documentation will be carried out by Nutritional Nurse Specialist across the Trust every six months to ensure ongoing monitoring and review of practice.

<table>
<thead>
<tr>
<th>Minimum Requirement to be Monitored</th>
<th>Responsible Individual</th>
<th>Process for Monitoring e.g. Audit</th>
<th>Frequency of Monitoring</th>
<th>Responsible Individual or Committee/ Group for Review of Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust-wide audit to assess compliance with NG Policy, in particular ‘Pathway of Care for Patients undergoing maintenance of feed via Nasogastric Tube ’ All patients with an NG feeding tube insitu on the day of audit will be included.</td>
<td>Nutrition Nurse Specialist</td>
<td>Audit of NG insertion practice</td>
<td>6 monthly</td>
<td>Nutrition and Hydration Steering Group</td>
</tr>
<tr>
<td>All incidents involving NG feeding tubes reported will be categorized according to level of risk Datix reports will be compiled and any themes for concern identified</td>
<td>Nutrition Nurse Specialist</td>
<td>Incidents recorded on Datix will be monitored and reviewed</td>
<td>Monthly</td>
<td>Nutrition and Hydration Steering Group</td>
</tr>
</tbody>
</table>
8.0 TRAINING AND IMPLEMENTATION

8.1 NG INSERTION TRAINING & ONGOING CARE
All registered doctors and nurses who insert NG tubes and perform testing of gastric aspirate must have been trained to do so. All registered nurses involved in the ongoing care of patients with NG feeding tubes should also have been trained to do so. NG tube insertion training for registered nurses is currently available through Nutrition Nurse Specialist as appropriate. For registered nurses this must be used as documentary evidence of competency to practice. Competency should be recorded on the Trust’s centrally held training registers.

Trust Registered Nursing and AHP staff seeking competency to insert NG tubes should be compliant with the following standards of training:
- Attendance at a recognised face-to-face classroom based theory session
- Complete and pass a theory assessment
- Complete a period of supervised practice

8.2 X-RAY INTERPRETATION TRAINING

Doctors and other registered practitioners (as appropriate to role) who check NG tube position by interpreting X-ray must be trained and competent to do so (NHS Improvement, 2016).

9.0 IMPACT ASSESSMENTS
- This document has been subject to an Equality Impact Assessment, see completed form at Appendix E
- This document is not subject to an Environmental Impact Assessment

10.0 EVIDENCE BASE (Relevant Legislation/ National Guidance) AND RELATED SFHFT DOCUMENTS

Evidence Base:
- MHRA Notice (2004) MHRS/MS/026


• See also list of Alerts with Links in Appendix D

**RELATED SFHFT DOCUMENTS:**

• Policy for consent to examination, treatment and care
• SFH Mental Capacity Act Policy
• Guideline for the Prevention and Management of Refeeding Syndrome in Adults
• Deprivation of Liberty Safeguards Policy (for adults 18 years and over)
• [Nasogastric Tube Feeding in Children Guideline](#)

**11.0 APPENDICES**

**Appendix A** – Representational Copy of: ‘Pathway of Care for Patients undergoing maintenance of feed via Nasogastric Tube’ – usable copies are accessible via the trust’s forms management system using ref FKIN030372

**Appendix B** – Flow Chart for insertion of Nasogastric tube.

**Appendix C** – Safe Practice for the Insertion and Management of a Nasal Bridle (NB) in adults to secure a NGT

**Appendix D** – Alerts Links

**Appendix E** – Equality Impact Assessment
Appendix A – Representational Copy of: ‘Pathway of Care for Patients undergoing maintenance of feed via Nasogastric Tube’ – usable copies are accessible via the trust’s forms management system using ref FKIN030372
Appendix B
Flow chart for insertion of Nasogastric tube

Key points before insertion of a nasogastric tube
- Is this necessary (NBM/dysphagia/poor nutritional intake)
- Has consent been obtained?
- If patient is deemed to lack capacity, is this in their best interests?
- Are you competent to insert a nasogastric tube?
- If out of hours, is this essential at this point in time?

If you are not competent at NG insertion, contact the Stroke Unit as all nurses are trained to insert NG’s and may be able to come and help. See policy for further understanding.

Gather equipment needed for NG insertion-
- Flocare NG tube 10fr
- 50ml Enteral syringe
- pH testing strips
- Apron
- Lubricating gel
- Non sterile gloves

Introduce self and explain procedure to the patient. Obtain their informed consent.
If patient lacks capacity complete a 2 stage mental capacity test and decide if this in their best interests.

Measure to NG tube from the bottom of the xiphoid process up to the ear lobe (NEX measurement) and to the tip of the nose (usually 60cm)

Check the guidewire moves freely in the tube and secure in place by tightening it at the end with the screw cap.

