1 Introduction

Displacement of nasogastric (NG) tubes can have serious implications if undetected. NG tubes can be misplaced into the lungs on insertion or displaced from the stomach into the oesophagus at a later stage. Incorrectly positioned tubes leave patients vulnerable to the risks of regurgitation and respiratory aspiration, which can cause serious harm and in some cases can be fatal (NPSA 2005). It is crucial to differentiate between gastric and respiratory placement on initial insertion to prevent potentially fatal pulmonary complications. The Trust is committed to reducing the incidence of incorrectly placed NG tubes.

2 Aim of the Policy

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 both adults and children but excludes neonates.

3 Roles and Responsibilities

Responsibility for ensuring the application of this policy lies with the Clinical Director of each Directorate, supported by the Directorate Manager and Matron.

Insertion and care of an NG tube should only be carried out by a 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. Assistant Practitioners and other unregistered staff must never insert Nasogastric feeding tubes or be involved in the initial confirmation of safe nasogastric tube position.

Removal of an NG tube should only be carried out by a registered doctor or nurse.
4 Background

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.

5 Key principles

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’ (Dougherty & Lister 2008). 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 ‘Key points of care for insertion of NG tube’ (Appendix 1). Any additional information should be recorded in the patient’s medical or nursing notes as appropriate.

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 medical notes. Such patients may require NG tube insertion under fluoroscopic control.

7 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.
The use of fine bore NG feeding tubes however comes at a price 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.

8 The Decision to Insert a NG Feeding Tube

8.1 Consider: Is NG tube feeding the right decision for this patient?

The decision to start NG tube feeding should be made following a risk assessment. Where possible this will include a Nutrition Nurse Specialist or Dietitian. 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 6 or above, making identification of an incorrectly placed tube more difficult.

8.2 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 sufficient 24 hour senior cover available to accurately confirm placement if an x-ray is needed. The National Patient Safety Agency (NPSA) has cited a number of errors occurring as the result of junior staff confirming tube position by x-ray out of hours (NPSA 2011).

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 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.
8.3 **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.

9 **Consent**

Where possible informed verbal consent should be obtained from the patient prior to the insertion of a NG tube. If the patient is assessed as not having the mental capacity to provide consent, the clinician in charge of the patients care should make this decision, taking into account the patient's best interest and if possible the opinions of the patient's family. This should be clearly documented in the patient's medical notes and indicated on the 'Key points of care for insertion of NG tube' form.

10 **Type of Tube**

NG tubes must be radio-opaque throughout their length at the time of insertion, and have visible external markings in 1cm increments along the length of the tube. NG tubes are available in a number of sizes and lengths, and the person inserting the NG tube should select the most appropriate. More information on this can be found in ‘Caring for adult & paediatric patients with enteral feeding tubes’ guidelines:

11 **Insertion**

It is the responsibility of the person inserting the NG tube 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.

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 2). 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 the pH of the aspirate should be checked and the internal tube length documented on the ‘Key points of care for insertion of NG 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.

11.1 Unsafe methods of testing which MUST NOT be used

There are a number of methods of testing to confirm NG tube position, which have been widely used in the past, and which now MUST NOT be used. These unsafe methods are;

11.1.1 ‘Whoosh test’

The auscultation of air injected into the feeding tube, or ‘whoosh test’, has often been used in the past to ascertain correct tube position. There are however reports on the ineffectiveness of this method (Metheny et al 1990, Metheny 1998, Neumann et al 1995). Cases have been highlighted where results indicated correct tube placement and feeds were started with disastrous results (NPSA 2005, Metheny 1998). The ‘Whoosh test’ must not be performed.

11.1.2 Litmus paper

Until relatively recently, it was common practice to identify position of NG tube by testing gastric aspirate with Litmus paper. However, this practice is not recommended as litmus paper cannot indicate degree of acidity. It is not sensitive enough to reliably distinguish between gastric acid (pH 3-5) and bronchial secretions (pH >6) (NPSA 2005, MHRA 2004, Rollins 1997). Litmus paper must not be used.

