CHOICES: A Framework for Supporting and Documenting Complex Decisions in those with Eating, Drinking and/or swallowing difficulties. Version 2

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[1] As defined in section 7.4 of the Trust-wide Document Control Policy

VERSION CONTROL SUMMARY

Version:	Page/Section of Document:	Description of change:	Date Exec Director/Chair of DLB approval given for change of review date only	Date approved:	Date published:
2023 Version 1		New guideline	N/A	20/4/2023	26/4/2023
2026 Version 2		Removal of appendix 2 & 3 Addition of CHOICES leaflet, NG Leaflet and PEG Leaflet. Updated patient example in appendix 6.	28/04/2026	N/A	28/04/2026

If a document is being updated in line with actions following a serious incident, patient safety incident or Never Event, please state this in the 'Description of change' column

DOCUMENT CONTRIBUTORS

Please list the details of all who contributed to the development of this document.

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1. INTRODUCTION

1.1 **CHOICES** was developed as a tool to guide through the principles of decision making and aid documentation (see appendix 3) of decisions in situations where there is a risk associated with continued oral intake in cases of eating, drinking and/or swallowing (EDS) difficulties and a risk feeding approach is being considered.

1.2 **Risk Feeding Definition**
A "risk feeding" approach may be appropriate for a number of reasons:

1) Benefits of eating and drinking orally (such as enjoyment and quality of life) are deemed to outweigh the risks (such as chest infections, choking, weight loss)
2) Clinically assisted nutrition and hydration (CANH) options may be limited by a person's medical condition or risk of CANH options may be too high.
3) The person may be approaching the end of their life and a palliative approach may be more appropriate.
4) CANH will not prolong or improve quality of life.
5) A person may not wish to give up the pleasure of eating and drinking, either to be nil by mouth or take modified foods and/or fluids.
6) A person may not wish to have an invasive procedure such as tube feeding.

1.3 **Move Away From Term "Risk Feeding"**
There has been criticism of the term "Risk Feeding" (Murray et al, 2019). There are several reasons this term is falling from favour:

1) "Risk Feeding" has negative connotations, with it having the potential to portray an unbalanced risk/benefit of potential treatment options and encourages a risk averse approach that may ultimately be detrimental to the person with EDS difficulties wellbeing.

2) It is unfair to label a patient as "risk feeding" when a patient is palliative/ approaching the end of their life. There are often no other alternative options and it can place an unnecessary burden of risk on carers / family members wanting to support a patient's comfort and quality of life.

3) The concept of risk from aspiration can be difficult to quantify, with there being a body of evidence that aspiration of food and/or drink does not always lead to aspiration pneumonia and that aspiration pneumonia is not always due to aspiration of food and/or drink (Langmore et al. 2002, RCP 2021).

4) There are risks from treatments considered to prevent aspiration:

   Thickened fluids may increase risks of dehydration and urinary tract infections (Robbins et al., 2008), have significant impact on quality of life (Lim et al. 2016) and cause more serious chest infections if aspirated (Robbins et al. 2000).

   Being nil by mouth can worsen oral hygiene, thus increasing risk of aspiration pneumonia (Pace and McCullough, 2010), can be further detrimental to swallow

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function and can significantly impact on a person's wellbeing, even if for a short period of time.

2. PURPOSE

2.1 The following documents are available to support ethical decision making. This tool is based on the best practice principles from these documents. It does not aim to be a substitute for the information contained within them. It is good practice for those supporting complex decisions in those with EDS difficulties to read and be familiar with their contents.

- Mental Capacity Act (2005)
- Supporting people who have eating and drinking difficulties**:** A guide to practical care and clinical assistance, particularly towards the end of life. RCP (2021)
- Clinically assisted nutrition and hydration (CANH) and adults who lack the capacity to consent. Guidance for decision making in England and wales. BMA/RCP (2018)
- Treatment and care towards the end of life; good practice in decision making'. GMA (2010)
- Eating and drinking with acknowledged risks: Multidisciplinary team guidance for the shared decision-making process –adults. RCSLT (2021)

3. PATIENT GROUP COVERED

3.1 CHOICES focuses on supporting adults with eating, drinking and/or swallowing (EDS) difficulties. A wide range of conditions can cause EDS difficulties, such as Dementia, Stroke, Progressive neurological conditions and Cerebral Palsy.

3.2 CHOICES should not be used with those that are at risk of imminently dying, as pursuing oral intake that is comfortable and maintains quality of life should be the priority (see *Appendix 1*), but may be applicable to those approaching the end of life in certain circumstances.

3.3 **Approaching End of Life**

The General Medical Council (GMC) defines that patients are 'approaching the end of life' when they are likely to die within the next 12 months. This includes patients whose death is imminent (expected within a few hours or days) and those with:

1. advanced, progressive, incurable conditions
2. general frailty and co-existing conditions that mean they are expected to die within 12 months of existing conditions
3. if they are at risk of dying from a sudden acute crisis in their condition
4. life-threatening acute conditions caused by sudden catastrophic events

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4. CHOICES EXPLAINED

4.1 CHOICES is an acronym for the main factors that need to be considered when making a decision with or for a person with risks associated with continued oral intake in the context of EDS difficulties. It aims to provide positive terminology and encourage a balanced approach to decision making and to reinforce that people with EDS problems have a choice. It is a flexible document to support a range of potential decisions and option scenarios.