Lubricate the tip and begin to insert the NG tube up the chosen nostril. Insert to around 12-14cm and ask the patient to swallow (this will help with insertion). Once a swallow is felt advance the tube down the oesophagus until at measured length. If rebound is felt or patient is coughing/distressed remove the tube and retry once patient is more comfortable.

Once in place secure to nose using the nasofix. Remove the guidewire and insert 30ml of AIR into the NG. Pull back to obtain aspirate to confirm placement.

Aspirate obtained <5.0pH
- Ensure patient is positioned at a minimum of a 30° angle (to reduce the risk of aspiration), flush with 30mls of water and commence feeding as per feeding guideline.

No Aspirate or Aspirate obtained >5.0pH
- Replace screw cap to end of NG and retry aspirate in 30 minutes. If after 30 minutes there is either no aspirate or the pH remains >5.0, chest x-ray will be required to confirm placement. Following review of the chest x-ray, the result must be documented in the medical notes. If in place commence feeding as per feeding guideline. If the NG cannot be identified on the chest radiograph consider removal and replace with a new NG.
Appendix C – Guidance for the safe practice for the insertion and management of a nasal bridle (NB) in adults to secure a nasogastric tube (NGT)

See also Flow chart for patients who repeatedly pull out NG tubes further at end of this guidance.

This guidance (or part thereof) is for use by:
- Consultant Physicians
- Junior Medical Doctors
- Relevant Specialist Nurses

Indications for a nasal bridle

- Patients in whom at least 3 NG tubes have become dislodged or where intubation has been difficult.
- Patients who require medium or long term (LT) feeding via a fine bore NG tube (using size 10).
- Patients to be discharged home with long term NG tube feeding.
- Confused patients in the short term, but they may attempt to pull them out (see appendix)

NB: LT enteral feeding via NG tube would be very unusual, a Percutaneous Endoscopic Gastrostomy (PEG) being preferred in this situation. If LT NG tube is to be used it should be replaced every 6 weeks. LT use of a nasal bridle may damage the nasal septum.

Exclusions: Basal skull fracture
- Deviated nasal septa
- Nasopharyngeal deformity.

Capacity
Assume patient has capacity:
- offer information in an appropriate way for the individual
- treat any medical condition that may influence capacity
- consider asking the question at another time when patient is better able to communicate, if capacity seems impaired.

Assessment:
- Does the patient have impairment of mind/brain which affects the way it works?
- Is the patient unable to make the decision in question as a result of this?

The following questions might be employed:-
- Does the patient have a general understanding of the decision to be made and the need to make it?
- Does the patient understand the consequences of making / not making this decision?
- Is the patient able to understand / retain / use / weigh up the information relevant to the decision?
- Can the person communicate a decision by any means, including help of a specialist?
- Can the choice be made without any outside influences?

If the patient’s responses to the above are not all affirmative, then this implies she/he may lack capacity.
Any act or decision made on behalf of a person without capacity must be done / made in their best interests.

When acting in a person’s best interest:-

- Encourage participation in the decision making process.
- Identify choices the person would have taken into account when acting for themselves.
- Find out person’s views: Past / present verbal or written
  Any personal beliefs/values that may influence choices

Do not make assumption on basis of age/condition/appearance/behaviour.

Will person regain capacity?
No assumption should be made about quality of life.
Consult with others (e.g. friends, relatives, carers, lasting power of attorney, court appointed deputy). Consider using an Independent Mental Capacity Advocate.
Avoid restricting a person’s rights.

Weigh up all of these factors, discuss with MDT. Consult with independent clinician or Ethics in Clinical Practice Committee.

Arrive at a final decision
Document discussion / conclusion

Procedure
The bridle may be placed prior to or following the NG tube insertion. For guidelines on safe insertion and management of NG tubes, see Practical Guidelines on Enteral Tube Feeding in Adults, on the Trust intranet. Instructions are available in the packet.

