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Nasogastric Tube Feeding

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PGN No:	**Description**
NTF-PGN-01	**Insertion and Management of NG Feeding Tubes**

1 Introduction

1.1 NG feeding tubes are tubes passed into the stomach via the naso-pharynx for the purpose of providing nutrition. 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.

1.2 This policy refers to the delivery of NG feeding to children and adults who have significantly impaired dietary intake secondary to a mental illness and are in-patients on designated wards within the Trust.

1.3 At the time of writing designated wards are ward 31a, Royal Victoria Infirmary and Ferndene, Prudhoe.

2 Purpose

2.1 To ensure that safe and effective Naso-gastric (NG) feeding is delivered to service users in a timely manner when necessary for their health and well-being.

2.2 To ensure this is delivered as part of individualised biopsychosocial multidisciplinary care plan.

2.3 To ensure NG feeding is delivered in the safest and least restrictive manner possible.

2.4 To ensure that risks and benefits of NG feeding are considered fully and that NG feeding is not commenced unnecessarily or when the risks outweigh the benefits.

2.5 To ensure that consent and practice are fully compliant with legislation and professional practice.

3 Duties, Accountability and Responsibilities

3.1 Responsibility for ensuring the application of this Policy lies with the Group Medical Director of each Locality Care Group, supported by the Group Nurse Director and Associate Nurse Director

3.2 The decision to commence NG feeding should be taken by an MDT including senior doctors, dietitian and senior nursing team. The MDT should either have specialist knowledge or expertise in this area, or else should obtain advice and support from more specialist services.

3.3 Insertion and care of an NG tube should only be carried out by a professionally registered doctor or nurse who has undergone theoretical and practical training and is deemed competent or is supervised by someone competent. Practitioners must have documentary evidence that competence has been achieved. Removal of an NG tube should only be carried out by a professionally registered doctor or nurse.

4 Definition of Terms

4.1 NG feeding tubes are tubes passed into the stomach via the naso-pharynx for the purpose of providing nutrition. 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.

5 Procedure / Process

5.1 In most cases nutritional needs are best met by an oral diet based on food and or food supplements. NG feeding must only be considered if it is impossible to adequately meet nutritional needs by these means and this has led to significant physical risk from the complications of starvation.

5.2 NG feeding must only be undertaken if the benefits of the intervention outweigh the risks.

5.3 NG feeding on a psychiatric unit must always be a planned intervention agreed by a multidisciplinary team. If NG feeding is needed urgently because of immediate risk to life, then the patient should be transferred to a medical or paediatric ward.

5.4 Professionals involved in making the decision to commence NG feeding must have appropriate training and knowledge. This must include following the best practice of attempting to get consent and cooperation from the patient and only if this is not possible, will other permissions be applied. The practical procedure of NG tube insertion and administration of feed and the psychological, nutritional and legal aspects of delivering this treatment must be adhered to.

5.5 NG feeding is not a stand-alone intervention but must be delivered as part of a wider biopsychosocial approach to treatment.

5.6 NG feeding must only be carried out with valid consent from the patient, or under the correct legal framework.

5.7 Although insertion and removal of NG tubes is not categorised as an “Aerosol Generating Procedure”. It is likely that undertaking these procedures will expose staff to respiratory secretions from the patient. Therefore, if possible patients should be tested for Covid-19 prior to planned insertion or removal of an NG tube. If the patient tests positive then a higher level of PPE should be used (i.e. eye protection in addition to gloves, mask and apron). If the patient is suspected to have Covid-19, but a test cannot be undertaken prior to tube insertion or removal being performed, then the patient should be assumed to be Covid- 19 positive and a higher level of PPE should be used. If the patient has had a negative Covid-19 test within 48 hours then normal PPE can be worn (e.g. mask, apron, gloves).

