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Royal Cornwall Hospitals NHS Trust

Inpatient and Outpatient Gastrostomy Referral and Placement Clinical Guideline (adult only)

V2.0

September 2022

1. Aim/Purpose of this Guideline

1.1. The aim of this guideline is to standardise care for inpatients who require a gastrostomy tube (GT) this can be Percutaneous Endoscopic Gastrostomy (PEG), Radiologically inserted Gastrostomy (RIG) or Surgical placement.

In March 2010, the National Patient Safety Agency issued a rapid response report on the early detection of complications after inserting a PEG tube.

This highlighted that between, October 2003 until January 2010, there were 11 reports of death and 11 reports of severe harm relating to PEG tubes. These reports identified that “red flag” symptoms were not recognised, and there were delays in recognising complications in the first 72 hours after gastrostomy insertion. These red flags include severe pain, fresh bleeding, and leakage of gastric contents.

Patients who are expected to recover their ability to tolerate oral intake or who are expected to die within 4 weeks are better managed with nasogastric (NG) feeding tubes.

PEG tubes do not improve survival, and in fact, they can be associated with significant morbidity and mortality rates.

PEG tubes do not decrease the risk of aspiration.

1.2. This guidance does not override the individual responsibility of health professionals to make appropriate decision according to the circumstances of the individual patient in consultation with the patient and / or carer.

1.3. The document applies to all health care professionals involved with adult patients requiring a gastrostomy within the hospital setting.

1.4. These guidelines provide information on:

1.4.1. PEG referral process

1.4.2. PEG assessment process

1.4.3. Roles and responsibilities of the MDT

1.4.4. Patient preparation for PEG

1.4.5. Immediate Post-procedure PEG care

1.5. The document should be read in conjunction with the following Trust Policies:

- Policy for Consent to Examination or Treatment
- Discontinuation Of Antiplatelet and Anticoagulation Medications
- Cardiology Anticoagulation Clinical Guideline

- Management of Adult Patients with Diabetes Mellitus during Surgery or Elective Procedures

- Clinical guideline for the administration of drugs via enteral feeding tubes

- Clinical guideline for troubleshooting gastrostomy in ED, MAU, SDMA, GP Acute services

These can be found on the Trust's Document Library

1.6. This version supersedes any previous versions of this document.

Data Protection Act 2018 (General Data Protection Regulation – GDPR) Legislation

The Trust has a duty under the Data Protection Act 2018 and General Data Protection Regulations 2016/679 to ensure that there is a valid legal basis to process personal and sensitive data. The legal basis for processing must be identified and documented before the processing begins. In many cases we may need consent; this must be explicit, informed, and documented. We cannot rely on opt out, it must be opt in.

Data Protection Act 2018 and General Data Protection Regulations 2016/679 is applicable to all staff; this includes those working as contractors and providers of services.

For more information about your obligations under the Data Protection Act 2018 and General Data Protection Regulations 2016/679 please see the Information Use Framework Policy or contact the Information Governance Team

Royal Cornwall Hospital Trust rch-tr.infogov@nhs.net

2. The Guidance

2.1. Enteral feeding should be considered if a patient is malnourished / at risk of malnutrition, despite the use of oral interventions and has a functional and accessible gastrointestinal tract (NICE 2017). Formation of a gastrostomy involves the creation of a tract between the stomach and the surface of the abdomen in endoscopy usually under conscious sedation. It should however be noted that nutritional support is not always appropriate.

2.2. This procedure can lead to complications that have the potential to be fatal if not detected early.

2.3. Scoping our practice NCEPOD 2004 recommended that the multidisciplinary team should discuss the value of gastrostomy feeding for a patient prior to insertion.

2.4. Patients who are being considered for a gastrostomy should be referred by the medical team in the first instance for an assessment by the:

- Speech & Language Therapist (SLT) if there are issues around a safe swallow

- Dietitian for nutritional assessment and requirements
- Learning disability team if appropriate

Please ensure this is completed or in conjunction with a referral to Nutrition nurse and/or Gastroenterologist

2.5. The decision to place a PEG/RIG requires an in-depth assessment of the potential benefit to the individual, requires consideration of physical, psychological, sociological, and ethical factors.

