

Nasogastric Insertion & Management for Adult Eating Disorders (In-Patients)

Ref CLIN-0078-v3

Status: Approved

Document type: Procedure

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1 Purpose

Following this procedure will help the Trust to:-

- To promote a clear, consistent and evidenced based approach to the insertion, care and management of Nasogastric (NG) tubes.
- To support the information provided by the Royal Marsden Manual On-line.
- To promote the safety and well-being of all patients who require NG enteral feeding.
- This procedure has been developed with evidence and guidance from the National Patient Safety Agency (NPSA) Alerts, Field Safety Notices (FSN) and the Medicines and Healthcare Products Regulatory Agency (MHRA).
- To provide clinical staff with supplementary evidence for managing adult patients requiring enteral feeding with a Mental Health and/or Learning Disability diagnosis.

Exceptions to Purpose



This policy is primarily for use with adults who have a diagnosis of an eating disorder. The insertion and management of a NG can only be implemented in practice by clinicians who are trained and deemed competent in this procedure. The NG policy is not designed for use outside of a specific eating disorder in-patient setting. If NG feeding is considered an option in another clinical area in the trust this would require escalation for senior management approval.



Children and Adolescent Mental Health Services (CAMHS)

Please refer to the separate relevant local CAMHS / Paediatric pathways for information in relation to assessment of refeeding syndrome and naso-gastric feeding.

2 Related documents



The Physical Health and Wellbeing Policy (Inpatients and Community) CLIN-0084-V2 must read, understood and clinicians be trained in before carrying out the procedures described in this document.

This procedure also refers to:-

- ✓ [Royal Marsden Manual Online \(RMMO\)](#)
- ✓ Medical Devices Policy
- ✓ Standard (Universal) Infection Prevention and Control Precautions
- ✓ Hand Hygiene Procedure
- ✓ Decontamination of Equipment Procedure
- ✓ Safe use of Physical Restraint Techniques
- ✓ Procedure for Using the Early Warning Score for the Early Detection and Management of the Deteriorating Patient
- ✓ [Mental Capacity Act 2005](#)
- ✓ [Mental Health Act 1983 \(2007\)](#)
- ✓ [Human Rights Act 1998](#)

3 Nasogastric Insertion and Feeding

Nasogastric and orogastric feeding has been common practice within healthcare in all patient groups. Thousands of nasogastric feeding tubes are inserted daily without incident, however there is a small risk that the nasogastric feeding tube can be misplaced in the lungs during insertion, or can migrate out of the stomach at a later stage.

The introduction of enteral feed, fluids or medication into the respiratory tract, lungs or pleura via a misplaced nasogastric tube is categorised as a 'Never Event'. Use of misplaced nasogastric tubes was 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 2011-2013 (NHS Improvement, 2016).

Between September 2011 and March 2016, 95 incidents were reported to the NRLS where enteral feed, fluids or medication were introduced into the respiratory tract or pleura via misplaced nasogastric tubes. These incidents show that risk to patient safety persist with misinterpretation of x-rays by medical staff who have not received the required competency based training as the most common type of error; other errors include ineffective pH testing, unapproved placement checks and communication failures. The incidents reported to the NRLS have involved multiple clinical staffing groups including medical, nursing and ambulatory care staff. This procedure reflects the NPSA guidance (2011, 2016).



Administration of enteral feeding, fluids or medication through a misplaced tube into the respiratory tract or pleura instead of the stomach can be fatal. This procedure has been developed to support clinical staff in the correct insertion of both wide and fine bore nasogastric (NG) feeding tubes and in the confirmation of tube placement to reduce risk to patients in line with current evidence based practice and RMMO.