6 Contraindications

The following are relative contraindications for the insertion of a NG feeding tube:

- Anatomical deformities
- Maxillo-facial surgery/trauma/disease
- Oral, nasal or oesophageal tumours/surgery
- Basal skull fractures
- Severe gastro oesophageal reflux disease
- Mucositis
- Allergies – to NG tube or securing material.

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 health care records. Such patients may require NG tube insertion under fluoroscopic control.

7 The decision to commence NG feeding

7.1 The decision to start NG tube feeding must be made following a comprehensive risk assessment of physical, nutritional and psychological factors. A senior doctor responsible for the patient's care, a senior ward nurse familiar with the patient, a dietitian and, if at all possible and appropriate, the patient and their carers must 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 and legal justification for inserting a nasogastric tube must be recorded in the patient's health care records.

7.2 Physical Risk assessment must include consideration of current weight and BMI, rate of weight loss and objective evidence of physical complications of starvation/malnutrition (junior MARSIPAN; Kings College risk assessment). Specialist advice should be sought if required e.g. from Specialist Eating Disorder Services or from a local physician, ideally a gastroenterologist or paediatrician with an interest in nutrition.

7.3 Physical risk assessment must also include an assessment by a dietitian and medical staff of the risk of re-feeding syndrome when NG feeding is commenced. This must include identification of known risk factors i.e. very low BMI, complete restriction of dietary intake, alcohol dependence, physical health co-morbidity. If the risk of developing refeeding is very high, then NG feeding must be initiated on a medical or paediatric ward and then transferred back to the psychiatric ward when medically stable.

7. 4 When using NG feeding in patients who are not eating for psychiatric or psychological reasons, clinicians must also carefully consider the diagnostic formulation applied to the patient's condition and the potential for increasing psychological risk by initiating NG feeding. Psychological risks may be particularly high for:

- those who are refusing food in order to elicit care, and who may escalate in their behaviour when interventions are withdrawn

- those who have somatoform psychopathology and may find it difficult to move away from physical interventions.

7.5 Consideration must also be given the patients capacity or competence, whether they are able and willing to give consent, and whether there are any Advance Directives or Lasting Power of Attorney in existence. It should be considered whether a legal framework (Mental Health Act or Mental Capacity Act) will be needed for treatment to proceed and whether a patient is likely to accept for resist the treatment being administered. If a patient is likely to need to be sedated or restrained in order to have an NG tube inserted or NG feed administered, then this would be an additional risk, and the threshold at which NG feeding would be considered would be higher. i.e. the risks of malnutrition should be weighed up against the iatrogenic risks of sedation and restraint. The legal rights of the patient must be explicitly addressed and recorded.

7.6 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.

7.7 Patients receiving medication which has an antacid effect are more likely to have stomach aspirate pH levels of 6 or above, making identification of an incorrectly placed tube more difficult.

8 Consent and legal Frameworks

8.1 Informed consent must be sought from a capable/competent patient prior to the insertion of a NG tube. If the patient objects or lacks capacity/competency to consent, then consideration should be given as to whether a legal framework can be used to treat the patient without their consent.

8.2 If NG feeding is required because of the malnutrition secondary to a physical illness e.g. a gastrointestinal or neurological disease, then the patient's capacity to consent to this decision must be assessed. If they lack capacity, then a Best Interests decision must be made under the Mental Capacity Act. In this case, the decision maker, must work through the Best Interests Checklist in order to ensure all relevant factors and circumstances are considered.

8.3 The assessment of capacity/competence and the decision-making process in relation to the insertion of a NG tube for a non-capacious patient must always be formally recorded in the health care records.

8.4 If NG feeding is required because of malnutrition secondary to a mental disorder e.g. anorexia nervosa or depression, then capacity/competence should still be assessed and the statutory criteria for detention under the Mental Health Act should also be considered. NG tube insertion and NG feeding can be carried out against the patient's wishes under the Mental Health Act if statutory criteria are met. The rationale and factors considered in making this decision should be clearly documented.