Therefore, patients who are being considered for a gastrostomy should be referred by the medical team for an assessment by the Nutrition Specialist Nurse

All patients attending endoscopy for PEG should have been referred and thoroughly assessed in advance.

NB: Endoscopy booking team and endoscopy department do not accept direct referrals for PEG placement

Main indications for PEG/RIG placement (not exhaustive)

- Dysphagia/ unsafe swallow – assessed by SLT
- Nutritional needs that cannot be met by eating and drinking alone
- Long-term feeding where patient is not tolerating NG feeding tube or NG no longer safe/ appropriate
- Acute ischaemic or haemorrhagic stroke
- Chronic progressive neuromuscular disease
- i.e., Motor neurone disease (bulbar and Pseudobulbar palsies)
- Multiple Sclerosis
- Parkinson’s
- Guillain-Barre Syndrome
- Huntington’s disease
- Cystic Fibrosis
- Head & Neck Surgery
- (RIG preferred technique and these patients should be assessed by the Radiologist and referring head and neck clinician) this falls outside the scope of this document

Patients with advanced dementia are unlikely to benefit from PEG/RIG placement but should be discussed

2.6. When selecting patients for PEG insertion the following criteria will be considered:

- Risk of significant malnutrition and /or delayed recovery
- Upper gastro-intestinal tract dysfunction
- Functional status of gastro-intestinal tract
- Whether enteral tube feeding is likely to be needed for more than 4 weeks
- Acceptability of the PEG to the patient
- Assessment of the patient's long-term prognosis/ medical management plan
- Impact on patients QOL
- Eating and drinking cessation, eating at risk. NBM

2.7. Referral process:

1.1.1. Inpatients Referrals

- All PEG referrals must be made on the Trust's MAXIMs system
- 'PEG assessment inpatient service failure to complete the electric form may mean that it is rejected and may delay the patient's assessment
- The Nutrition Specialist Nurse and/or Gastroenterologist will assess the patient once the referral form is completed within 48-72 hours
- A Second opinion may need to be requested from Gastroenterologist by the Nutrition Specialist Nurse where patient may have complex needs/ co morbidities. A best interest discussion/meeting may also need to be undertaken for patients who lack capacity, and a decision is needed in their best interests
- If the referral is urgent, please contact the 07880465070 or through switchboard to discuss
- If Nutrition Specialist Nurse is not available, please contact the Gastroenterologist on call through RCHT switchboard 01872 250000 or refer to Gastroenterology inpatient service in addition to PEG assessment inpatient service

1.1.2. Outpatient referrals

- All PEG referrals must be made on the Trust's MAXIMs system

- PEG assessment Outpatient service
- Or the GP must refer to the Consultant Gastroenterologist. All Referrals will be vetted by the Nutrition Team Consultant Lead and or the Nutrition Specialist Nurse/ Physician Associate
- Outpatient referral will be offered a clinic appointment with the Nutrition support team usually held once a month. where this may be difficult for the patient to attend or is urgent a domiciliary appointment may be offered by the Nutrition Specialist Nurse
- All Patients referred inpatient or outpatient will be discussed at the monthly PEG MDT

2.8. Referral for RIG

Patients are assessed for PEG suitability but in some cases, this may be a contraindicated procedure and the patient referred for RIG. If a RIG is deemed the safer option, the referring ward must discuss this with the Consultant Radiologist and refer on MAXIMS – The pathway for RIG procedure extends beyond the scope of this document.