3.1 Indications and contra indications for nasogastric tube feeding

Nasogastric tube feeding is an option for patients who require short term enteral nutrition and feeding i.e. 4-6 weeks. It can also be used to administer fluids and some prescribed medications to the stomach



As an invasive procedure all staff involved in the insertion and management of a nasogastric (NG) tube must be aware of the following associated risks which include, but are not limited to:

- Misplacement of the tube
- Perforation
- Pneumothorax
- Aspiration

Indications for Nasogastric feeding

NG tube feeding is suitable for patients who:

- Are malnourished and/or cannot fulfil adequately their individual fluid requirements orally
- Have a functioning GI tract.
- Require short-term tube feeding (up to 4-6 weeks)
- Have been unable to fulfil their nutritional requirements with normal /modified diet +/- nutritional supplements
- Are not predicted to fulfil their nutritional requirements with normal / modified diet +/- nutritional supplements
- Have increased nutritional requirements e.g. sepsis, trauma, post-op stress & burns, anorexia nervosa
- Have a diagnosis of dysphagia which means they cannot manage consistently sufficient nutrition and/or fluids to meet their needs
- Require prescribed medications which they are unable to consistently swallow
- Have altered levels of consciousness which make it very difficult for them to manage consistently adequate amounts of nutrition, hydration or prescribed medications
- Experience regular and at times prolonged episodes of food refusal e.g. anorexia nervosa, pervasive refusal disorder, which can result in a very limited oral intake and a high malnutrition risk

(NB This is not an exhaustive list, other conditions/reasons may be considered on an individual basis)

Nutrition support should be considered in people who are malnourished, as defined by any of the following:

- a BMI of less than 18.5 kg/m²
- unintentional weight loss greater than 10% within the last 3–6 months
- a BMI of less than 20 kg/m² and unintentional weight loss greater than 5% within the last 3–6 months.
- Nutrition support should be considered in people at risk of malnutrition who, as defined by any of the following:
 - have eaten little or nothing for more than 5 days and/or are likely to eat little or nothing for the next 5 days or longer
 - have a poor absorptive capacity, and/or have high nutrient losses and/or have increased nutritional needs from causes such as catabolism. (NICE 2006)

Contra-indications to the placing of nasogastric tubes include:

Absolute contraindications

- Non-functioning GI tract e.g. ileus
- Complete obstructive pathology in oropharynx, oesophagus preventing passage of the tube (e.g. stricture, tumour)
- Large gastric aspirate and/or high risk of aspiration (includes mechanical pyloric obstruction due to tumour or stricture)
- Intractable vomiting not resolved by adequate anti-emetic
- Significant known allergies to the nasogastric tube and/or securing material where appropriate alternatives cannot be sourced

Relative contraindications

- Mask C.P.A.P
- Basal skull fracture, as the tube may enter the brain if malpositioned - in this instance insertion needs to be under direct vision with a laryngoscope or naso-endoscope (if not available the orogastric route may be used as an alternative)
- Oesophageal varices
- Severe gastro oesophageal reflux disease
- Mucositis
- Vomiting responding to anti-emetics
- Anatomical deformities including maxillo facial disorders, surgery or physical trauma to the area – these to be assessed on an individual basis

Clinical circumstances where an enteral feeding tube must be inserted under endoscopic or radiological guidance:

- Partial obstructive pathology in oropharynx or oesophagus preventing passage of the tube (e.g. stricture, tumour)
- Previous partial, total or extended total gastrectomy
- Any previous bariatric surgery



Consent

Verbal consent for the procedure should be sought and valid informed consent obtained prior to the procedure. Where a nasogastric tube is to be used for feeding purposes, patients and carers should be made aware of the associated complications which may be caused by tube insertion or misplacement, and the procedures which should be taken to prevent this.

If the patient is unable to give informed consent due to incapacity, the tube may be inserted if it is considered to be in the patient's best interests to do so.

For patients who do not have the capacity to consent, in order to comply with the Mental Capacity Act 2005, the following process and PARIS documentation needs to be completed:

1. The Mental Capacity Assessment for insertion of an NG tube for enteral feeding, fluids and/ or medication, completed on the PARIS mental capacity assessment form.
2. PARIS documentation must be completed and state the risks and benefits of an NG tube for enteral feeding, fluids and/ or medication.