8.5 Although NG tube insertion and NG feeding can legally be given without consent under both the Mental Capacity Act and the Mental Health Act, his does not mean that it will be practically easy to administer. Whilst some patients may accept treatment once the legal framework is in place, others may not. Therefore, consideration must be given to how this will be practically delivered if a patient resists the intervention. This may include one-to-one supervision, sedation, or, in extreme circumstances, use of restrictive interventions. Preference must be given to the least restrictive option, with evidence recorded as to how the decision was made, will be reviewed and care planned.

9 Inserting the NG tube

9.1 NG tubes should only be inserted by registered nurses or medical doctors who have been trained and signed off as being competent in this technique. It is the responsibility of this person to complete the insertion record section of the 'Key points of care for insertion of NG tube' form. 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.

9.2 NG tubes should be inserted using the technique outlined in the CNTW PGN on NG tube insertion.

9.3 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 Specialist Practitioner i.e. Nurse Specialist or paediatric ward.

9.4 Once the tube is safely inserted, the position of the tube should be checked using techniques outlined below, and the internal tube length documented on the 'Key points of care for insertion of NG tube 'form. Thereafter this can be referred to when assessing tube position (Wallace 2002).

9.5 Insertion of NG tubes should not occur at night unless there is sufficient 24-hour senior cover available to accurately confirm placement. When a decision is made to insert an NG tube out of hours, the rationale for the decision must be documented in the patient's health care records

10 Checking NG tube position

10.1 Following initial insertion and on subsequent testing, there are only two reliable methods for checking that the NG feeding tube is correctly positioned: testing the pH of a nasogastric aspirate and chest X-ray.

10.2 PH testing of an aspirate from the NG tube is the first line test method. A pH reading between 1 and 5 confirms a correct placement and NG feeding can be commenced.

10.3 If unable to obtain an aspirate consider: changing the person's position, checking inside the mouth to see if the NG tube is coiled up, offering a drink, instilling 1-3mls air to expel any blockage such as stomach wall or debris or advancing the tube to ensure it is in the stomach (10-20cm in an adult; 1-2 cm in an infant or child).

10.4 If still unable to obtain an aspirate then a chest X-ray should be obtained to confirm correct placement. The purpose of the X-ray must be stated clearly on the form to the correct view is taken. X-rays must only be interpreted by trained and competent professionals. It must be remembered that the X-ray only confirms the position of the tube at the time of the X-ray and it can be subsequently misplaced.

10.5 Chest X-ray is the second line test method for checking tube position. Due to risks from radiation, it should not be used unless attempts to obtain an aspirate are unsuccessful.

10.6 Nasogastric tubes must not be flushed with water, nor should any feed be introduced prior to confirmation of gastric placement as this could cause aspiration pneumonia if the tube is misplaced in the lung.

10.7 The position of the NG tube should be re- checked 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, an obvious increase in external length);

10.8 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. The check should be documented on the 'Key points of care for insertion of NG tube' form.

10.9 If the internal length of the tube has changed, feed and medication must not be given via the NG tube until a further check of tube position has been made;

10.10 This further check consists of checking the pH of aspirate and where required a chest X-ray as described above. This check should be recorded both on the 'Key points of care for insertion of NG tube' form and in the patient's health care records.

10.11 If the aspirate obtained has pH of 5.5 this may be because the NGT has been misplaced into the lungs on initial insertion or become displaced at a later stage either into the intestine or the lung (pH >6.0). However, it may also be due to:

- Acid inhibiting drugs e.g. PPI's
- Presence of feed in the stomach

10.12 No other methods of checking position of tube should be used other than those outlined above.

Please refer to NTF-PGN-01 on NG tube insertion for further information on how to correctly check tube position.

11 Administration of Feed through NG tube

11.1 Ideally, a dietitian will be involved in the decision to start NG feeding. If not, then an urgent dietetics referral should be made as soon as the decision has been taken.