2.9. Individual roles within the MDT

Speech and Language Therapist role

2.9.1. Assess the patients swallow and apply recommendations for practice i.e., as per International Dysphasia Diet Standardised Initiative (IDDSI) framework (objective measurement for liquid thickness)

- Recommend instrumental assessment i.e., Fibre Endoscopy Evaluation of Swallowing (FEES), Video Fluoroscopy Swallowing Assessment (VFSA)
- Ongoing regular review
- Involved in MDT/BIM decisions where the patient does not have mental capacity to consent to treatment

2.9.2. Dietitian role

- Carry out a full nutritional and hydration assessment
- Devise a clear Dietetic and nutritional care plan based on recommendations of SLT
- To maximise oral nutritional intake if feasible and safe (i.e., oral diet, oral nutritional supplements, oral trials) alongside NG feeding

- Involved in decisions around appropriateness for Mittens and nasal securement device to help to establish nutritional routes when risk of NGT removals

- Involved in MDT/BIM decisions where the patient does not have mental capacity to consent to treatment including advising the team on the CAHN guidelines and process as indicated

2.9.3. Acute Liaison Nurse for Learning Disability and Autism role

- Liaise with the Community LD Team when they inform us of a PEG referral

- Ensure the patient is flagged and a hospital passport is in place, send out the team information and make initial contact with patient/family

- Discuss with The Nutrition support Team at the hospital, add to the MDT list if we agree at appropriate stage

- Possible clinic appointment with Consultant and Nutrition Support team will attend to support. This appointment can be a combined BIM at this stage if required

- Separate BIM if needed or complex, Consultant is the decision maker so must be included

- If an inpatient, we will support the ward with this process and work closely with the Nutrition Specialist Nurse

- Support with any further investigations in the hospital that may be required prior to procedure i.e., CT scan to check anatomy

- Receive confirmed date from and the Nutrition Specialist Nurse and liaise with the pre-op team if support needed through this process

- Liaise with the patient's family or care home to ensure that reasonable adjustments that will support the admission and stay are put in place when required and prior to the procedure taking place

- Liaise with the anaesthetic team who will be supporting the procedure and the endoscopy Unit, if pre-med is required the team will order it at this point

- Complete an admission plan if required for the procedure

- Ensure a clear plan for commencing use of PEG is in place and any medications are requested in liquid form if required. Guidelines in place for pain medication prescribing if the patient has a low BMI

- Ensure that all people who are accessing the PEG after discharge have had the appropriate training

- Support discharge where required back to the community

- Support the endoscopy unit in facilitating a pre procedure visit with patients who have been identified of benefiting from this

2.9.4. Nutrition Specialist Nurse and Gastroenterologist responsibilities

- Inpatients: aim to complete PEG assessment within 48 hours of referral as service allows

- Outpatients: arrange to be seen in Nutrition clinic as appropriate

- Refer to SLT/ Dietitians if they are not already involved in the patients' care

- Refer to LD team if not already referred as applicable

- Following PEG assessment, inform the referring ward of any recommendations ahead of requesting/booking PEG i.e., BIM, Instrumental monitoring, supporting restrictive practice i.e., Nasogastric retention device, mittens, IV fluids and refeeding syndrome medications, bloods

- Attend and support BIM/MDT which should be arranged by the referring ward

- Discuss and review the patient with the Gastroenterologist where the patient is complex for a second opinion

- Discuss with the Radiologist where PEG may be contraindicated or advise the medical ward to discuss RIG placement for the patient with a radiologist where a PEG is contraindicated and where RIG may be deemed a safer alternative

- Discuss PEG with the patient/ family/ carer/ risks/ benefits, implications in practice, affect it may have on patients Quality of Life, placement i.e. Nursing Home

- Ensure that carers and family have received adequate education and counselling, informing them of the potential impact on their lifestyle and body image, including risks and benefits.

- The patient, family / carer should be provided with an information booklet Gastrostomy feeding explained RCHT – hyperlink

- Provide PEG information leaflet
- Continue to liaise with the SLT/ Dietitians and the medical team
- If appropriate liaise with endoscopy booking team to process the referral and arrange a date for PEG placement at the earliest convenience.
- Advice General anaesthetic and pre-operative assessment if required
- Confirm date for PEG to allow forward planning and preparation and to co-ordinate this process.
- Liaise with Gastroenterologist/ Endoscopist and / or endoscopy Nursing team as appropriate
- Support the ward with pre-PEG work up and planning
- Support the ward with the first flush post PEG insertion where possible.
- Provide immediate post PEG insertion review and follow up within 48 hours where possible.
- Liaise with Community Gastrostomy dietician to support training for outpatients who will be coming into the hospital for the PEG insertion.
- Support inpatient training of patients post PEG insertion.
- Support training for the ward staff
- Support safe discharge home or to a nursing home to the community where appropriate