For treatment where there is a confirmed mental health diagnosis e.g. anorexia nervosa and NG refusal, the Mental Health Act 1983 (2007) would need to be considered for treatment under section. This must be clearly documented on PARIS and in the patients' medical notes



Individual consideration will be part of the intervention to place a NG. At all times the patient will be part of and involved in the process. If needed adaptations and change to the process will be made in order to respect and consider the individual needs of the patient. The Human Rights Act 1998 must be taken into consideration at all times when implementing this clinical intervention

3.2 The Decision to Insert a Nasogastric Feeding Tube

- ✓ A decision to insert a Nasogastric tube for the purpose of feeding, hydration or the administration of prescribed medication must be made by the multi-disciplinary team responsible for the patient's care.
- ✓ Prior to insertion a referral to a Dietitian should always be made for nutritional assessment and the recommendation of an appropriate feeding regime.
- ✓ Any medications placed down a NG must be in agreement with the pharmacist responsible for the patient's treatment and only medications which are prescribed can be considered
- ✓ The decision to insert a NG should only be made following careful assessment of the risks and benefits of the procedure which the patient should be made aware of and where possible agree to
- ✓ Prior to insertion the rationale for insertion of an nasogastric feeding tube must be considered and responses to the following documented on the Nasogastric insertion intervention plan within Paris:
 - Is nasogastric tube feeding the right decision for this patient?
 - Has the psychological impact of inserting a nasogastric and providing enteral feed been considered? Is this documented?
 - Is this the right time to place the nasogastric feeding tube and is appropriate equipment available?
 - Is there sufficiently trained staff available at this time to test for safe placement?
- ✓ The rationale for inserting a nasogastric tube should be recorded clearly in the patient's PARIS record and medical notes.
- ✓ Once a NG is in use the ongoing rationale for continuing to use this method of delivery for nutrition, hydration or medication must be made by the MDT. The MDT should review this practice on a regular basis. The recommendation review period for an in-patient is a minimum of weekly
- ✓ This ongoing rationale should also be documented regularly in the patients PARIS record and medical notes



Nasogastric feeding tubes should only be placed when there is experienced support available for nasogastric tube insertion and for confirming the nasogastric tube position.

Unless clinically urgent, if there is insufficient, experienced staff available (for example at night), placement should be delayed until that support is available. Rationale for any decisions made should be recorded on the intervention plan within Paris.

Due to the ongoing management needs for a patient requiring enteral feeding, planned admissions should only occur if a comprehensive assessment has been completed. A detailed care plan should be developed to reflect this assessment.

3.3 Nasogastric intubation with tubes using an internal guidewire or stylet

- ✓ The Royal Marsden Manual of Clinical Nursing Procedures On-line (RMMO) is available to all trust staff. This on-line tool provides best practice information on pre, peri and post insertion of the NG tube.
- ✓ Pictorial Guidance is available on performing measuring the distance on the tube from the patient's earlobe to the bridge of the nose plus the distance from the earlobe to the bottom of the xiphisternum (the NEX measurement).
- ✓ All clinicians inserting Nasogastric tubes must be trained and assessed as competent in the technique before undertaking the procedure.
- ✓ Staff should perform effective hand hygiene before, during and post procedure. As this involves direct clinical contact they should be bare below the elbow and the use of personal protective equipment is essential.
- ✓ The equipment can be ordered via Cardea using the Trust Approved Medical Device Template- Enteral Equipment (PEG/NG). For any additional equipment not listed within the replace please refer to the trust Medical Devices Team

3.4 Confirming correct placement of a nasogastric feeding tube

First Line Test Method: pH Testing

Correct placement of a nasogastric feeding tube should be established by aspirating 0.5-1ml of stomach contents and placing a drop of aspirated fluid on **pH** indicator strips (**CE marked**) which must be available in all clinical areas that use nasogastric feeding tubes.