11.2 The feed regime prescribed by the dietitian will be recorded on RIO under "service specific files>dietetics>feeding regime". Feeds will also be written onto the medication prescribing chart. Feed should only be administered by a registered nurse who has received appropriate training

11.3 Feeds can be administered via feeding pump (either continuously or as pump assisted bolus') or as a syringe bolus. The decision regarding the use of continuous or bolus feeding should be patient centred and based upon the individual's symptoms, therapeutic interventions and patient preferences.

11.4 It is important to discuss the method of NG feeding with both the patient and/or their carer and multidisciplinary team to determine the most suitable enteral feeding regime.

11.5 The volume of a bolus feed must not exceed 1,000 mls in total (including fluid flushes).

11.6 If feeding under restraint, the multi-disciplinary team must weigh up the risks of prolonged restraint against the risk of feeding large volumes of feed in a short space of time. The aim being to ensure that a nutritionally adequate feed can be administered in the safest manner possible.

11.7 Feeds must be stored according to manufacturer's guidelines. For more detailed explanation of types of feeding refer to Trust Nutrition policy.

11.8 If other prescribed medications are to be administered via an enteral tube, pharmacy should be contacted to advise on how this should be undertaken

12 Refusal of NG insertion/feeding

12.1 Should a patient refuse NG feeding, it is paramount that every avenue is explored prior to using restrictive interventions.

12.2 Patient's often struggle to accept and rationalise the need for NG feeding and may require a lot of reassurance, support and guidance prior to accepting

this. For example, an explanation of the whole procedure from a member of staff the patient knows and has a therapeutic relationship with. The member of staff will spend time informing and discussing with the patient what they are going to do and what this entails, by answering any questions that they may have about the procedure. This includes a step by step process of how the NG tube will be inserted and who will be involved. Staff must always be open and honest with patients.

12.3 This explanation should ideally occur over a period of time, to allow the patient to process the information. If safe to do so, the patient should be given a trial period of oral diet (food or supplement drinks or a combination) to see if they can avoid the need for NG feeding. The length of trial that is appropriate depends on the degree of risk.

12.4 A key factor whilst placing the NG tube is reminding the patient that they are able to pause the insertion, remaining collaborative in their approach throughout. Where possible try to minimise the volume of staff involved with the planning and implementation of an NG feeding regime. Staff should remain calm in both their manner and tone, trying to work collaboratively with the patient where possible.

12.5 If the patient continues to refuse NG feeding and they are informal – a mental health act assessment may be required. This should be discussed within the whole MDT, ensuring that all least restrictive options have been explored and ensuring the patient has full involvement with the process where possible. This could be by exploring different options i.e. supplement drinks. However, if the patient remains at significant risk, continues to refuse NG feeding and all safe alternatives have been tried then a MHA assessment should be arranged.

12.6 If the patient continues to refuse NG feeding, if risk from starvation is serious and potentially life threatening, and the patient is detained under the Mental Health Act, use restrictive interventions should be considered. In this case, an individual care plan must be drawn up in consultation with CNTW tutors and training department. This is to ensure the safest possible plan is put in place. The use of restrictive interventions should not replace the continued use of verbal de-escalation, psychological interventions and therapeutic engagement with the patient.

12.7 The need for NG feeding must be frequently and regularly reviewed. Where restrictive interventions are required, the need for continued NG feeding versus the risks of restraint must be reviewed daily by the MDT. When restrictive interventions are regularly required, then the care plan must be formally reviewed by the MDT on a weekly basis. This must include review of the psychological formulation, consideration of the maintaining factors and whether the care plan is inadvertently providing positive reinforcement for certain behaviours.

12.8 Where restrictive interventions are required, consideration must be given to use of syringe bolus feeds, to reduce the time the patient remains in restraint. This should be weighed against the risks of giving large amounts of feed in a short space of time.

13 Managing tube removal

13.1 Due to distress, some patients may remove tube overtly, others may damage the tube so that they do not function properly i.e. become blocked or leak.

13.2 If a tube is removed or damaged, then this should be replaced as soon as possible, and NG feeding regime continued as planned with minimal interruption.