11.1.3 Absence of respiratory distress

Observing for signs of respiratory distress is often ineffective in detecting a misplaced tube (Rassias et al 1998, Metheny et al 1990). This test is made even less effective with the widespread use of fine bore tubes which can enter the respiratory tract with few, if any, symptoms. If the patient has a reduced level of consciousness, large
bore tubes can enter the respiratory tract without causing symptoms (Torrington & Bowman 1981). The absence of respiratory distress must not be used as a sign of correct placement.

11.1.4 Bubbling at the end of the tube
Placing the proximal end of the NG tube under water and observing for bubbling is unreliable. The stomach also contains air and could falsely indicate respiratory placement resulting in the unnecessary removal of correctly positioned tubes (Metheny et al 1990). Testing for bubbling from the end of the NG tube must not be performed.

11.1.5 Appearance of aspirate
Evidence indicates that relying on the appearance of feeding tube aspirate to rule out misplacement is unreliable as gastric contents can look similar to respiratory secretions (NPSA 2005). The appearance of aspirate must not be used as a sign of correct placement.

11.2 Safe methods for testing correct placement
Following initial insertion and on subsequent testing, there are two reliable methods for checking that the NG feeding tube is correctly positioned; testing the pH of a nasogastric aspirate and X-ray appearances. (Metheny 2001, Metheny 1989).

11.2.1 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 (NPSA 2005, Metheny 2001). 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.

There are some limitations to the testing for gastric pH. Gastric pH can 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.

Gastric pH can also be altered by the prescribed feeds given to patients. In the case of continuous NG feeding, feed should be stopped for an hour before obtaining the aspirate. The decision to stop continuous feeding must however be subject to a risk assessment.

IMPORTANT

Adult patients - 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.
Paediatric patients - If unable to obtain an aspirate consider; changing the child's position, checking inside the mouth to see if the NG tube is coiled up, offering a drink if not contraindicated, adjusting the position of tube either in or out, instilling 1-3mls air to expel any blockage such as stomach wall or debris. If concerns with the correct position of tube continue, discuss with relevant medical staff.

11.2.2 X-ray

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 (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 (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 key points of care chart. Subsequent use of the tube will be subject to the checks detailed in section 11.2.3 of 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.

A small amount of air may be used to flush a tube to relieve any blockage and to facilitate aspiration of gastric contents for pH testing as described above in section 11.2.1

11.2.3 Ongoing checks of NG tube position
The position of the NG tube should be 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, 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 ‘Key points of care for insertion of NG tube’ form.

11.2.4 When NOT to feed
In the following circumstances, patients should NOT be fed 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 ‘Key points of care for insertion of NG tube’ form or the medical or nursing notes.

11.2.5 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 2) to ensure aspirate can be obtained.

• Use the correct sized, purple-coloured oral/enteral polyurethane syringe as advised by the NG tube manufacturer (50ml syringes for Merck Corflo NGTs).

• Instill air (10-20mls for adults, 1-3mls infants and children dependent on size) 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.

• 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.

11.2.6 Obtaining a pH of 5.5 or above

The aspirate obtained may have a pH of 5.5 or above 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.

However, the pH of gastric fluid may also be elevated due to acid inhibiting drugs or due to the presence of feed in the stomach. Where patients are receiving acid inhibiting drugs a pH of 5 or less has still been found in the majority of cases (NNNG 2004). It is recommended however that aspiration be done as long as possible after giving medication to reduce the possible effect of drugs on gastric pH.

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 managing team.

12 Discharge to community care

Discharging a patient from acute to community services with an NG tube in place requires planning. A multidisciplinary risk assessment should be performed and documented (NPSA 2011). Guidance and support can be provided by contacting the
Nutrition Nurse Specialist and further information is also available in ‘Caring for adult and paediatric patients with enteral feeding tubes (excludes neonates)’

13 Learning from mistakes

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 Datix.

14 Training

14.1 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.

Competency assessment documents are available for registered doctors and nurses and can be found on the patient services site on the Intranet:

For registered nurses this must be used as documentary evidence of competency to practice.

E-learning is currently being developed to support competency training in practice for all registered practitioners. NG tube insertion training for registered nurses is currently available through Clinical Educators and Nutrition Nurse Specialists as appropriate.

14.2 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 as competent to do so using the Trust e-learning package ‘Reducing the risk of feeding through a misplaced NG tube’, which can be found on the mandatory training site.