CHOICES stands for:

Centred around the person
Holistic
Options
In best interests
Communicated
Evidenced
Shared

5. CENTERED AROUND THE PERSON

5.1 Safe and efficient EDS skills are not only necessary to maintain adequate nutrition and hydration but are also essential to participating in a range of socio-cultural experiences (Kenny, 2015). Dietary restrictions that are unduly onerous or do not consider the range of implication for that individual on their cultural identity, social opportunities, quality of life and pleasure are likely to put a strain on professional relationships and reduce compliance and satisfaction (Colody, 2005).

It is therefore essential that when making a choice about oral intake with or for a person with dysphagia it is centred around them as an individual and that risks of potential treatment options are presented as well as potential risks of continued oral intake.

If a person is unable to make choices for themselves it is important that information is gathered from the patient's behaviour, family, friends and carers in order to build a picture of what the person might have wanted and/or what they want now.

The following questions may be helpful to consider:

- Has the person expressed any past/present wishes?
- What is the quality of his/her life at present (from his or her perspective)?
- What is his/her awareness of the world around him/her?
- Is there any (or any significant) enjoyment in his/her life? If so, how can this be maximised? Is food/drink a source of enjoyment?
- Is there any real prospect of recovery of any functions or improvement to a quality of life that he/she would value?

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- What are the implication of any of the options on the individual, e.g. care/placement implications if CANH is pursued?

This information should be listed in the "Centred around the person" section on the CHOICES form.

6. HOLISTIC

6.1 It is important that risk associated with EDS problems is considered in the context of other co-morbidities so that undue weight is not given to risk of deterioration from oral intake versus other illnesses.

The following should be considered so that a balanced decision around oral intake is made:

1. Is the person "approaching the end of their life" (GMC)?
2. What is their frailty score?
3. What are the other co-morbidities / risks to life?
4. Are there any reversible causes of EDS difficulties?
5. What were previous levels of functioning?
6. What is the prognosis if CANH were to be started / continued/ discontinued?

Other relevant co-morbidities, prognosis and reversible causes should be listed in the "Holistic" section on the CHOICES form.

7. OPTIONS

7.1 It is important that the viability of oral intake methods +/- CANH options are explored and discussed as an MDT before being presented to the person with EDS difficulties or other decision making partners. This encourages a consistent message to be presented by all health care professionals involved and avoids unnecessary confusion about the risks and options.

Examples of things to consider are:

- Can oral intake be modified/supported?
- Would the person with EDS difficulties be a candidate for CANH, e.g. PEG?
- Would they medically be able to tolerate this procedure?
- Is there evidence that this patient group would benefit?
- Would the person be a candidate for a trial of NG feeding? (See appendix 8 for NG Leaflet)
- What advance care planning needs to be considered (e.g. preferred place of death, avoiding further admissions?

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- How will future infections be managed (e.g. ceilings of care, oral versus IV antibiotics)?

A list of relevant options should be listed here with an outline of pros/cons for that individual in the "Options" section on the CHOICES form.

8. IN BEST INTERESTS

8.1 If the person with EDS difficulties mental capacity is in doubt then a mental capacity assessment needs to be completed.

8.2 If the person has communication difficulties, it is important to facilitate communication so lack of capacity is not presumed. A speech and language therapist may be needed to support with this.

8.3 It needs to be established whether an Advance Directive is in place or whether anyone holds a Lasting Power of Attorney (LPA) for Health and Welfare (including decisions regarding life sustaining treatment).

8.4 An IMCA (independent mental capacity advocate) should be requested when there is no next of kin or anyone other than a paid carer or any other 'appropriate representative' to advocate on the patients behalf. IMCAs are required when someone has lost capacity for decisions regarding change of accommodation/ serious medical treatment (e.g. PEG insertion) / accommodation review/ Safeguarding of Adults at Risk (with a protective measure). Other advocacy options are available. Please see Peterborough and Cambridgeshire – Total Voice www.voiceability.org for further information/referral process.

8.5 The Mental Capacity Act (2005) states that if making a decision in someone's best interests "treatment and care provided to someone who lacks capacity should be the least restrictive of their basic rights and freedoms". This is important when considering restrictions such as NBM.

Whether a person has capacity or whether a trust MCA form has been completed should be listed here in the "In best interests" section on the CHOICES form.

If there is an Advance Directive or Lasting Power of Attorney for Health and Welfare, this should be listed in the "In best interests" section on the CHOICES form. Copies should be put in the medical notes. Whether an IMCA is required should be listed here.

9. COMMUNICATED

9.1 It is important to communicate effectively (a) as a group of professionals (b) with the person with EDS difficulties or family/other representatives and (c) when transferring to another ward/ on discharge to avoid confusion and mixed messages.

9.2 It is important to give explanations, back up discussions with written information, repeat information and give time to understand information and make choices (Miles 2016).

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9.3 Sometimes rapid decisions may need to be made, however, in cases where delaying a decision can cause further harm/distress/ medical interventions that are not in the persons best interests, e.g. keeping someone nil by mouth in cases of advanced dementia/frailty.

9.4 Any decisions should be communicated effectively to those caring for the individual, to prevent unnecessary concerns around coughing or perceived risk of aspiration impacting on the patient's continuity of care.

9.5 The decision must be shared with those professionals responsible for the future care of the patient e.g. GP, district nursing team, care home staff. Advance care planning discussions should be documented and shared appropriately on the CHOICES form and ReSPECT document and summarised on discharge paperwork.