- Aspirate 0.5-1ml of stomach contents using a sterile syringe and test using CE marked pH paper.
- If a pH of between **1** and **5.5** has been obtained, feeding maybe commenced.
- The pH reading should be documented on the NG Tube Insertion and Management Form.
- The NPSA has identified the potential difficulty experienced by some staff in differentiating pH readings using currently available pH indicator paper between pH 5 and 6 It is therefore recommended that two competent members of staff check any readings that fall within the pH range of 5 to 6. The second check should be undertaken by a registered nurse, who has completed their competency assessment.
- pH can be affected by frequency of feeds and medication, for example antacids, H2 receptor antagonists and proton pump inhibitors could elevate the pH reading.
- Consideration should be given to changing the timing of medication administration or aspiration to enable correct pH readings to be carried out.
- In these rare situations a chest x-ray may be required and should be arranged by medical staff with the local acute hospital.



Clinical staff undertaking pH testing must be **trained** and **assessed** as competent in the technique.

Second line test method: X-ray

X-ray is used only as a second line test when no aspirate could be obtained or pH indicator strips have failed to confirm the location of the nasogastric feeding tube.



- The request form must clearly state that the purpose of the x-ray is establish the position of the nasogastric tube for feeding.
- X-rays must be interpreted and nasogastric tube position confirmed by someone competent to do so.
- If there is any difficulty in interpretation the advice of the radiologist should be sought.

The following methods **MUST NOT BE USED** to test the position of nasogastric feeding tubes:



- Use of Litmus paper
- Auscultation –introducing air into the nasogastric tube and checking for a bubbling sound via a stethoscope
- Absence of respiratory distress

These tests are not accurate or reliable to confirm the position of a nasogastric tube, as they have been shown to give false positive results. The NPSA (2011) reported 21 deaths and 79 cases of harm occurred since NPSA Alert of 2005 due to misplaced nasogastric tubes using unreliable testing methods.



Following the checks detailed if the nasogastric feeding tube is found to be in the lung the feeding tube should be removed immediately. This must be recorded on Paris and in the patients' medical notes.

3.5 When should testing take place?

Regular checks of nasogastric feeding tube placement are imperative as there is a risk that tubes can be misplaced into the lungs on insertion or can migrate out of the stomach at a later stage. Once inserted the tube must be securely fixed to the patients face with hypertape (after first checking no allergy to this tape) and marked next to the nostril so any movement or migration of the tube is clearly evident to clinicians. This must be documented on the appropriate NG paper work and on PARIS



ONLY CLINICIANS WHO HAVE UNDERGONE AND BEEN SIGNED OFF AS BEING COMPETENT THROUGH THE TRUSTS 'COMPETENCY ASSESSMENT PROCESS INSERTION AND CARE OF NASOGASTRIC TUBES' TRAINING PACKAGE ARE ELEGIBLE TO PASS AND THEN MONITOR THE ONGOING USE IN PATIENTS. It is the responsibility of the individual clinician to ensure they are fully trained in the use of NG and their competency is up to date



Nasogastric feeding tube position should be checked in the following circumstances:

- Following insertion of the nasogastric feeding tube
- Before administration of medication or commencement of feed
- At least once a day if the patient is on continuous feed (stop the feed for an hour, flush with water and then check the pH before restarting the feed).
- Following episodes of vomiting, retching or coughing spasms
- 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

In addition:

Tube length should be recorded on a daily basis and prior to administration of any liquid via the nasogastric tube. If there is any indication that the length of the tube has changed appropriate action should be taken to assess tube tip position prior to using the nasogastric tube. Staff must ensure that before and after the nasogastric tube is used for any nutrition or medication it must be flushed with sterile water to ensure it is not blocked and functioning correctly. Aspirates must be taken before any flushes are administered. If the tube is in place but not currently being used it must be flushed with sterile water a minimum of once every 24 hours to reduce the risk of it blocking and maintain hygiene