15 Monitoring

Compliance with this policy will be monitored by the Nutrition Nurse Specialists, who will monitor the number and type of incidents. Audit of NG insertion practice and documentation will be carried out by Clinical Governance & Risk Department across the Trust every six months to ensure ongoing monitoring and review of practice.
<table>
<thead>
<tr>
<th>Standard / process / issue</th>
<th>Monitoring and audit</th>
<th>By</th>
<th>Committee</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audit of NG insertion practice</td>
<td>Trust-wide audit to assess compliance with NG Policy, in particular ‘Key points of care NG insertion chart’ All patients with an NG feeding tube insitu on the day of audit will be included.</td>
<td>CGARD</td>
<td>Clinical Risk Group &amp; Nutritional Steering Committee</td>
<td>6 monthly</td>
</tr>
<tr>
<td>Incidents recorded on Datix will be monitored and reviewed</td>
<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>CGARD</td>
<td>Clinical Risk Group &amp; Nutritional Steering Committee</td>
<td>On-going</td>
</tr>
</tbody>
</table>

16 References

- MHRA Notice (2004) MHRS/MS/026
- [http://www.nrls.npsa.nhs.uk/resources/?EntryId45=133441](http://www.nrls.npsa.nhs.uk/resources/?EntryId45=133441)
ADULTS AND CHILDREN (EXCLUDES NEONATES): KEY POINTS OF CARE FOR INSERTION OF A NASOGASTRIC FEEDING TUBE

To be completed by staff caring for a patient with a nasogastric feeding tube.

| Site: | __________________________________________________________ |
| Ward: | ________________________________________________________ |

1. The decision to insert a nasogastric feeding tube for feeding should be made, involving the patient if possible. A risk assessment should be performed. Elective placement of nasogastric feeding tubes should not occur at night unless there is sufficient senior cover available.

2. Patient’s informed consent must be obtained prior to the insertion of a nasogastric feeding tube. Ensure that the patient’s privacy and dignity are maintained at all times.

3. Nasogastric feeding tube insertion must be undertaken by a qualified, trained and competent healthcare professional.

4. The nasogastric feeding tube must be radio-opaque at the time of insertion and have externally visible length markings.

5. Nasogastric feeding tubes SHOULD NOT be flushed or lubricated with water prior to insertion. Nothing should be introduced down a Nasogastric feeding tube until gastric placement has been confirmed.

6. It is the responsibility of the person inserting the nasogastric feeding tube to complete the insertion record found below.

7. Immediately after insertion, fluid should be aspirated from the nasogastric feeding tube. The pH of the fluid should be checked using pH indicator strips or pH paper. If the aspirate has a pH of between 1 and 5 then feeding can be commenced. If fluid cannot be aspirated, or the pH is not between 1 and 5, an X-Ray MUST be obtained to confirm position. Litmus paper should not be used to check the pH.

8. Care must be taken when interpreting X-Rays for nasogastric feeding tube position. The interpretation of X-Rays for nasogastric feeding tube position must be undertaken by a qualified, trained and competent healthcare professional.

9. The following methods are unacceptable for confirming correct placement of a nasogastric feeding tube; the ‘whoosh’ test, the absence of respiratory distress, the absence of bubbling at the end of the tube and the appearance of aspirate.

10. All qualified healthcare professionals must ensure that the insertion record shows a signed and printed confirmation of correct nasogastric feeding tube position before using the nasogastric feeding tube.

11a. A check of internal length should be carried out by the qualified nurse and recorded on the reverse of this page in the following circumstances:
   - Before restarting feed after a rest period and before administering medication.
   - Daily in the case of continuous feed.
   - If there are any concerns that the tube may have become displaced.

11b. If there is any evidence or concern that the internal length may have changed e.g. after vomiting, retching or coughing, in the presence of new or unexplained respiratory symptoms/reduction in oxygen saturation or if external cm markings have changed. Feed must be stopped, and the tube must be checked before it is used. This check should be as described in Key Point of Care 7 and recorded both in the ‘Action Taken’ column and in the patient’s nursing or medical notes.

12. In the interest of improving patient safety staff are requested to report any incident involving displacement of nasogastric feeding tubes by completing a Datix incident form.