9.6 The CHOICES form should be transferred with the patient on discharge to aid continuity of care and should be referenced in the hospital discharge summary.

***Who* has been communicated with (full name, title, relationship to person with EDS difficulties), *how* choices have been communicated (e.g. best interest meeting) and *when* (date) should be listed in the "Communicated" section on the CHOICES form.**

10. EVIDENCED

10.1 It is important that a risk of aspiration/choking of food and/or drink is evidenced and not presumed. Aspiration pneumonia is not always due to aspiration of food and drink.

10.2 "It is important to distinguish between the effects of oral intake on the patient's symptoms and experiences and risk to life" (Murray et al, 2019).

10.3 Evidence may be in the form of:

- A speech and language therapy clinical assessment
- Instrumental assessments such as video fluoroscopies
- Case-history information correlating EDS problems with the clinical presentation
- Dietetic assessments
- Weight loss history

Evidence of risks including nature, frequency and severity where possible, should be listed in the "Evidenced" section of the CHOICES form.

11. SHARED

11.1 The professionals most appropriate to the decision should be part of the CHOICES process. For example, in cases where options for alternative nutrition and hydration are being explored, a consultant or senior doctor would need to be involved in the process. However, in cases where a person with mental capacity is choosing between possible SLT treatments, e.g. whether to take thickener, a consultant may not be required. *Appendix 6* Provides a list of possible MDT members.

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12. APPROVAL

12.1 This guideline was approved by the Nutrition Steering Group, Rehabilitation Services Quality & Governance Meeting, Patient Safety Insight & Involvement Committee, FISS Divisional Leadership Board and the Quality Governance & Operational Committee.

13. DISTRIBUTION

13.1 This guideline is available on SharePoint.

14. ACKNOWLEDGEMENTS

14.1 Thank you to the following for reviewing and supporting this piece of work:

Dr S. Carding (Palliative Care Consultant)
Dr L. Ellis (Geriatrician)
Dr. Bashford (Ortho-Geriatrician)
N. Craner (Adult Safeguarding Lead Practitioner)
NWAngliaFT Speech and Language Therapy Department
Nutrition Steering Group
CHOICES working group / MDT

15. REFERENCES

15.1 BMA/RCP (2018): Clinically assisted nutrition and hydration (CANH) and adults who lack the capacity to consent. Guidance for decision making in England and wales. www.bma.org.uk/media/1161/bma-clinically-assisted-nutrition-hydration-canh-full-guidance.pdf

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Murray, A., Mulkerrin, S. and O'Keefe, S. (2019) Perils of risk feeding. Age and Ageing. 0:1-4.

Pace CC., McCullough GH. (2010) The association between oral microorgansims and aspiration pneumonia in the institutionalized elderly: review and recommendations. *Dysphagia*. 2010;25(4):307-322. doi:10.1007/s00455-010-9298-9

RCP (2021): Supporting people who have eating and drinking difficulties: A guide to practical care and clinical assistance, particularly towards the end of life.

RCSLT (2021) Eating and drinking with acknowledged risks: Multidisciplinary team guidance for the shared decision-making process (adults)

Robbins, Joanne (2000). Protocol 201: A NIDCD-Funded MultiSite Clinical Trial in Swallowing. Perspectives on Swallowing and Swallowing Disorders (dysphagia). 9. 2-3. 10.1044/sasd9.2.2.

Robbins J., Gensler G., Hind J., et al. (2008) Comparison of 2 interventions for liquid aspiration on pneumonia incidence: a randomized trial. Ann Intern Med. 148(7):509-518.