Re Nasal Bridle

- The aseptic non-touch technique should be used
- Lubricate the distal ends of both introducing probes with water soluble jelly
- Insert the retrieving probe into the nostril until the first rib is at the bottom of the nostril
- Insert the bridle catheter into the opposite nostril with the stylet in place to stiffen it.
- Gently manipulate the probes until contact is made between the 2 magnets at the end of the probes. An audible click will be heard.
- If no contact has occurred, advance the bridge and retrieving probes to the second rib.
- Once contact has occurred, remove the stylet completely from the catheter.
- Slowly withdraw the retrieving probe while allowing the bridle catheter to advance into the nose. Continue until only the umbilical tape is in the nose.
- Using scissors cut the bridle catheter off the umbilical tape, leaving only the tape in the nose. Dispose of both the catheter tube and probe.
- Select the correct size retaining clip for the feeding tube.
- Place the umbilical tape and the NG tube in the deep channel of the clip. This should be positioned so that it just rests on the upper lip when released. Snap the 2 halves of the clip shut until it clicks. Verify that the clip has closed tightly. Knot the ends of the tape together and trim any excess tape.
- Note the position of NG tube at either end of the bridle and mark with indelible ink. Record in the patient’s notes and monitor this regularly to use as a guide when checking for feeding tube migration.
- Monitor carefully for discomfort.
- Inspect regularly for local trauma.
• Ensure the date of insertion is documented in the patients’ medical notes and/or nursing notes.

Hygiene/ After Care
Clean and dry the nasal bridle at least daily.
It may be necessary to do this more frequently if there are excessive secretions from the nose. The nasal mucosa should be observed carefully each day for signs of irritation or bleeding.
Mouth care should be provided as per the Trust’s oral hygiene guidelines.

Removal
The bridle can remain in situ for up to 6 weeks, after this there is a risk of damage to the nasal septum.
When removal is required, cut one side of the umbilical tape (between nose and clip) and gently pull both the bridle and feeding tube out at the same time.
Document removal in patients’ medical and/or nursing notes.

TRAINING REQUIREMENTS
Ensure all nurses who undertake any activities within this guideline complete the relevant documentation to evidence competency.

Flow chart for patients who repeatedly pull out NG tubes

<table>
<thead>
<tr>
<th>Patient is repeatedly pulling out NG tube (more than 3 times)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the patient confused?</td>
</tr>
<tr>
<td>YES</td>
</tr>
<tr>
<td>Establish cause for confusion</td>
</tr>
<tr>
<td>Treat accordingly. Wait 24 hours.</td>
</tr>
<tr>
<td>Reassess for nasal bridle.</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

APPENDIX D – ALERT LINKS
<table>
<thead>
<tr>
<th>Reference</th>
<th>Alert Title</th>
<th>Originated By</th>
<th>Issue Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>MDA/2017/035</td>
<td>Nasogastric (NG) feeding tubes – recall due to risk of neonatal or paediatric patient choking on ENF ...</td>
<td>MHRA Medical Device Alerts</td>
<td>19-Dec-2017</td>
</tr>
<tr>
<td>NHS/PSA/RE/2016/006</td>
<td>Nasogastric tube misplacement: continuing risk of death and severe harm</td>
<td>NHS Improvement</td>
<td>22-Jul-2016</td>
</tr>
<tr>
<td>NHS/PSA/W/2013/001R</td>
<td>Placement devices for nasogastric tube insertion DO NOT replace initial position checks</td>
<td>NHS England</td>
<td>06-Dec-2013</td>
</tr>
<tr>
<td>NHS/PSA/W/2013/001</td>
<td>Placement devices for nasogastric tube insertion DO NOT replace initial position checks</td>
<td>NHS England</td>
<td>05-Dec-2013</td>
</tr>
<tr>
<td>MDA/2013/009</td>
<td>Nasogastric feeding tubes – Ryles tubes (weighted tip). Manufactured by Vygon Ltd. Size 12FG 125cm, ...</td>
<td>MHRA Medical Device Alerts</td>
<td>26-Feb-2013</td>
</tr>
<tr>
<td>NPSA/2012/RRR001</td>
<td>Harm from flushing of nasogastric tubes before confirmation of placement</td>
<td>National Patient Safety Agency</td>
<td>22-Mar-2012</td>
</tr>
<tr>
<td>MDA/2011/003</td>
<td>Nasogastric feeding tube. Feeding tube with male Luer lock. Manufactured by Unomedical. Sizes: 4Fr ...</td>
<td>MHRA Medical Device Alerts</td>
<td>06-Jan-2011</td>
</tr>
</tbody>
</table>
APPENDIX E – EQUALITY IMPACT ASSESSMENT FORM (EQIA)