13. Further information and guidance can be found in the Trust policy ‘Insertion and Management of NG Feeding Tubes’

---

### Insertion Record

<table>
<thead>
<tr>
<th>Date: DD/MM/YYYY</th>
<th>Time:</th>
<th>Indication:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Verbal consent from pt obtained</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Verbal consent from parent/guardian obtained</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Best interest decision made</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**When X-ray Viewed Confirm:**

- Most recent X-ray of correct patient.
- Tube is seen crossing the diaphragm in the midline.
- Tip is clearly visible below the left hemi-diaphragm.

**Nasogastric Ready for Safe use confirmed by:**

(Must be signed by nurse or doctor once insertion checks confirmed as correct)

**Name:**

**Signature:**

**Designation:**

---

Printed by Potts Print (UK)
IMPORTANT!: NG tube should not be used and pH aspirate should be checked: following episodes of vomiting, retching or coughing, in the presence of any new or unexplained respiratory symptoms or reduction in oxygen saturation or if there is any concern at any time that internal length may have changed. If pH aspirate test is inconclusive then a chest X-ray should be carried out to confirm position.

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Length of Nasogastric Feeding Tube at Nose</th>
<th>Tube Taped Securely?</th>
<th>Action Taken</th>
<th>Sign and Print Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>DD/MM/YYYY</td>
<td>:</td>
<td>cm</td>
<td>Y / N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DD/MM/YYYY</td>
<td>:</td>
<td>cm</td>
<td>Y / N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DD/MM/YYYY</td>
<td>:</td>
<td>cm</td>
<td>Y / N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DD/MM/YYYY</td>
<td>:</td>
<td>cm</td>
<td>Y / N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DD/MM/YYYY</td>
<td>:</td>
<td>cm</td>
<td>Y / N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DD/MM/YYYY</td>
<td>:</td>
<td>cm</td>
<td>Y / N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DD/MM/YYYY</td>
<td>:</td>
<td>cm</td>
<td>Y / N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DD/MM/YYYY</td>
<td>:</td>
<td>cm</td>
<td>Y / N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DD/MM/YYYY</td>
<td>:</td>
<td>cm</td>
<td>Y / N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DD/MM/YYYY</td>
<td>:</td>
<td>cm</td>
<td>Y / N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DD/MM/YYYY</td>
<td>:</td>
<td>cm</td>
<td>Y / N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DD/MM/YYYY</td>
<td>:</td>
<td>cm</td>
<td>Y / N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DD/MM/YYYY</td>
<td>:</td>
<td>cm</td>
<td>Y / N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DD/MM/YYYY</td>
<td>:</td>
<td>cm</td>
<td>Y / N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DD/MM/YYYY</td>
<td>:</td>
<td>cm</td>
<td>Y / N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DD/MM/YYYY</td>
<td>:</td>
<td>cm</td>
<td>Y / N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DD/MM/YYYY</td>
<td>:</td>
<td>cm</td>
<td>Y / N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DD/MM/YYYY</td>
<td>:</td>
<td>cm</td>
<td>Y / N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DD/MM/YYYY</td>
<td>:</td>
<td>cm</td>
<td>Y / N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DD/MM/YYYY</td>
<td>:</td>
<td>cm</td>
<td>Y / N</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The Newcastle upon Tyne Hospitals NHS Foundation Trust

Equality Analysis Form A

This form must be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

PART 1

1. **Assessment Date:** 22.10.14

2. **Name of policy / strategy / service:**
   Adult & Paediatric Policy (excludes neonates) - Insertion and Management of NG feeding tubes

3. **Name and designation of Author:**
   Jo Ledger, Clinical Nurse Specialist – Adult Nutrition

4. **Names & designations of those involved in the impact analysis screening process:**
   Jo Ledger, Sarah Cunningham,

5. **Is this a:**
   Policy × Strategy [ ] Service [ ]
   **Is this:**
   New [ ] Revised ×
   **Who is affected:**
   Employees × Service Users × Wider Community [ ]

6. **What are the main aims, objectives of the policy, strategy, or service and the intended outcomes?**
   (These can be cut and pasted from your policy)
   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 both adults and children but excludes neonates.