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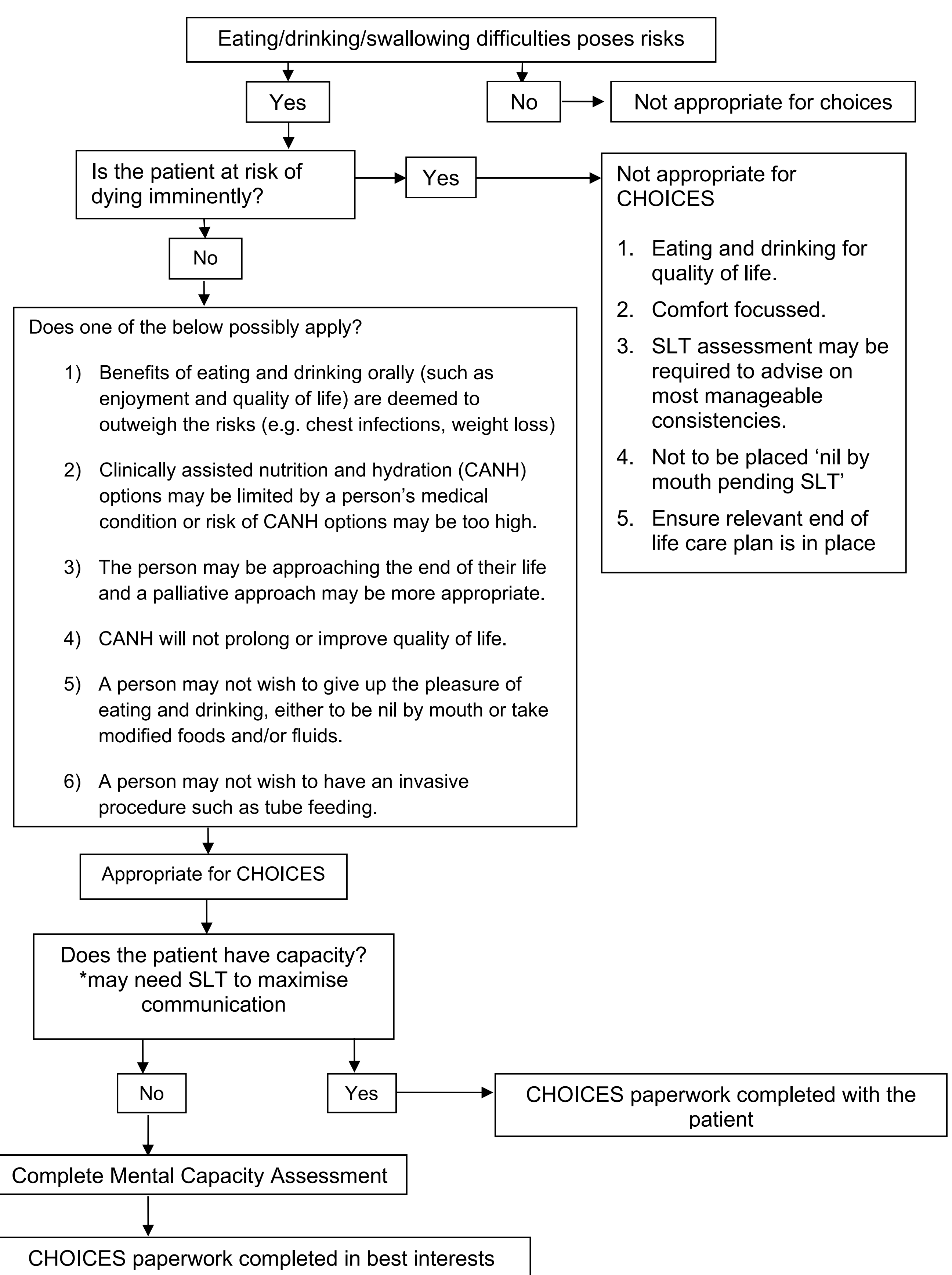
APPENDIX 1: HOW TO USE CHOICES



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APPENDIX 2: CHOICES LEAFLET (ALSO AVAILABLE ON THE INTRANET)

How we support decision-making with or for people with difficulties eating and drinking

An Information Leaflet for service users

What are EDS difficulties?

Eating, Drinking and/or Swallowing (EDS) difficulties can happen for many reasons, including:

Dementia, stroke, neurological conditions, learning disabilities, acute or chronic illness.

These difficulties may prevent someone from getting enough food or fluids and may increase the risk of aspiration (when food, drink, or saliva enters the lungs instead of the stomach).

Aspiration can lead to coughing or spluttering. This can lead to aspiration pneumonia. Sometimes, it happens with no visible signs, which is called silent aspiration.

Both aspiration and not being able to eat or drink enough can lead to a deterioration in health, but it's important to consider these difficulties within the context of the person's overall health.

Why decisions around EDS can be complex

Managing EDS difficulties is highly individual. A person's unique circumstances will determine which options are chosen. Sometimes:

- It's more appropriate to focus on quality of life.
- The person is in an advanced stage of illness.
- Swallowing is unlikely to improve.
- The person chooses to eat and drink despite possible risks.
- Tube feeding is not appropriate or possible.

The CHOICES Framework

To guide this decision-making process, we use CHOICES. This is a structured way to support individuals and their families in making the right decision for them. This will include looking at appropriate options and making sure decisions are in the best interests of the person.

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Aspiration can lead to coughing or spluttering. This can lead to aspiration pneumonia. Sometimes, it happens with no visible signs, which is called **silent aspiration**.

Both aspiration and not being able to eat or drink enough can lead to a deterioration in health, but it's important to consider these difficulties within the context of the person's overall health.

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- It's more appropriate to focus on quality of life.
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The CHOICES Framework

To guide this decision-making process, we use **CHOICES**. This is a structured way to support individuals and their families in making the right decision for them. This will include looking at appropriate options and making sure decisions are in the best interests of the person.

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Department: Rehabilitation
Author: Nutrition and Dietetics
Review date: February 2028

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APPENDIX 3: CHOICES FORM. MAKING DECISIONS WITH OR FOR PEOPLE WITH EATING AND DRINKING DIFFICULTIES

Name		DOB		NHS/DIS		Date	

Centred around the Person: (Past/present wishes and beliefs, implications for the individual)

Holistic: (Consider in context of other co-morbidities, prognosis, reversible causes.)

Options: (List the choices in this case? Pros and cons of options? Advanced care planning options?)

In best Interests: (If yes to 2 and/or 3 put copies in notes)

1. Presumed mental capacity? Yes ☐ No ☐ If no =Trust MCA ☐ IMCA needed? Yes ☐ No ☐
2. LPA Health & Welfare? Yes ☐ No ☐ Can make decisions about life sustaining treatment Yes ☐ No ☐
3. Advance Directive? Yes ☐ No ☐

Communicated: Who have the choices been discussed with (name, relationship to person), how and when?

When (date): How:
Who:

Evidenced: (What is the problem? What are the risks? How do we know they exist? How frequent /severe are they?)

Shared: (Which professionals have been involved in this decision making process? Name and profession):

Who needs to know for the future?

