

Document Type:	Standard Operating Procedure	
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Title:	Care And Management Of A Nasogastric Tube (CFHD-SOP006)	
Document Author:	Service Lead	
Applicability:	For Children & Family Health Devon Specialist Community Nurses And For Healthcare Professionals Employed by Children & Family Health Devon	

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1. Background

Children & Family Health Devon provide care for children who may require nutritional support or medicines via a nasogastric tube. All children who require nutritional support via a nasogastric tube will have been assessed by the multi-disciplinary team and in conjunction with the parents.

Care and management of nasogastric tubes may be undertaken by a registered practitioner or a non-registered practitioner who has been delegated the task and have achieved the required competencies in all aspects of the care as specified within Children & Family Health Devon competency document.

Training will be provided by the registered practitioner to non-registered practitioners employed within Children & Family Health Devon and to direct carers.

Short-term tubes are made of polyvinylchloride (PVC) and can remain in place for between 3-10 days. Manufacturer's guidelines should be used to determine the length of time a tube can be left in place. If a tube is accidentally removed prematurely a new tube should be used. 'Single use' is usually recommended.

Long-term tubes are made of polyurethane and have a wire to aid passing the tube. The wire is removed once the tube has been passed but should be kept in a safe place in case the tube has to be re-passed. The guide wire should be cleaned, dried and placed in a sealed container, and labelled with the child's name for reuse. The manufacturer will provide guidance regarding the length of time the tube can remain in place,

For the purpose of this document child will mean child and young person from birth until the day before their 18th birthday. Parent will mean parent/carer. If there is any cause for concern regarding a nasogastric tube the community children's nurses should be contacted before its use for further advice.

2. Inserting a Nasogastric Tube

Insertion of a nasogastric tube can only be carried out by:

A registered health care practitioner (HCP) who has undergone appropriate training and is deemed competent in the skill. Mature patients and/or parents/carers who have been trained in the skill and have been formally assessed and deemed competent by a registered nurse.

Unregistered healthcare staff will currently not insert a nasogastric tube.

1. Wash your hands before and after the procedure, always use appropriate PPE wearing approved gloves
2. Obtain and record consent for the procedure.
3. Collect equipment (nasogastric tube, enteral use 50mls syringe, pH indicator paper or strip, water to flush, tape to secure, glass of water/juice If appropriate)
4. Explain to the child/young person that you are going to pass the nasogastric tube.

-
5. Babies can be wrapped in a blanket or towel to help keep them secure and laid flat on their back (unless another adult is available to assist holding the child); older children may prefer to sit up with their head tilted slightly forward
 6. Select a nostril that is clear; where possible alternate the nostril being used.
 7. Determine length of tube to be inserted by measuring the tip of the tube from nose to ear and then measure from ear to xiphisternum note the mark on the tube or keep your fingers on the point measured.
 8. Ensure end cap is firmly in place on the end of tube, to prevent leakage of gastric contents.
 9. Lubricate tip of the tube using water and/or follow manufacturer's guidelines
 10. Insert tip of tube into nostril and slide backwards along the floor of the nose
 11. If there is any obstruction, pull tube back and turn it slightly and advance again.
 12. If obstruction is felt again try the other nostril.
 13. If the child has an appropriately safe swallow and is NOT nil by mouth, then as the tube passes to the back of the nose, advise child/young person to take sips of water to help the tube go down or in the case of a baby offer them a dummy if they have one.
 14. If at any time the child/young person starts coughing or their colour changes stop the procedure immediately and remove the tube
 15. Advance the tube until you reach the point where the tube was measured.
 16. Secure the tube in position using a barrier product such as hydrocolloid dressings to protect the skin and transparent films.
 17. The position of the tube must be confirmed after passing and prior to using the tube. Once the position has been confirmed by suitable pH the guide wire (for long-term tubes) can be removed by inserting 1-2 mls water to lubricate. Follow manufacturer's guidance for specific tubes.

18) Document the procedure following pH testing should include:

- Whether aspirate was obtained.
- What the aspirate pH was.
- Who checked the aspirate pH; when it was confirmed to be safe to administer feed and/or medication (i.e. gastric pH between 1 and 5.5).
- Consent for procedure or mental capacity assessment and best Interest decision.
- Date and time of insertion and when it would be due to be replaced. Tube type (which should be radio opaque and have measured markings through its length). Method for securing the tube. External tube length remaining. Once it has been sited unless the site has been confirmed.