7. **Does this policy, strategy, or service have any equality implications?**
   Yes × No [ ]
   If No, state reasons and the information used to make this decision, please refer to paragraph 2.3 of the Equality Analysis Guidance before providing reasons:
### 8. Summary of evidence related to protected characteristics

<table>
<thead>
<tr>
<th>Protected Characteristic</th>
<th>Evidence, i.e. What evidence do you have that the Trust is meeting the needs of people in various protected Groups</th>
<th>Does evidence/engagement highlight areas of direct or indirect discrimination? If yes describe steps to be taken to address (by whom, completion date and review date)</th>
<th>Does the evidence highlight any areas to advance opportunities or foster good relations. If yes what steps will be taken? (by whom, completion date and review date)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Race / Ethnic origin (including gypsies and travellers)</td>
<td>Appropriate enteral liquid feed options for NG feeding are available for patients with different cultural and dietary needs. Dietetic specialist advice is available for all patients with different requirements e.g. vegetarian, vegan, kosher</td>
<td>No direct discrimination</td>
<td>No</td>
</tr>
<tr>
<td>Sex (male/ female)</td>
<td>Not applicable</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Religion and Belief</td>
<td>Appropriate enteral liquid feed options for NG feeding are available for patients with different religious needs and specialist Dietetic advice is available.</td>
<td>No direct discrimination</td>
<td>No</td>
</tr>
<tr>
<td>Sexual orientation including lesbian, gay and bisexual people</td>
<td>Not applicable</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Age</td>
<td>The Policy covers older adults with cognitive impairment through acute delirium or Dementia. These patients would have their mental capacity 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 family and carers. The Trust has developed ‘Guidance for clinical management of complex feeding problems in patients with cognitive impairment’ which gives advice to the MDT on assessment &amp; decision making to ensure appropriate care of this patient group. The Policy promotes mandatory safe practice. Six monthly Trust wide audits demonstrates that every patient who has an NG feeding tube inserted has a key points of care chart documented, which includes a prompt for consent and best interest documentation. The Policy covers children &amp; young people (excludes neonates). Parents will give consent for NG feeding tube insertion &amp; feeding for infants and children.</td>
<td>No direct discrimination. Insertion of NG feeding tube is based on clinical need and in the best interest of every patient.</td>
<td>No</td>
</tr>
</tbody>
</table>
Disability – learning difficulties, physical disability, sensory impairment and mental health. Consider the needs of carers in this section

| The Trust protects patients with learning difficulties by ensuring that advocates are available to assist in best interest decision making. If a patient with learning difficulties lacks the mental capacity to provide informed consent for NG insertion procedure, decision will be made in the best interest of each patient along with the managing consultant, with involvement of any family and carers. |
| No direct discrimination. Insertion of NG feeding tube is based on clinical need and in the best interest of every patient. |

1. The Policy promotes mandatory safe practice. Six monthly Trust wide audits demonstrates that every patient who has an NG feeding tube inserted has a key points of care chart documented, which includes a prompt for consent and best interest documentation.

2. The Trust has developed ‘Guidance for clinical management of complex feeding problems in patients with cognitive impairment’ which gives advice to the MDT on assessment & decision making to ensure appropriate care of this patient group.

3. Hospital Passports and Care Pathways 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.

Gender Re-assignment | Not applicable |
| No |

| Marriage and Civil Partnership |
| Not applicable |
| No |

| Maternity / Pregnancy |
| Not applicable |
| No |

9. Are there any gaps in the evidence outlined above? If ‘yes’ how will these be rectified?

No

10. Engagement has taken place with people who have protected characteristics and will continue through the Equality Delivery System and the Equality Diversity and Human Rights Group. Please note you may require further engagement in respect of any significant changes to policies, new developments and or changes to service delivery. In such circumstances please contact the Equality and Diversity Lead or the Involvement and Equalities Officer.
Do you require further engagement?  

Yes ☐  No ☒

11. Could the policy, strategy or service have a negative impact on human rights? (E.g. the right to respect for private and family life, the right to a fair hearing and the right to education?)

No

PART 2

Name: Jo Ledger

Date of completion: 22.10.14

(If any reader of this procedural document identifies a potential discriminatory impact that has not been identified, please refer to the Policy Author identified above, together with any suggestions for action required to avoid/reduce the impact.)