13.3 To maximise effectiveness of NG feeding, there should always be staff available who are competent to insert NG tubes.

13.4 A care plan should be made, following MDT discussion, as to what should be done if NG tube insertion is required and no competent staff are available. This should include an assessment of the risks of having a break in feeding versus the risk of transferring to another unit/ward for insertion. There may need to be a different care plan for in-hours and out-of- hours, depending on local resources.

13.5 If a patient on bolus feeding repeatedly removes the NG tube, and NG feeding is still considered necessary, then the tube may need to be reinserted at a planned time immediately prior to administration of each feed.

13.6 If a patient on continuous feeding repeatedly damages the tube, or interferes with delivery of feed, then continuous one-to-one supervision must be considered.

14 NG feeding as part of a wider care plan

14.1 NG feeding for patients who have disordered eating secondary to a mental disorder must never be a stand-alone intervention but must be part of a multi-disciplinary biopsychosocial care plan. This must include:

- on-going dietetic review
- monitoring of weight and physical health parameters affected by starvation and refeeding.
- nursing interventions aimed at increasing engagement, developing a therapeutic relationship with the patient and increasing motivation to change
- management of anxiety, distress and agitation related to the refeeding process
- development of an individual psychological formulation for the patient, to allow understanding of the function of dietary restriction, maintaining factors for their illness and what might motivate them to change.
- identification and treatment of the underlying cause of the dietary restriction e.g. anorexia nervosa, depression, personality disorder
- regular review of capacity and consent and the need for a legal framework to administer NG feeding.
- regular MDT discussion and review.

15 Discontinuation of NG feeding

15.1 Whenever NG feeding is commenced, consideration must be given to how and when it will be discontinued. This must be discussed and agreed with the MDT and the patient and carers if appropriate

.

15.2 If the patient is receiving planned feeds instead of oral diet, generally the amount of feed should be reduced in a stepwise fashion, as the amount of food (or supplement drinks) are increased.

15.3 While NG feeding should be discontinued as soon as possible, it is also important to consider the pace of change which the patient is able to manage. This should be a collaborative process working with the patient and the MDT to determine the pace of change.

15.4 Careful consideration must be given to what factors may motivate the patient to change and what behaviours are being positively reinforced by the care plan.

16 Community NG feeding

16.1 Patients requiring NG feeding for malnutrition secondary to a mental disorder would rarely be discharged to the community if NG feeding is still required.

16.2 Discharging a patient from Acute to Community Services with an NGT in place requires careful planning. A multidisciplinary risk assessment should be performed, which should include relevant Dietitian and Community Services.

17 Learning Events

17.1 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 the Trust Clinical Governance and Risk Department and recorded as an incident on the incident system.

17.2 Local learning across the organisation and at a service level is imperative to promote the culture of positive patient safety. To do this, the NG tube pooled team will have access to clinical monthly supervision as a group and there will be case audit as part of this process. This will be led by the Lead Educator and themes identified 3 monthly for learning with team members and sharing across the organisation. This will include reviewing the insertion and management of the NG tube alongside the management of the mental health aspects of care.

17.3 To support a positive patient safety culture, there will be an expectation that the incident system will be used to record near miss and any harm caused to patients in order that we can learn and reflect on the management of individual cases. The incidents will follow the normal reporting hierarchy but will also be copied into the lead educators. Incidents that relate to harm will follow the

usual incident management processes. Incidents that are recorded on the CNTW system but relate to other organisations will be shared through the usual incident management processes.

17.4 As this is a new area of work and with very low numbers of patients who have this intervention, the policy will be reviewed six monthly and after the first year of implementation alongside the audit findings and always following a serious safety incident. Where there is system wide learning, this will be directly shared with the Directors of Nursing.

17.5 Learning from feedback from service users and their carers will be integral to the development of the team. Service user feedback will also be collated through individual one to one discussion as appropriate with patients and include family members.