3. Checking the Position of a Nasogastric Tube

The responsibility for ensuring correct tube placement lies with the nurse, parent or carer caring for that child and he/she must be satisfied that the tube is correctly placed before commencing or continuing with feeding or medicine administration via the nasogastric tube. The only method (described below) to be used to check the position of the nasogastric tube is using pH paper.

The following methods are not reliable for confirming tube placement and **must not** be used:

- Auscultation of air insufflate through the tube (whoosh test)
- Testing pH using blue litmus paper
- Monitoring bubbling at the end of the tube immersed in liquid
- Observation of feeding tube aspirate
- Interpreting absence of respiratory distress as an indicator of correct positioning

Aspirated fluid is tested using only pH strips or paper that must be CE marked and manufactured specifically for the purpose of checking the pH of human gastric aspirate. If no aspirate is obtained or the position of the tube in the stomach is not confirmed then do not feed via the tube and contact the Community Childrens Nurse or local hospital for advice.

If there is any doubt about the pH value (especially in the 5-6 range) then feeds and /or medicines should not be administered via the tube. Refer immediately to the independent prescriber for the patient concerned if medicines cannot be administered.

- A pH value of less than 5.5 excludes tube pulmonary placement and it is safe to commence
- administration of feed/medicines via the tube.
- A pH value greater than 5.5 indicates possible placement in the intestine or tracheobronchial tree. Do not administer anything via the tube.

The position of the nasogastric tube must be checked:

- On insertion
- Before administering each feed or water flush
- Before giving medication if not during a feed. (When children are receiving continuous feed it may be impossible to obtain an aspirate within the pH range. In this circumstance, so long as tube placement has been confirmed at the start of feeding and that there are no other reasons to suspect tube displacement, it is acceptable to check that the external length of tube has not changed before cautiously administering medicines via the nasogastric tube.)
- Following episodes of vomiting, retching, coughing or other potential causes of tube displacement
- If there is evidence of possible tube displacement (e.g. loose tape or external tubing appears longer)
- At least every 24 hours

3.1 Method

- 1) Wash your hands before and after the procedure
- 2) Explain to the child that you are going to check their tube
- 3) Remove the end cap from the tube
- 4) Attach a 50ml syringe to the end of the tube unless contraindicated by manufacturer's Instructions.
- 5) Aspirate gastric contents from the child/young person's stomach by gently pulling back on the plunger until a small amount of fluid appears in the syringe
- 6) Detach the syringe from the tube remembering to replace the end cap of the tube
- 7) Test the pH of the fluid using pH indicator paper or strip. The indicator paper or strip should change colour to read a pH of 5.5 or less.
- 8) If it is difficult to obtain aspirate any or all of the following should be attempted
- 9) Attempt to push the tube's end away from the stomach wall by inserting 3-5ml of air via syringe, down the nasogastric tube.
- 10) Lie the child/young person on their left side
- 11) Ask the child/young person to take a small drink, if it is clinically safe to do so.
- 12) Try advancing or pulling the tube back slightly
- 13) If unsure if the tube is correctly positioned, remove and re-pass the tube or seek further advice from community children's nurses or hospital professionals
- 14) Document the procedure (including the following) in the child's health care record.
- 15) The date and time the check was made
- 16) The value of the pH result (i.e. it is not acceptable to record 'within range' or similar)
- 17) Who performed the check

4. Care of a Nasogastric Tube

- Check tube position every time it is used and at least every 24 hours
- Only when position of tube is conformed Flush with between 5 and 20mls of drinking water for children prior to and after feed or medication in accordance with dietetic plan
- Check skin around insertion site and around taped site
- Change tube as directed by manufacturer.
- The tube should be positioned either on the front of the nose and then fixed on the forehead or to the side of the nose and fixed to the cheek.
- A hydrocolloid dressing should be placed under the tube at the nostril and secured with a clear dressing in order to prevent skin breakdown
- Only use the nasogastric tube to administer prescribed feeds or medication.
- To avoid tube blockages wherever possible use liquid formulations of medicines or those explicitly for enteral tube use. Where this is not possible and other formulation have been considered, tablets should be crushed to a fine powder and administered as prescribed with adequate water flushes before and after administration.