The integrity and hygiene of the tube should also be checked before use and if there are any concerns it should be replaced immediately. Due to the increased risk of infection connected to their use nasogastric tubes must be replaced as standard irrespective of their use every 4 weeks and this change documented in the patients PARIS record and medical notes

3.6 Record Keeping and Documentation



At insertion of the nasogastric feeding tube record the following on PARIS and NG tube checklist:

- Type and size of tube
- External length of tube or cm marking at nostril
- pH of aspirate
- Which nostril the tube is placed in

At each subsequent test document on PARIS and NG tube checklist:

- The external tube length measurement or cm marking at nostril, checked against the initial measurement for signs of movement.
- The pH reading
- Any actions taken.

Documentation following X-ray should include:

- Who authorised the x-ray
- Who confirmed the position of the nasogastric tube? The person must be assessed as competent to do so.
- A clear instruction whether it is 'safe to feed' or other required actions, which reduces the risk of communication error.

The decision to feed a patient following X-ray confirmation of Nasogastric tube must be documented in the patient's PARIS record dated, timed and signed by that person.

All feeds must be initiated on the prescription and administration chart by the Dietitian. Transcription on to new charts must be undertaken by a Dietitian or suitably qualified prescriber.

Administration of feeds must be signed on the prescription and administration chart by the nurse undertaking the feeding and complete the nutritional supplement chart

3.7 Nasogastric insertion under Physical Intervention



Use of this approach under the application of physical intervention should only be carried out as part of a behaviour support plan and in line with TEWV's clinical procedure for Safe Use of Physical Restraint Techniques.

During insertion under physical intervention staff must be aware that on occasion the nasogastric tube can migrate from the stomach or become damaged. Please ensure all visual and confirmation of correct placement checks are undertaken prior to using commencing enteral feeding or administering medication.

- ✓ A decision to insert a Nasogastric tube for the purpose of feeding, hydration or the administration of prescribed medications under the application of physical intervention must be made by the MDT responsible for the patient's care including input from the patients responsible clinician
- ✓ The decision to insert a nasogastric tube under the application of physical intervention should only be made following careful assessment of the risks and benefits which have been made clear to the patient and after which where possible they have consented to the treatment
- ✓ Prior to insertion under the application of physical intervention a referral to a Dietitian should always be made for assessment and the recommendation of an appropriate feeding regime.
- ✓ Prior to insertion under the application of physical intervention any medications placed down a NG must be in agreement with the pharmacist responsible for the patient's treatment and only medications which are prescribed can be considered
- ✓ Prior to insertion under the application of physical intervention the rationale for insertion of an nasogastric feeding tube must be considered and responses to the following documented on the Nasogastric insertion intervention plan within Paris:
 - Is nasogastric tube feeding the right decision for this patient at this time?
 - Has the psychological impact of inserting a nasogastric tube under the application of physical intervention to provide enteral nutrition/hydration/medication been considered? Is this documented?
 - Is this the right time to place the nasogastric feeding tube and is the appropriate equipment available?
 - Is there sufficiently trained staff available at this time to test for safe placement?
- ✓ The initial rationale for inserting a nasogastric tube under the application of physical intervention should be recorded clearly in the patient's PARIS record and medical notes. After each physical intervention a DATIX must be completed
- ✓ If deemed necessary the ongoing rational for continuing to use a nasogastric tube under application of physical intervention for the delivery for nutrition, hydration or medication must be made by the MDT. This ongoing rational should also be documented regularly in the patients PARIS record and medical notes

- ✓ Following any procedure of placement of NG with physical intervention there needs to be a debrief with the patient. The debrief should be after all occasions when physical intervention is required.
- ✓ Debriefs/supervision is to be offered to all members of the MDT when physical intervention is used to place a NG

3.8 Care of the patient post Nasogastric tube insertion

The insertion of a Nasogastric tube can cause localised facial or upper airway trauma, and can also be psychologically difficult for the patient.