2.10. Ward responsibilities

2.10.1. **Best interest meetings**

- Where the patient is deemed not to have mental capacity, or it is not clear then a formal documented capacity assessment should be considered or completed and filed in the patients' medical notes
- Where the patient is deemed to lack capacity a best interest meeting and best interest decision should be considered and arranged. This should be arranged by the responsible clinician. An Independent Mental Capacity Advocate (IMCAO) may be required where there is no Lasting Power of Attorney (LPOA) and/or the patients have not expressed their wishes nor have an advanced directive

- Consider the use of Clinical assisted hydration and nutrition (CAHN) Clinical Guidelines 2019, this can be supported by the Dietitian and/or Nutrition nurse specialist as appropriate

2.10.2. **Consent**

- The patient must be consented for PEG procedure using the PEG consent form

- Patients requiring Consent via Form 1, will have the initial consent completed on the ward using the procedure specific consent form, this will then be countersigned as part of the two-stage consent process when the patient arrives on the unit by the clinician completing the procedure

- Where the patient lacks mental capacity to consent a form 4 must be completed prior to the procedure. This must be completed on the ward before PEG procedure by the referring Consultant, this will then be countersigned as part of the two-stage consent process when the patient arrives on the unit by the clinician completing the procedure

2.10.3. **General anaesthetic**

The majority of patients are able to tolerate the PEG procedure for endoscopy with conscious sedation.

The patient must be able to tolerate lying flat for at least 30 minutes for the procedure.

However, a small number of patients may require a general anaesthetic (GA) for the procedure to protect airway and facilitate safe procedure.

GA will be considered for patients with:

- Respiratory compromise

- Bulbar involvement

- Learning disabilities

- Extremely anxious and/or distressed patients who may not tolerate procedure with conscious sedation alone

The ward will be advised to request an anaesthetic assessment pre-GT procedure if this is felt necessary.

This assessment can be arranged with the emergency floor anaesthetist for the day through RCHT switchboard: 01872 250 000

2.10.4. **Ward responsibilities pre procedure checks ensure that:**

- If travelling from community hospital i.e., CRCH, Bodmin transport will need to be arranged by the referring ward
- Consent form to be signed by appropriately informed clinician – consent form 4 required if patients deemed to lack mental capacity consent form PEG specific procedure – hyperlink
- Consent form 4 – see section above regarding consent
- Refer to Management of Patients Taking Anticoagulants in Endoscopy Clinical Guideline V4.0 July 2022
- Nil by mouth/ NG midnight before the procedure
- Check INR/ platelets count 24-48 hours pre procedure Note INR must be <1.5 for procedure to progress
- Up to date MRSA screen (within 3/12) as per RCHT policy
- Covid-19 screen as per RCHT policy
- Ensure the patient has a patent IV cannula
- Ensure Patient is wearing theatre gown and complete pre-op checklist
- Baseline observations (NEWS) have been carried out and documented
- Endoscopy will contact the ward to send for the patient

If the patient is unwell on day of or prior to procedure, or no longer requires GT i.e., clinical condition improved/ deteriorated please contact the endoscopy department in advance as the procedure may need to be postponed or cancelled

2.10.5. **Endoscopy team responsibilities**

- If a patient is an outpatient, they will need to follow the unit's usual preparation on arrival to the unit (Endoscopy patient booklet completed, observations, cannulated, consented etc.) For inpatients this should have been completed prior to arrival to the unit
- Prophylactic antibiotic dose given to reduce risk of peristomal infection note these are to be administered in endoscopy at time of procedure
- The endoscopy team will ensure that the PEG care plan (CHA 3399) is commenced as soon as the patients PEG is inserted

- The procedure is documented on the Scorpio report by the endoscopist, and this is automatically transferred to the patients Maxims record

- Patients will initially recover on the endoscopy unit for their first stage of recovery if not requiring a HDU bed