CHOICE: (including wishes for future management of infections +/- hospital readmission)

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APPENDIX 4: CHOICES EXAMPLE FORM 1

Name	Example 1	DOB	58yrs	NHS		DIS	

Centred around the Person: (Past/present wishes and beliefs, implications for the individual)

- No formally expressed previous wishes.
- Staff at Care Home told IMCA that X has been much less interactive over the past months
- Son concerned that if X is fed via the PEG that she will lose interaction opportunities at meal times. X's friend told IMCA about X's previous suicide attempt when she became more dependent and was having little interaction with people except for visits for care.
- IMCA asked whether a PEG would enable a more peaceful death. Palliative care Dr explained that X symptoms could be managed without a PEG. IMCA raised the issue that X may need to move to a different part of care home if had a PEG and therefore would not be able to return to "home" as she knew it and to staff that were familiar to her.

Holistic: (Consider in context of other co-morbidities, prognosis, reversible causes)

End stage MS. Fully dependent on care and nutrition needs. Prognosis likely to be weeks to a small number of months. PEG unlikely to extend prognosis.

Options: (List the choices in this case? Pros and cons of options? Advanced care planning options?)

1) PEG – High risk in this case.
2) Continue oral intake with acknowledgement that full nutrition and hydration needs are not met and that end of life is supported.

In best Interests:

Does person have presumed mental capacity: Yes ☐ No X IMCA needed? Yes x No ☐
If no =Trust MCA - YES LPA Health & Welfare – no Advance Directive - no

X is unable to communicate due to both physical and cognitive disability.
IMCA as has no next of kin and family have not been in contact with X for some years.

Communicated: Who have the choices been discussed with (name, relationship to person), how and when?
(Son), (sister), Mother, Sister (x/x/2021- best interest meeting).

Evidenced: (What are the risks? How do we know they exist? How frequent /severe are they?)
There is no evidence that X is at risk of aspiration. She has not had repeated chest infections. Her chest has remained clear during the admission. There is, however, a reduced efficiency which results in her not meeting her hydration and nutrition needs orally

Shared: (Which professionals have been involved in this decision making process? Name and profession):
Dr S. (Gastroenterology Consultant), Speech and Language Therapist, community dietitian, hospital dietitian, IMCA, Dr C (Palliative Medicine consultant).

CHOICE: (including wishes for future management of infections +/- hospital readmission)

All agreed PEG not in x's best interests. To continue oral intake as able of thin fluids and puree diet.

Not for future admission – for end of life care including management of X's epilepsy which would need to be managed to ensure she did not have a seizure. She is currently still taking her anti-epileptic medication orally.

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APPENDIX 5: CHOICES EXAMPLE FORM 2

Name	Example 2	DOB	70yrs	NHS		DIS		Date	

Centred around the Person: (Past/present wishes and beliefs, implications for the individual)

- Has expressed a wish to continue to drink normal thin drinks, even though he knows they make him cough.
- Has expressed that he would not want to have a puree or minced and moist diet but would prefer choice in the types of food that he can have based on what he enjoys the most.
- Would want to reduce the risk of choking if possible. He also gets tired chewing and coughing on food & drink.

Holistic: (Consider in context of other co-morbidities, prognosis, reversible causes)

Diagnosis of Wernicke's encephalopathy; TBI; COPD; T2RF; T2DM. He has a history of ETOH and smoking. Overall health has been declining for some time. He is likely to continue to deteriorate.

Options: (List the choices in this case? Pros and cons of options? Advanced care planning options?)

1.Thin fluids. Cons - aspiration risk, potentially uncomfortable to swallow due to coughing. Pros - might be more palatable. Consistent with wishes.
2. Level 2 thickened fluids. Cons - may still present an aspiration risk pros- less likely to cause coughing. Due to less coughing, this option might also be less tiring to tolerate. Cons- has expressed a dislike of thickened drinks.
Food:
1. Level 7 regular diet. Cons- aspiration and choking risk, tiring to chew and swallow, causes coughing, which can be uncomfortable. Pros- potentially more enjoyment, can eat more of his favourite foods.
2. Eat a modified diet (this might be anything from level 4 puree, through level 5 minced and moist, to level 6 soft and bite-sized diet). Cons- might be less enjoyable, risk of aspiration. pros- potentially cause less coughing, meaning it would be less tiring, less uncomfortable, and also presents less of a choking risk.

In best **I**nterests:

Does person have presumed mental capacity: Yes ☐ No X If no =Trust MCA x
LPA Health & Welfare Yes ☐ No X (if yes- who. Copy in notes).
Advance Directive Yes ☐ No X (if yes- copy in notes).

Communicated: Who have the choices been discussed with (name, relationship to person), how and when?

When (date): x/x/x How: In person and via telephone Who: Person; Medical team; sister.

Evidenced: (What are the risks? How do we know they exist? How frequent /severe are they?)

FEES showed aspiration on all consistencies as well as indicating choke risk on level 7
Assessed clinically over a meal- coughing more on thin drinks and level 7 diet with more fatigue.
From clinical assessment, medical notes and Dietitian's assessment - unlikely to be able to meet his hydration and nutritional needs, as evidenced by dry mouth, medical team consideration of IV fluids and weight loss.