- ✓ Staff should check immediately post insertion for trauma to the nares including any bleeding or irritation. For tubes which may remain in-situ for longer these checks should be performed during every intervention (enteral feed/medication administration).
- ✓ Observe respiratory rate and for any signs of respiratory distress
- ✓ Encourage the patient, where possible, to communicate any pain or discomfort in the throat and also if there is any blood present when coughing.
- ✓ Psychological support can be sought through the MDT and the Psychology Team.
- ✓ Post nasogastric tube insertion you must observe the patient closely for any respiratory distress and where possible complete physiological observations with any changes to Vital Signs (NEWS) documented and if required acted upon.

3.9 Training and Clinical Supervision


- ✓ Within CAMHS and Eating Disorder Services there are locally agreed training programmes, assisted by the Nursing and Governance Directorate.
- ✓ The training and Education Department hold a comprehensive list on clinical staff members who are trained in NG insertion and Management and also those who are able to provide training (National Patient Safety Agency 2016).
- ✓ Monitoring of training needs analysis within clinical areas will occur in Locality Management and Governing Boards (LMGB).
- ✓ Clinical teams should also utilise the expertise of local acute secondary care trusts and the SLA's associated with them.

4 Definitions

Term	Definition
Nasogastric feeding tube	<ul style="list-style-type: none"> • Fine Bore tube is typically used for administration of nutrition through specially designed feeds, hydration and if required some prescribed medications
Nasogastric Aspirate	<ul style="list-style-type: none"> • Gastric fluid removed from the stomach once a nasogastric tube is in place – if placed correctly in the stomach this aspirate is then checked with pH indicator strips (CE marked) and will have a pH between 1 to 5.5

Respiratory tract	<ul style="list-style-type: none"> The passage formed by the mouth, nose, throat, and lungs, through which air passes during breathing
Pleura	<ul style="list-style-type: none"> A thin layer of thin tissue which covers the lungs and also lines the inside of the chest cavity – if a nasogastric tube is misplaced fluid can build up in the pleura (lung lining) resulting in a pleural effusion
Pneumothorax	<ul style="list-style-type: none"> The presence of air or gas in the cavity between the lungs and the chest wall which can result in the collapse of the lung
Dysphagia	<ul style="list-style-type: none"> The medical term for swallowing difficulties. Can be described as an ‘altered swallow’ Some people with dysphagia have problems swallowing certain foods or liquids, while others can't swallow at all. Dysphagia can result in a patient requiring the placement of a nasogastric tube for nutrition, hydration or the administration of some prescribed medications
Maxillo-facial	<ul style="list-style-type: none"> The jaw and face.
Basal skull fracture	<ul style="list-style-type: none"> A basilar skull fracture (or basal skull fracture) is a fracture of the base of the skull, typically involving the temporal bone, occipital bone, sphenoid bone, and/or ethmoid bone
Mucositis	<ul style="list-style-type: none"> Inflammation of the mouth or gut.
Oesophageal varices	<ul style="list-style-type: none"> Enlarged veins in the oesophagus which can easily become damaged and bleed if a nasogastric tube is introduced to the oesophagus
Aspiration	<ul style="list-style-type: none"> When material from the stomach or mouth enters the lungs which can result in, amongst other things, infection within in the lungs
Mask C.P.A.P.	<ul style="list-style-type: none"> A mask worn over the mouth and nose which delivers continuous positive airway pressure ventilation
Anorexia Nervosa	<ul style="list-style-type: none"> A psychological disorder resulting in a pathological fear of weight gain typically resulting in persistent food refusal and malnutrition evidenced by a very low body weight/BMI and a lack of awareness of the significant risks to health caused by this
Refusal Disorder	<ul style="list-style-type: none"> An eating disorder characterised by a persistent refusal to consume adequate food to meet requirements for ongoing health. If severe and longstanding it can result in malnutrition
Enteral Feeding	<ul style="list-style-type: none"> Any method of feeding that uses the gastrointestinal (GI) tract to deliver part or all an individual's nutritional

	requirements. This includes an oral food-based diet, liquid oral nutritional supplements or the use of tube feeding. It is in contrast to parenteral nutrition which uses routes outside the GI tract such as intravenous feeding
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 Individual consideration will be part of the intervention to place a NG. At all times the patient will be part of and involved in the process. If needed adaptations and change to the process will be made in order to respect and consider the individual needs of the patient. The Human Rights Act 1998 must be taken into consideration at all times when implementing this clinical intervention