- If the patient is an outpatient and a HDU bed is required, this will be known about pre procedure and the endoscopy nurse in charge will liaise with bed managers/ site co-ordinators and the nurse in charge on HDU to co-ordinate transfer post procedure to either HDU or theatre recovery

- Facilitate the safe transfer back to the ward for inpatients or liaise with bed managers/site co-ordinators if a bed is required. This will be known about prior to the procedure

- Handover the patient back to the inpatient or destination ward if applicable

- Administer analgesia as required, initially simple analgesics can be administered via the homely remedies, if the patient is experiencing increasing pain which is not resolved with simple analgesics, then the nursing team will escalate this to the clinician who has completed the procedure for review and prescribing of further analgesia if appropriate

- Whilst the patient is not anticipated to remain on the endoscopy unit for a prolonged period of time it is recognised that due to the nature of the procedure taking place most patients will remain on the unit for a significant period of time. During this time patients should be supported with their activities of daily living specifically related to continence and pressure area care. This support will be given to patients by the endoscopy team during their stay

- Skin bundles should be completed for those patients deemed to be high risk of pressure damage

- If the patient remains on the endoscopy unit either prior to discharge or is awaiting a bed, then the endoscopy staff will complete the patients initial 4-hour post procedure flush. This is where the registered Practioner will check the peg site for leaking and bleeding. If the Peg site is fine then they will administer 50mls of sterile water down the peg, monitoring for any signs of pain, leaking and bleeding

- Patients who are attending the endoscopy unit from another ward or unit from outside of the hospital will remain on the endoscopy unit until their 4 hour post procedural flush has been completed. The unit will then complete a verbal and written hand over to the receiving unit prior to the patient being discharged from the Endoscopy Unit

- The patients PEG should not be rotated or pulled during their initial stay

- Contact Nutrition Nurse post PEG placement to support if needed

2.10.6. **Post PEG Insertion**

Hyperlink to:

http://doclibrary-rcht-intranet.cornwall.nhs.uk/DocumentsLibrary/RoyalCornwallHospitalsTrust/Clinical/Gastroenterology/TroubleshootingPercutaneousEndoscopicGastrostomyAndRadiologicallyInsertedGastrostomyForAdultsOnlyClinicalGuideline.pdf

2.10.7. **Complications post procedure**

Complications may result in serious illness or death in the **immediate period** after gastrostomy insertion. Signs of complications may include:

- Pain on feeding

- Prolonged or severe pain post procedure

- External leakage of gastric contents

- Fresh bleeding

- Aspiration pneumonia

Monitor NEWS as indicated and check PEG site regularly as per care plan CHA3399 (see Appendix.6 Care Plan CHA3399).

Staff should be aware of these signs / symptoms and know what to do and who to contact.

2.10.8. **Gastric Leakage**

Normally a small amount of leakage can be expected to last for a few days after insertion, but this should not be excessive and should stop by itself. If the leakage is continuous and there are large volumes along with pain or problems using the tube, medical advice should be sought.

2.10.9. **Pain**

Pain around the PEG site is common for a few days after insertion, regular analgesia should be prescribed.

However, If the patient complains of severe pain on feeding, fresh bleeding or leakage of gastric contents feed and medication delivery should be stopped immediately and senior medical advice should be obtained urgently or gastroenterologist/ surgeon.

2.10.10. **Consider:**

- Abdominal USS
- CT scan
- Surgical referral
- Lineogram
- Abdominal X-ray

2.10.11. **Post-insertion PEG care / feeding**

Nothing should be administered via the PEG tube until 4 hours post placement.

Thereafter an Initial bolus of water (50mls) should be administered before commencing feeding regimen to ensure correct and safe position of PEG and reduce risks of associated peritonitis. The Nutrition specialist Nurse will aim to support this when the patient returns or is transferred to a ward.

Setting up and monitoring of the enteral feeding system, flushing the PEG tube, administration of medications down the tube and initial cleansing of the PEG site post insertion must only be carried out by a Registered Nurse.

A Feeding regimen will be prescribed by the Dietitian in the hospital and transferred to the care of the Home Enteral Feeding Dietitian for ongoing nutritional support and monitoring.