Shared: (Which professionals have been involved in this decision making process? Name and profession):

SLT & Medical Team
Who needs to know for the future? Staff at care home; GP

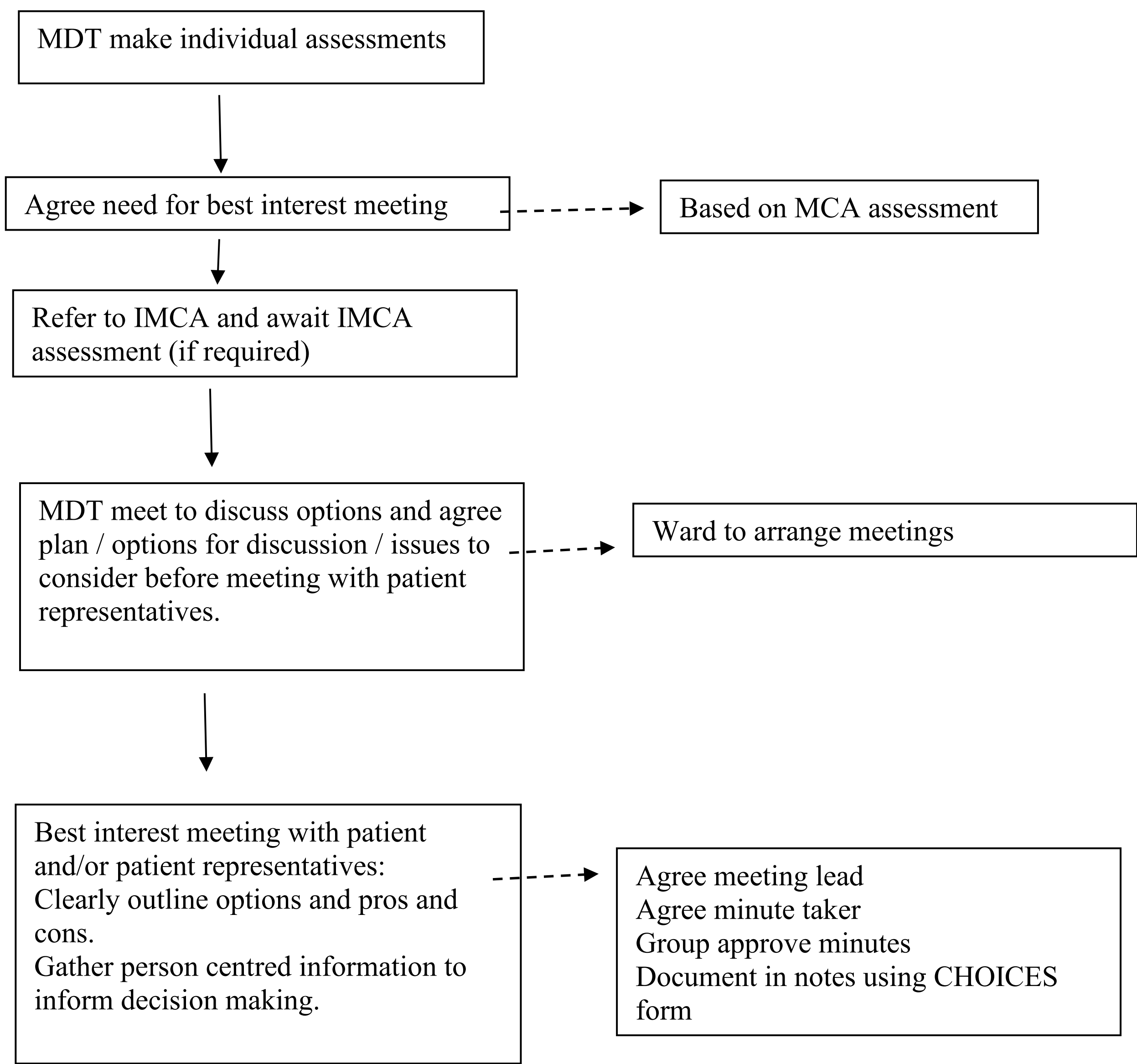
CHOICE: (including wishes for future management of infections +/- hospital readmission)
To take thin drinks
To take level 6 soft and bite-sized diet.
He said he didn't want to come back into hospital anymore.

APPENDIX 6: MULTI DISCIPLINARY TEAM MEMBERS

Lead Consultant*
Palliative care consultant and/or geriatric consultant (CHOICES team)*
Ward Nurse
Speech and Language Therapist *
Dietitian*
Nutrition Nurse*
Pharmacist
Palliative Care Nurse
Gastroenterologist
Physiotherapist
Safeguarding Team
Learning Difficulties Specialist Nurse
Other Specialist Nurses, e.g. MS
IMCA

*Core members

APPENDIX 7: GUIDANCE ON BEST INTEREST DECISION MEETINGS



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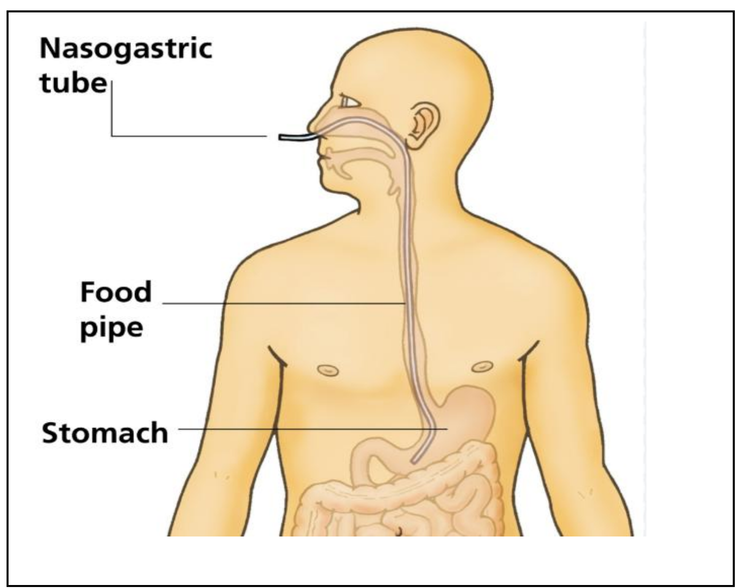
APPENDIX 8: NG LEAFLET (ALSO AVAILABLE ON THE INTRANET)

Nasogastric Feeding Tube
Information guide for adult patients and carers

The multi-disciplinary team (MDT) have suggested that a Nasogastric (NG) feeding tube would be appropriate for your current treatment needs.
This leaflet aims to provide general information about the NG tubes, why they are used, how they are inserted and how to care and maintain the tube.