5 How this procedure will be implemented

- This procedure will be published on the Trust's intranet and external website.
- Line managers will disseminate this procedure to all Trust employees through a line management briefing.
- The procedure will be referenced on the RMMO Nasogastric Procedure guidance.
- Training modules will make reference to the procedure and emphasise the need for compliance.
- This procedure will be utilised when assessing clinical competence.

6 How the implementation of this procedure will be monitored

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	Nasogastric Tube Insertion and Management Central Audit	Yearly Data Collection in the clinical environment Modern Matron (or delegate)	LMGB reporting to Local QUAG to QUAC Physical Health and Well-being Group.

7 References

DH Patient Safety and Investigations (2012) The 'never events' list 2012/13

Human Rights Act (1998)

NPSA (2005) Reducing the harm caused by misplaced nasogastric feeding tubes. Patient safety alert 05, February 05. NPSA. London

NPSA (2005) How to confirm the correct position of nasogastric feeding tubes. Patient safety alert 05, February 05. NPSA. London

National Patient Safety Agency (NPSA) NPSA/2011/PSA002 Reducing the harm caused by misplaced nasogastric feeding tubes in adults, children and infants

NPSA Patient Safety Agency (2012) NPSA/2012/RRR001: Rapid Response Report Harm from flushing of nasogastric tubes before confirmation of placement.

National Patient Safety Agency (2016) Patient Safety Alert NPSA/PSA/RE/2016/006 Nasogastric tube misplacement: continuing risk of death and severe harm.

NHS England (2013) Patient Safety Alert NHS/PSA/W/2013/001 Placement devices for nasogastric tube insertion DO NOT replace initial checks.

NHS England (2016) Patient Safety Alert: NHS/PSA/RE/2016/006 Nasogastric tube misplacement: continuing risk of death and severe harm

National Institute for Health and Clinical Excellence (NICE) (2006) Nutrition support for adults: oral nutrition support, enteral tube feeding and parenteral nutrition, Clinical guideline [CG32] Published date: February 2006 Last updated: August 2017

Royal Marsden Manual of Clinical Procedures 9th edition (2015) Procedural guidelines for the insertion of a nasogastric tube without using an introducer, John Wiley and sons

8 Document control

Date of approval:	19 October 2020	
Next review date:	19 October 2023	
This document replaces:	CLIN-0078-v2 Nasogastric Insertion and Management Procedure	
Lead:	Name	Title
	Esther Walton	Specialist Dietitian Adult Eating Disorders
	Jason Newstead	Nurse Consultant Adult Eating Disorders
Members of working party:	Name	Title
	Kayleigh Grainger	Specialist Dietitian CAMH's and Adult Eating Disorders Community
	Sharon Stevens	Physical Health Nurse
This document has been agreed and accepted by: (Director)	Name	Title
	Elizabeth Moody	Executive Director of Nursing and Governance
This document was approved by:	Name of committee/group	Date
This document was ratified by:	Name of committee/group	Date
	Gold Command	19 October 2020
An equality analysis was completed on this document on:	01 July 2020	

Change record

Version	Date	Amendment details	Status
3	19 Oct 2020	Full revision	Published

Appendix 1 - Equality Analysis Screening Form

Please note; The Equality Analysis Policy and Equality Analysis Guidance can be found on InTouch on the policies page