2.10.12. **PEG Grab box (appendix)**

All wards receiving patients with a PEG should have a stocked grab box or know where the nearest one is.

These can be found on Phoenix, Tintagel, GALU and ED and should contain emergency equipment in the event that the patients PEG falls out.

The Nutrition Specialist Nurse will provide the Patient with one, following their PEG tube insertion information leaflet, along with a red flag sticker and advice to attend ED if any complications i.e., bleeding, increased pain, leakage of gastric contents and

- Information card with interventional radiology contact details for fast-track admission if PEG falls out or becomes displaced (01872 253962)
- Do not send ward feeding pump home with the patient

- The Nutrition Specialist Nurse will send a SERF to the District Nursing team at discharge to support PEG care in the community and provide ongoing supply of consumables i.e., syringes, Saline, and gauze for cleaning. Spare Tube and Enplug

3. Monitoring compliance and effectiveness

This part must provide information on the processes and methodology for monitoring compliance with, and effectiveness of, the policy using the table below.

Information Category	Detail of process and methodology for monitoring compliance
Element to be monitored	Compliance of all this policy is to be monitored.
Lead	Gastroenterology Nutritional Support Team
Tool	Datix Incident Reporting
Frequency	Monitoring will be an ongoing practice within the specialty
Reporting arrangements	Any concerns regarding the ongoing implementation of this procedure should be reported to the Nutritional Specialist Nurse who will investigate and report back to Consultants/Staff.
Acting on recommendations and Lead(s)	Any recommendations/changes to this procedure will be reported at the specialty business and governance meetings/nurses' meeting and changes implemented.
Change in practice and lessons to be shared	Required changes to practice will be identified and actioned within a specific time frame. The Nutritional Specialist Nurse will take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders.

4. Equality and Diversity

4.10. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the 'Equality, Inclusion & Human Rights Policy' or the Equality and Diversity website.

4.11. Equality Impact Assessment

The Initial Equality Impact Assessment Screening Form is at Appendix 2.

Appendix 1. Governance Information

Information Category	Detailed Information
Document Title:	Inpatient and Outpatient Gastrostomy Referral and Placement Clinical Guideline (adult only) V2.0
This document replaces (exact title of previous version):	Percutaneous Endoscopic Gastrostomy (PEG) Referral and Placement Clinical Guideline V1.0
Date Issued/Approved:	August 2022
Date Valid From:	September 2022
Date Valid To:	September 2025
Directorate / Department responsible (author/owner):	Tracy Lee – Nutritional Specialist Nurse Chris Mitchell – Clinical Matron James Bebb – Gastroenterologist (Nutritional Lead Consultant) Lynsey Farrell – Endoscopy Unit Lead
Contact details:	01872 253247
Brief summary of contents:	Standards expected for referral and placement of Gastrostomy Tubes in the Endoscopy department
Suggested Keywords:	Gastrostomy, Referral, Placement, PEG, Endoscopy Unit
Target Audience:	RCHT: Yes CFT: No KCCG: No
Executive Director responsible for Policy:	Medical Director
Approval route for consultation and ratification:	Speciality Business and Governance Meeting SSS Senior Management Team Governance Meeting SSS Care Group Board
General Manager confirming approval processes:	Roz Davies
Name of Governance Lead confirming approval by specialty and care group management meetings:	Maria Lane
Links to key external standards:	None required
Related Documents:	As listed in section 1

Information Category	Detailed Information
Training Need Identified?	No
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet & Intranet
Document Library Folder/Sub Folder:	Clinical / Gastroenterology

Version Control Table

Date	Version Number	Summary of Changes	Changes Made by
12/2020	V1.0	Initial issue	Tracy Lee – Nutritional Specialist Nurse
08/2022	V2.0	Full Update and transfer to new template. Additional updates made to: • Referral process • Consent • Endoscopy Responsibilities	Tracy Lee – Nutritional Specialist Nurse Chris Mitchell – Clinical Matron James Bebb – Consultant Gastroenterologist Lynsey Farrell – Endoscopy Unit Lead

All or part of this document can be released under the Freedom of Information Act 2000

This document is to be retained for 10 years from the date of expiry.
This document is only valid on the day of printing

Controlled Document

This document has been created following the Royal Cornwall Hospitals NHS Trust Policy for the Development and Management of Knowledge, Procedural and Web Documents (The Policy on Policies). It should not be altered in any way without the express permission of the author or their Line Manager.