<table>
<thead>
<tr>
<th>Name of service/policy/procedure being reviewed:</th>
<th>New or existing service/policy/procedure:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Assessment:</td>
<td>For the service/policy/procedure and its implementation answer the questions a – c below against each characteristic (if relevant consider breaking the policy or implementation down into areas)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Protected Characteristic</th>
<th>a) Using data and supporting information, what issues, needs or barriers could the protected characteristic groups’ experience? For example, are there any known health inequality or access issues to consider?</th>
<th>b) What is already in place in the policy or its implementation to address any inequalities or barriers to access including under representation at clinics, screening?</th>
<th>c) Please state any barriers that still need to be addressed and any proposed actions to eliminate inequality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Race and Ethnicity</td>
<td>No direct impact identified</td>
<td>Not applicable</td>
<td>None identified</td>
</tr>
<tr>
<td>Gender</td>
<td>No direct impact identified</td>
<td>Not applicable</td>
<td>None identified</td>
</tr>
<tr>
<td>Age</td>
<td>The Policy covers older adults with cognitive impairment through acute delirium or Dementia.</td>
<td>Where required mental capacity will be assessed and decisions around NG insertion made with the managing consultant and based on the best interest of each individual patient with the involvement of patient, family and carers as appropriate.</td>
<td>None identified</td>
</tr>
<tr>
<td>Religion</td>
<td>No direct impact identified</td>
<td>Appropriate enteral liquid feed options for NG feeding are available for patients with specific dietary requirements and specialist Dietetic advice is available.</td>
<td>None identified</td>
</tr>
<tr>
<td>Disability</td>
<td>The Policy promotes mandatory safe practice. Six monthly Trust wide audits Traffic light documents are available for</td>
<td>The Trust will have a Learning Disability Specialist Lead who will help support patients with learning difficulties by</td>
<td>None identified</td>
</tr>
</tbody>
</table>

The area of policy or its implementation being assessed:

<table>
<thead>
<tr>
<th>Race and Ethnicity</th>
<th>No direct impact identified</th>
<th>Not applicable</th>
<th>None identified</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>No direct impact identified</td>
<td>Not applicable</td>
<td>None identified</td>
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<tr>
<td>Age</td>
<td>The Policy covers older adults with cognitive impairment through acute delirium or Dementia.</td>
<td>Where required mental capacity will be assessed and decisions around NG insertion made with the managing consultant and based on the best interest of each individual patient with the involvement of patient, family and carers as appropriate.</td>
<td>None identified</td>
</tr>
<tr>
<td>Religion</td>
<td>No direct impact identified</td>
<td>Appropriate enteral liquid feed options for NG feeding are available for patients with specific dietary requirements and specialist Dietetic advice is available.</td>
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<tr>
<td>Disability</td>
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<td>The Trust will have a Learning Disability Specialist Lead who will help support patients with learning difficulties by</td>
<td>None identified</td>
</tr>
</tbody>
</table>
patients with learning disabilities which prompt staff to consider what reasonable adjustments may be required, and facilitate sharing of information in regard to nutritional care and patient preferences. ensuring that advocates are available to assist in best interest decision making. If following appropriate assessment a patient with learning difficulties lacks the mental capacity to provide informed consent for procedure and ongoing care decision will be made in the best interest of each patient along with the managing consultant, with involvement of any family and carers as appropriate. Traffic light documents are available for patients with learning disabilities which prompt staff to consider what reasonable adjustments may be required, and facilitate sharing of information in regard to nutritional care and patient preferences.

<table>
<thead>
<tr>
<th>Protected Characteristic</th>
<th>No direct impact identified</th>
<th>None identified</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexuality</td>
<td>No direct impact identified</td>
<td>None identified</td>
</tr>
<tr>
<td>Pregnancy and Maternity</td>
<td>No direct impact identified</td>
<td>None identified</td>
</tr>
<tr>
<td>Gender Reassignment</td>
<td>No direct impact identified</td>
<td>None identified</td>
</tr>
<tr>
<td>Marriage and Civil Partnership</td>
<td>No direct impact identified</td>
<td>None identified</td>
</tr>
<tr>
<td>Socio-Economic Factors (i.e. living in a poorer neighbourhood / social deprivation)</td>
<td>No direct impact identified</td>
<td>None identified</td>
</tr>
</tbody>
</table>

**What consultation with protected characteristic groups including patient groups have you carried out?**
- No direct consultation undertaken as no specific barriers identified.

**What data or information did you use in support of this EqIA?**
- Review of evidence from knowledge and library service review.
As far as you are aware are there any Human Rights issues be taken into account such as arising from surveys, questionnaires, comments, concerns, complaints or compliments?

<table>
<thead>
<tr>
<th>Level of impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>From the information provided above and following EQIA guidance document Guidance on how to complete an EIA (click here), please indicate the perceived level of impact:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Low Level of Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>For high or medium levels of impact, please forward a copy of this form to the HR Secretaries for inclusion at the next Diversity and Inclusivity meeting.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name of Responsible Person undertaking this assessment: Hazel Saddington</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signature: Hazel Saddington</td>
</tr>
<tr>
<td>Date: 19&lt;sup&gt;th&lt;/sup&gt; April 2018</td>
</tr>
</tbody>
</table>