17.6 During the first year of operation, it is envisaged that the NG Tube working group will meet monthly to review the policy application, review of incidents and learning to support the policy implementation and operational delivery and provide strategic organisational oversight. This group will report to the Physical Health Group, (correct name). During this meeting, the performance information will be reviewed to monitor compliance and provide assurance.

18 Identification of Stakeholders

This is a new policy therefore circulated to those listed below for a period of 2 weeks.

- North Locality Care Group
- North Cumbria Locality Care Group
- Central Locality Care Group
- South Locality Care Group
- Corporate Decision Team
- Business Delivery Group
- Safer Care Group
- Communications, Finance, IM&T
- Commissioning and Quality Assurance
- Workforce and Organisational Development
- NTW Solutions
- Local Negotiating Committee
- Medical Directorate
- Staff Side
- Internal Audit
- Health Safety Security and Resilience

19 Training

19.1 All staff who insert NG tubes and perform testing of gastric aspirate must have been trained to do so.

19.2 A competence assessment form can be found as Appendix 3. This form can be used a documentary evidence of ability to safely insert a nasogastric tube

19.3 Training will be provided by professionals from Newcastle Upon Tyne Hospitals Foundation Trust as part of a Service Level Agreement.

20 Implementation

20.1. The Policy will only be implemented immediately following ratification within Ferndene and Ward 21A.

20.2 Compliance with this Policy will be monitored by the Clinical Nurse Manager, who will monitor the number and type of incident and carry out spot check audits.

21 Equality and Diversity

In conjunction with the Trust's Equality and Diversity Officer this policy has undergone an Equality and Diversity Impact Assessment which has taken into account all human rights in relation to disability, ethnicity, age and gender. The Trust undertakes to improve the working experience of staff and to ensure everyone is treated in a fair and consistent manner. (See Appendix A)

22 Fair Blame

The Trust is committed to developing an open learning culture. It has endorsed the view that, wherever possible, disciplinary action will not be taken against members of staff who report near misses and adverse incidents, although there may be clearly defined occasions where disciplinary action will be taken.

23 Fraud and Corruption

In accordance with the Trust's policy CNTW(O)23 – Fraud and Corruption/Response Plan, all suspected cases of fraud and corruption should be reported immediately to the Trust's Local Counter Fraud Specialist or to the Executive Director of Finance.

24 Monitoring

This policy will be reviewed at 6 months taking into consideration audit findings, staff and patient feedback. The NG Tube Task and Finish group will develop into a monitoring group reporting into the Physical Health Care Committee and the Nutrition sub group.

25 Associated documents

Clinical Policies should always consider the links to:

CNTW(C)04 Safeguarding Children Policy
CNTW(C)24 Safeguarding Adults at Risk Policy

CNTW(C)27 Nutrition Policy

CNTW(C)16 – Positive and Safe Recognition, Management of Violence and Aggression PMVA policy

"Caring for adult and paediatric patients with enteral feeding tubes"
Newcastle upon Tyne Hospitals NHS Foundation Trust March 2018