Appendix 2. Equality Impact Assessment

Section 1: Equality Impact Assessment (EIA) Form

The EIA process allows the Trust to identify where a policy or service may have a negative impact on an individual or particular group of people.

For guidance, please refer to the Equality Impact Assessment Policy (available from the document library) or contact the Equality, Diversity & Inclusion Team rcht.inclusion@nhs.net

Information Category	Detailed Information
Name of the strategy / policy / proposal / service function to be assessed:	Inpatient and Outpatient Gastrostomy Referral and Placement Clinical Guideline (adult only) V2.0
Directorate and service area:	Specialist Services & Surgery Care Group
Is this a new or existing Policy?	Existing
Name of individual completing EIA (Should be completed by an individual with a good understanding of the Service/Policy):	Chris Mitchell – Clinical Matron
Contact details:	01872 253416

Information Category	Detailed Information
1. Policy Aim - Who is the Policy aimed at? (The Policy is the Strategy, Policy, Proposal or Service Change to be assessed)	To support the clinical teams referring and completing the placement of Gastrostomy tubes for patients within the Endoscopy Unit at Royal Cornwall Hospital.
2. Policy Objectives	To ensure that clinical teams have clear guidance on referring and placing gastrostomy tubes. This will also ensure that the specialty and endoscopy unit are compliant with NICE guidance.
3. Policy Intended Outcomes	To ensure that teams referring and placing gastrostomy tubes follow a standardized process and guidance. To ensure that roles and responsibilities are defined and clear so that staff understand what is expected of them.
4. How will you measure each outcome?	Reviewing incidents and complaints related to the patient pathway for referral and insertion of Gastrostomy tubes.

Information Category	Detailed Information
5. Who is intended to benefit from the policy?	Clinical teams providing care to Nutritional patients. Our patients will also benefit from the teams understanding what process to follow when referring and inserting gastrostomy tubes.
6a. Who did you consult with? (Please select Yes or No for each category)	• Workforce: Yes • Patients/ visitors: No • Local groups/ system partners: No • External organisations: No • Other: No
6b. Please list the individuals/groups who have been consulted about this policy.	**Please record specific names of individuals/ groups:** Gastroenterology Specialty Multi-Disciplinary Team members NICE Guidance
6c. What was the outcome of the consultation?	Changes were made to ensure that the document and process is compliant with national guidance in relation to Gastroenterology.
6d. Have you used any of the following to assist your assessment?	**National or local statistics, audits, activity reports, process maps, complaints, staff or patient surveys:** No

7. The Impact

Following consultation with key groups, has a negative impact been identified for any protected characteristic? Please note that a rationale is required for each one.

Where a negative impact is identified without rationale, the key groups will need to be consulted again.

Protected Characteristic	(Yes or No)	Rationale
Age	No	
Sex (male or female)	No	
Gender reassignment (Transgender, non-binary, gender fluid etc.)	No	
Race	No	

Protected Characteristic	(Yes or No)	Rationale
Disability (e.g., physical or cognitive impairment, mental health, long term conditions etc.)	No	
Religion or belief	No	
Marriage and civil partnership	No	
Pregnancy and maternity	No	
Sexual orientation (e.g. gay, straight, bisexual, lesbian etc.)	No	

A robust rationale must be in place for all protected characteristics. If a negative impact has been identified, please complete section 2. If no negative impact has been identified and if this is not a major service change, you can end the assessment here.

I am confident that section 2 of this EIA does not need completing as there are no highlighted risks of negative impact occurring because of this policy.

Name of person confirming result of initial impact assessment: Chris Mitchell, Clinical Matron, Specialist Services

If a negative impact has been identified above OR this is a major service change, you will need to complete section 2 of the EIA form available here:
Section 2. Full Equality Analysis