Name of Service area, Directorate/Department i.e. substance misuse, corporate, finance etc.	Nursing and Governance/IPC and Physical Healthcare			
Name of responsible person and job title	Elizabeth Moody, Director of Infection Prevention and Control/Nursing & Governance			
Name of working party, to include any other individuals, agencies or groups involved in this analysis	Esther Walton - Specialist Dietitian Adult Eating Disorders Jason Newstead - Nurse Consultant Adult Eating Disorders Kayleigh Grainger - Specialist Dietitian CAMH's and Adult Eating Disorders Community Sharon Stevens - Physical Health Nurse			
Policy (document/service) name	Nasogastric Insertion and Management Procedure			
Is the area being assessed a...	Policy/Strategy	<input type="checkbox"/>	Service/Business plan	<input type="checkbox"/>
	Procedure/Guidance	<input checked="" type="checkbox"/>	Code of practice	<input type="checkbox"/>
	Other – Please state			
Geographical area covered	Trust wide			
Aims and objectives	To set standards in practice to ensure the delivery of patient care is carried out safely and effectively by trust staff			
Start date of Equality Analysis Screening (This is the date you are asked to write or review the document/service etc.)	01 July 2020			
End date of Equality Analysis Screening (This is when you have completed the equality analysis and it is ready to go to EMT to be approved)	01 July 2020			

You must contact the EDHR team if you identify a negative impact. Please ring Sarah Jay or Julie Barfoot on 0191 3336267/3046

1. Who does the Policy, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan benefit?					
Trust staff and patients					
2. Will the Policy, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan impact negatively on any of the protected characteristic groups below?					
Race (including Gypsy and Traveller)	No	Disability (includes physical, learning, mental health, sensory and medical disabilities)	No	Gender (Men, women and gender neutral etc.)	No
Gender reassignment (Transgender and gender identity)	No	Sexual Orientation (Lesbian, Gay, Bisexual and Heterosexual etc.)	No	Age (includes, young people, older people – people of all ages)	No
Religion or Belief (includes faith groups, atheism and philosophical belief's)	No	Pregnancy and Maternity (includes pregnancy, women who are breastfeeding and women on maternity leave)	No	Marriage and Civil Partnership (includes opposite and same sex couples who are married or civil partners)	No
<p>Yes – Please describe anticipated negative impact/s</p> <p>No – Please describe any positive impacts/s</p> <p>No barriers to access or implementing this policy</p>					

3. Have you considered other sources of information such as; legislation, codes of practice, best practice, nice guidelines, CQC reports or feedback etc.? If 'No', why not?	Yes			
Sources of Information may include: <ul style="list-style-type: none"> • Feedback from equality bodies, Care Quality Commission, Equality and Human Rights Commission, etc. • Investigation findings • Trust Strategic Direction • Data collection/analysis • National Guidance/Reports 	<ul style="list-style-type: none"> • Staff grievances • Media • Community Consultation/Consultation Groups • Internal Consultation • Research • Other (Please state below) 			
4. Have you engaged or consulted with service users, carers, staff and other stakeholders including people from the following protected groups?: Race, Disability, Gender, Gender reassignment (Trans), Sexual Orientation (LGB), Religion or Belief, Age, Pregnancy and Maternity or Marriage and Civil Partnership				
No – Please describe future plans that you may have to engage and involve people from different groups				

5. As part of this equality analysis have any training needs/service needs been identified?					
No	Please describe the identified training needs/service needs below				
A training need has been identified for;					
Trust staff	No	Service users	No	Contractors or other outside agencies	No
Make sure that you have checked the information and that you are comfortable that additional evidence can provided if you are required to do so					
The completed EA has been signed off by: You the Policy owner/manager: Type name: Esther Walton, Jason Newstead					Date: 01/07/2020
Your reporting (line) manager: Type name: Elizabeth Moody					Date: 01/07/2020
If you need further advice or information on equality analysis, the EDHR team host surgeries to support you in this process, to book on and find out more please call: 0191 3336267/3046					