26 References

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Appendix A

Equality Analysis Screening Toolkit			
Names of Individuals involved in Review	**Date of Initial Screening**	**Review Date**	**Service Area / Locality**
Linda Bennetts Dr Caroline Reynolds	Oct 2020	Oct 2021	Trust wide
Policy to be analysed		**Is this policy new or existing?**	
CNTW(C)61 – Nasogastric Tube Feeding- Ferndene and Ward 31A		New	
What are the intended outcomes of this work? Include outline of objectives and function aims			
To support the safe use of NG tubes in ward 31A and Ferndene			
Who will be affected? e.g. staff, service users, carers, wider public etc			
Service users and guidance for staff			
Protected Characteristics under the Equality Act 2010. The following characteristics have protection under the Act and therefore require further analysis of the potential impact that the policy may have upon them			
Disability	Consider and detail any evidence on attitudinal, physical and social barriers. None noted		
Sex	Consider and detail any evidence on men and women (potential to link to carers below).none noted		
Race	Consider and detail any evidence on difference ethnic groups, nationalities, Roma gypsies, Irish travellers, language barriers. None noted		
Age	Consider and detail any evidence across age ranges on old and younger people. This can include safeguarding, consent and child welfare. none noted		
Gender reassignment (including transgender)	Consider and detail any evidence on transgender and transsexual people. This can include issues such as privacy of data and harassment. None noted		
Sexual orientation.	Consider and detail any evidence on heterosexual people as well as lesbian, gay and bi-sexual people. None noted		
Religion or belief	Consider and detail any evidence on people with different religions, beliefs or no belief.. None noted		
Marriage and Civil Partnership	Consider and detail any evidence on working arrangements. None noted		
Pregnancy and maternity	Consider and detail any evidence on working arrangements, part-time working, and infant caring responsibilities. None noted		
Carers	Consider and detail any evidence on part-time working, shift-patterns, and general caring responsibilities. None Noted		
Other identified groups	Consider and detail other groups experiencing disadvantage and barriers to access. None Noted		

How have you engaged stakeholders in gathering evidence or testing the evidence available?
Yes. The NG tube focus group has been representative of the clinical areas where the policy will be used.
How have you engaged stakeholders in testing the policy or programme proposals?
Yes through the focus group and presentation at BDG. Discussed at Physical health group
For each engagement activity, please state who was involved, how and when they were engaged, and the key outputs:
A task and finished group explored the options and no exceptions were noted. service users have also been consulted through the clinical teams
Summary of Analysis Considering the evidence and engagement activity you listed above, please summarise the impact of your work. Consider whether the evidence shows potential for differential impact, if so state whether adverse or positive and for which groups. How you will mitigate any negative impacts. How you will include certain protected groups in services or expand their participation in public life.
This policy will ensure that patients have an increased service within the trust and have less need to have NG tubes inserted within an acute hospital unless it is clinically indicated. This reduces the restrictive interventions used and increases patient experience.
Now consider and detail below how the proposals impact on elimination of discrimination, harassment and victimisation, advance the equality of opportunity and promote good relations between groups. Where there is evidence, address each protected characteristic

Eliminate discrimination, harassment and victimisation	Awareness training is being provided as part of a tier approach from awareness raising through to detailed specific training.
Advance equality of opportunity	The decision to use the policy is linked to a clinical decision as to what is best for the patient. This will be audited.
Promote good relations between groups	Ongoing service user feedback and staff supervision groups monthly.
What is the overall impact?	Consider whether there are different levels of access experienced, needs or experiences, whether there are barriers to engagement, are there local variations and what is the combined impact? The only variations are based upon clinical presentation and treatment needs.
Addressing the impact on equalities	Please give an outline of what broad action you or any other bodies are taking to address any inequalities identified through the evidence. This is being addressed through 3 levels of training. 1. Awareness of NG tubes. 2. Guidance and support for monitoring of refeeding and clinical observations to patients

	who have an NG tube 3. Bespoke training for the group of staff working in the specific clinical areas to insert and re insert Ng tubes. There are two clinical teams to manage the difference in age and presentations, he team at Ferndene and the team at ward31A

From the outcome of this Screening, have negative impacts been identified for any protected characteristics as defined by the Equality Act 2010?

If yes, has a Full Impact Assessment been recommended? If not, why not? NO, THIS HAS BEEN MITIGATED WITHIN THE TRAINING AND SUPERVSION PROGRAME AND THE ENED TO RUN TWO SEPARATE TEAMS BESPOKE TO PATIENTS AGE AND THERFORE LEGAL REQURIEMENTS.