What is an NG tube?
An NG tube is a thin, flexible tube inserted through the nose, passed down your food pipe (oesophagus) and down into the stomach. It is commonly used for giving nutrition, medications and providing liquid.



Why do I need an NG tube?
The NG tube can deliver nutrition and medications directly to your stomach, if you are unable to eat enough. This may be the case if your swallow is impaired, you require more nutrition to support healing or you have difficulty in swallowing medications.

How is the tube placed?
A trained member of staff will talk you through the procedure. This will give you an opportunity to ask any questions you may have. To be able to place the tube, you will be asked to sit in an upright position either in a chair or in bed. The tube is measured out in advance from your nose around your ear and then down to your breastbone.

The tube will be inserted through one of your nostrils, aiming down your food pipe (oesophagus) slowly advancing and into your stomach. If it is safe to do so, you will be asked to drink throughout to help the tube to be advanced more easily. Once the tube is inserted to the measurement, the trained member of staff will secure the tube with tape on your nose and to your cheek to prevent it moving.

Does having an NG tube hurt?
It can be a little uncomfortable, but not acutely painful when inserted. At the beginning, some people report discomfort in the nose or the throat, but this usually improves with time. You may experience some bleeding from the nose.

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How do they know the tube is in my stomach?
A syringe will be attached to the end of the NG tube to try to get some 'stomach acid' and the fluid (aspirate) is tested on pH test paper. The pH needs to be below 5.5 which indicates the aspirated fluid is from the stomach and confirms that the tube is in the stomach. If they cannot withdraw any 'stomach acid' with a syringe, an x-ray will be requested to make sure the tube is in your stomach. Once the tube has been confirmed in the correct place then the tube can be used for medications and nutrition. During this time feeds and medications maybe delayed or missed due to aspirates too high or unable to safely confirm the position of the NG.

What are the risks of having an NG tube placed?
As with any procedure, there are risks involved. One of the main risks is that the tube may accidentally be placed into the lung instead of the stomach. This is why it is important that position checks are undertaken every time the tube is accessed for feed, medications and water flushes and if the position cannot be confirmed then there can be delays in giving feed and medications until it can be safely confirmed either by stomach acid or by x-ray.

Are there any on-going risks with having an NG tube?
The tube may move out of the stomach if it is accidentally pulled, or if you vomit or have a coughing episode. You may also experience some discomfort in your nose and throat.
The medical team may decide that an NG tube may not be safe to insert if a patient is very confused and has pulled out other medical devices such as a drip or catheter. A safety risk assessment will take place prior to the NG tube being inserted.

If you do vomit or have a coughing episode, it is important that you inform your nurse immediately as a position check will need to be done. You must do the stomach acid test if you are at home.

What if the tube can't be inserted on the ward?
If this happens, you may need to go to another department where trained staff will use an endoscope camera to view down your throat to help to insert the tube. This simple procedure will be explained to you in more detail before the NG tube is passed.

How long will I need the tube for?
The tube is designed to be used for a short period of time, usually a few weeks. It can be used for nutrition or a trial of treatment when you are unable to eat and drink safely, after this it may be replaced with a longer-term feeding tube. Longer term tubes are not always appropriate and decisions about this will be made with you and the multi-disciplinary team caring for you.

Will I go home with my NG tube?
In some cases, patients will go home with their NG tube in place. If this is required, you and your family or carers will be trained to do the stomach test and administer nutrition and medications. You will be shown how to care for your tube and how to troubleshoot.

How will the NG tube be removed when it is no longer needed?
The nurse will loosen the tape and gently pull on the end of the tube until it is out. Removing the tube should not be painful but may feel strange as it is pulled out.

If you have any further questions, please speak to your nurse, doctor or dietitian

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APPENDIX 9: PHARMACY QUALITY ASSURANCE CHECKLIST

Pharmacy Quality Assurance Checklist for all Medicine-Related Clinical Policies, Procedures and Guidelines

This form must be completed by the appropriate designated pharmacist for all policies, procedures and guidelines relating to medicines prior to being submitted to the Drugs and Therapeutics Committee.