Manager's signature: LJ Bennetts Date: Oct 2020

Appendix B

Communication and Training Check list for policies
Key Questions for the accountable committees designing, reviewing or agreeing a new Trust policy

Is this a new policy with new training requirements or a change to an existing policy?	This is a new policy based upon a previous PGN. New training is put in place as above.
If it is a change to an existing policy are there changes to the existing model of training delivery? If yes specify below.	Yes bespoke training via an SLA with NUTH
Are the awareness/training needs required to deliver the changes by law, national or local standards or best practice? Please give specific evidence that identifies the training need, e.g. National Guidance, CQC, NHS Resolutioins etc. Please identify the risks if training does not occur.	Yes There are different age requirements and safeguarding arrangements and therefore different consent processes which will be taught through bespoke sessions. 1. Ferndene under 18 2. Ward 31A over 18
Please specify which staff groups need to undertake this awareness/training. Please be specific. It may well be the case that certain groups will require different levels e.g. staff group A requires awareness and staff group B requires training.	Ferndene and ward 31A 1. Awareness of NG tubes within the clinical setting. 2. Guidance and support for monitoring of refeeding and clinical observations to patients who have an NG tube 3. Bespoke training for the group of staff working in the specific clinical areas to insert and re insert Ng tubes. There are two clinical teams to manage the difference in age and presentations, he team at Ferndene and the team at ward31A
Is there a staff group that should be prioritised for this training / awareness?	Yes,, dates booked for Ferndene
Please outline how the training will be delivered. Include who will deliver it and by what method. The following may be useful to consider: Team brief/e bulletin of summary Management cascade Newsletter/leaflets/payslip attachment Focus groups for those concerned Local Induction Training Awareness sessions for those affected by the new policy Local demonstrations of techniques/equipment with reference documentation Staff Handbook Summary for easy reference Taught Session E Learning	Booked sessions via NUTH leads as part of an SLA. 1. Ferndene via specialist Educator post. 2. The same model is being put into place for ward 31A This is also supported by each team having access to monthly supervision to learn and share experience. A training schedule will be written. Training 2-3 times a year to include doctors in training and new starters to the service
Please identify a link person who will liaise with the training department to arrange details for the Trust Training Prospectus, Administration needs etc.	Linda Bennetts

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Appendix B – continued

Training Needs Analysis

Staff/Professional Group	Type of training	Duration of Training	Frequency of Training
Ferndene MDT all	Awareness training	2-3 hours	Once only
All registered professionals and band 4	Level two training	2-3 hours	Annually
Bespoke NG team	Level 3-	2 day	Initial training and update 6 monthly for bespoke refresher session
Ward 31A MDT all	Awareness training	2-3 hours	Once only
All registered professionals and band 4	Level two training	2-3 hours	Annually
Bespoke NG team	Level 3-	2 day	Initial training and update 6 monthly for bespoke refresher session

Appendix C

Monitoring Tool

Statement

The Trust is working towards effective clinical governance and governance systems. To demonstrate effective care delivery and compliance, policy authors are required to include how monitoring of this policy is linked to auditable standards/key performance indicators will be undertaken using this framework.

Nasogastric Tube Feeding in Ferndene and Ward 31A - Monitoring Framework			
Auditable Standard/Key Performance Indicators		**Frequency/Method/Person Responsible**	**Where results and any Associate Action plan will be reported to implemented and monitored;** (this will usually be via the relevant Governance Group).
1.	Decision making processes are followed and the patient is included in this decision	6 monthly	NG Tube practice development group reporting to the Physical Health Care Committee
2.	Audit of training and supervision of the MDT and bespoke NG Tube teams	6 monthly	NG Tube practice development group reporting to the Physical Health Care Committee
3.	Review of incident, complaints and feedback	6 monthly themed review but monthly review within supervision group	NG Tube practice development group reporting to the Physical Health Care Committee
4.	Appendix 1of NTF-PGN-01 Insertion and Management of NG Feeding Tubes Audit of NG tube intervention sheet.	Monthly in supervision and formally at 6 month themed review but monthly review within supervision group	NG Tube practice development group reporting to the Physical Health Care Committee

The Author(s) of each policy is required to complete this monitoring template and ensure that these results are taken to the appropriate Quality and Performance Governance Group in line with the frequency set out.