Title of Document:			**Central Index Number:**
1.	**Document particulars:**	**Yes / No / N/A**	**Comments (as necessary)**
	Is the document written in clear, unambiguous language?		
	Does the document also apply for Hinchingbrooke Hospital/ Peterborough City Hospital/ Stamford Hospital?		
	If the answer to the above question is YES, has the relevant pharmacist at the cross site location been contacted for their input? **(Please indicate name of person contacted in comments)**		
2.	**Evidence Based**		
	Are the product(s) on the Formulary? If non-formulary then please submit Formulary request/Business case.		
	Have indications been clearly reviewed?		
	Are the medicines, hospital supply only?		
	Have doses of medication been clearly reviewed?		
	Are definitions in the document clearly explained?		
	Are roles and responsibilities in the document clearly explained?		
	Are the products listed in the document licensed, unlicensed or off license? If unlicensed then please complete unlicensed form.		
	Are there any Patient Safety Alerts/MHRA Alerts/NICE guidance associated with the document?		
	Is there any specific ordering or storage requirements with the product(s) in the document?		
	Are there any cost implications with the product(s) in the document?		
	Is there any supporting evidence to support the document? **(References should be checked and updated)**		
	Are there measurable standards to support the monitoring of compliance? **(Audit table applicable to policies only)**		
3.	**Pharmacist Compliance Approval:**		
	Name:		
	Signature:		
	Role:		
	Date:		

Please return completed form to the Pharmacy Medicines Governance Team.

Pharmacy Medicines Governance – updated December 2022

APPENDIX 10: QUALITY ASSURANCE CHECKLIST

CORPORATE GOVERNANCE COMPLIANCE OFFICER'S USE ONLY

		Y/N/ n/a	COMMENTS (to author for amendments)
1	**Title of document**		
	Is the title clear and unambiguous	Y	
2	**Type of document (e.g. procedure, guidance)**		
	Is it clear whether the document is a procedure, guideline, SOP?	Y	
3	**Introduction**		
	Are reasons for the development of the document clearly stated?	Y	
4	**Content**		
	Are all sections of the front cover completed correctly?	Y	
	Is the document in the correct Trust approved format?	Y	
	• Paragraphs numbered consecutively	Y	
	• Headers: only on front page to contain logo	Y	
	• Footers: on every page except front page	Y	
	Has the Author's Checklist (pg. 2) been fully updated?	Y	
	Are the Version numbers correct in the title, summary and the footers?	Y	
	Has the Version Control Summary (pg. 3) been fully updated with changes?	Y	
	Has the Document Contributors section (pg. 3) been completed?	Y	
	Are the objectives/aims clearly stated?	Y	
	Does this document concern the handling, moving or storage of personal identifiable or commercially sensitive information? If yes, has a Summary Privacy Impact Assessment been completed?	N/A	
5	**Evidence Base**		
	Is the type of evidence to support the document explicitly identified?	Y	
	Are associated documents referenced?	Y	
6	**Approval Route**		
	Has email approval been received for change of review date only?	Y	
	Does the document identify which committee/group will approve it?	Y	
	Does the document meet the criteria for Second Level approval or Information Only?	Y	

If answers to any of the above questions is 'no', then this document is not ready for approval, it needs further review.

It is vitally important that documents are forwarded to the Corporate Governance Compliance Team after every amendment and approval meeting to ensure the most up-to-date version is held by the team at all times.

CORPORATE GOVERNANCE COMPLIANCE TEAM:		
1.	Date comments returned to author by Compliance Lead:	
2.	Date of Corporate Governance Compliance Team approval:	26.03.2026
3.	Name of Compliance Lead:	Viv Allchin V. Allchin

Please do not delete any of the below approval sections.
If certain sections are not applicable to the document's journey, please enter 'N/A'

SPECIALTY APPROVAL MEETING: Nutrition Steering Group			
On approval, Chair to sign below and send the document and the minutes from the approval committee to the Corporate Governance Team. **To aid distribution all documentation should use electronic signatures and be sent electronically wherever possible.**			
Chair's Name	Linda Parker	**Date**	08/04/2021
Signature			

CBU APPROVAL MEETING: FISS - Rehabilitation Services Quality and Governance Meeting			
On approval, Chair to sign below and send the document and the minutes from the approval committee to the Corporate Governance Team. **To aid distribution all documentation should use electronic signatures and be sent electronically wherever possible.**			
Chair's Name	Susan M Bentley	**Date**	28/11/2022
Signature			

ADDITIONAL APPROVAL MEETINGS: Complete all that apply			
On approval, Chair to sign below and send the document and the minutes from the approval committee to the Corporate Governance Team. **To aid distribution all documentation should use electronic signatures and be sent electronically wherever possible.**			
Patient Safety Committee		Select Meeting.	
Chair's Name	SUZANNE HAMILTON	**Chair's Name**	
Date	25/11/2022	**Date**	Enter date
Signature		**Signature**	
Select Meeting.		Select Meeting.	
Chair's Name		**Chair's Name**	
Date	Enter date	**Date**	Enter date
Signature		**Signature**	

FIRST-LEVEL APPROVAL: Enter name of **Divisional Leadership Board/Meeting**			
On approval, Chair to sign below and send the document and the minutes from the approval committee to the Corporate Governance Team. **To aid distribution all documentation should use electronic signatures and be sent electronically wherever possible.**			
Chair's Name	DR TIM JONES	**Date**	28/04/2026
Signature			

Please confirm if document requires Second-Level **approval** or it is to be submitted for **information only**. Please see section 6.4 of the Trust's Document Control Policy.	☐ **APPROVAL** ☐ **INFORMATION ONLY**

SECOND-LEVEL APPROVAL: Quality Governance Operational Committee			
On approval, Chair to sign below and send the document and the minutes from the approval committee to the Corporate Governance Team. **To aid distribution all documentation should use electronic signatures and be sent electronically wherever possible.**			
Chair's Name	Dr Suzanne Hamilton	**Date**	20/04/2023
Signature			