5. Unblocking a Nasogastric Tube

There is no safe and reliable method of unblocking a nasogastric tube. Consequently if a nasogastric tube is blocked it must be removed and a new tube sited.

6. Incident Reporting

The line manager/nurse in charge/shift leader must be informed of incident or error relating to the insertion, care of or use of a nasogastric tube. The parents will also be fully informed.

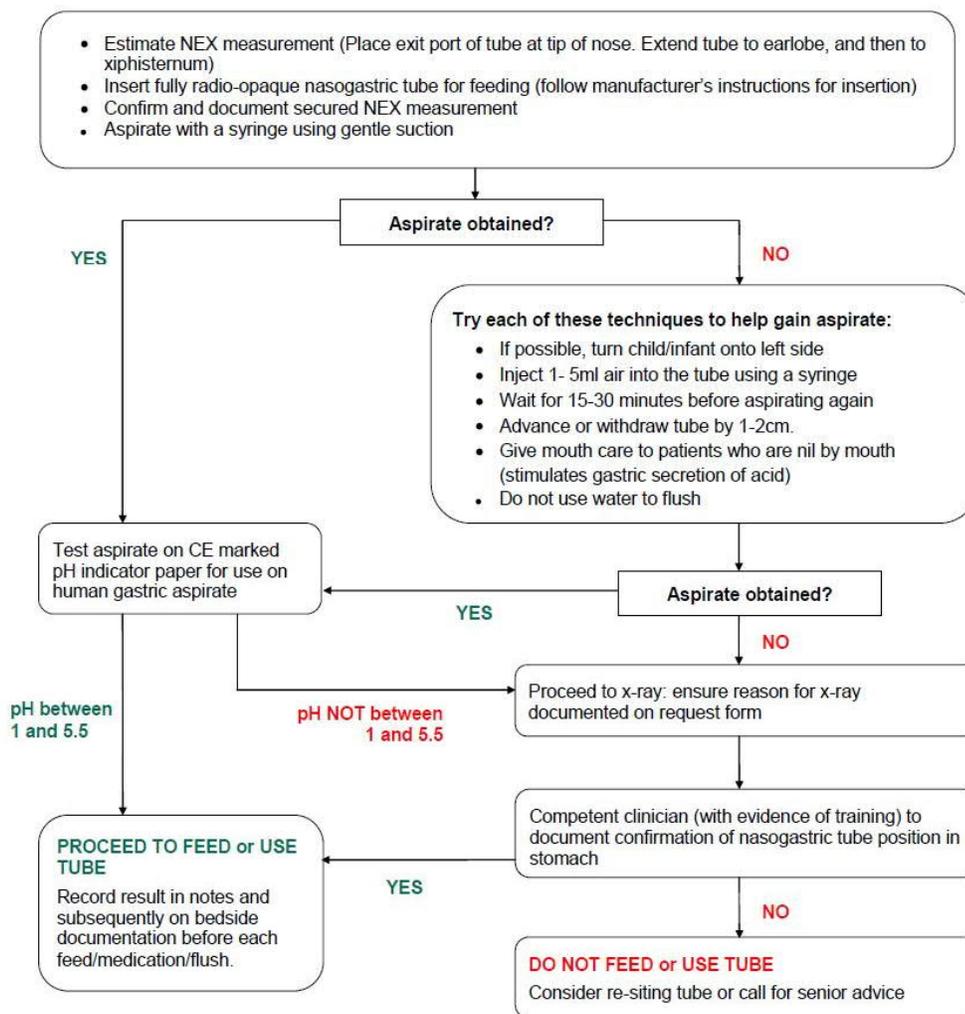
Any error or incident must be reported in accordance with the Children & Family Devon incident policy and reported on DATIX.

If any equipment used is faulty or inappropriate, the equipment must be removed and retained in addition to a DATIX report.

Decision Tree for Nasogastric Tube Placement

NHS
National Patient Safety Agency

Decision tree for nasogastric tube placement checks in **CHILDREN** and **INFANTS** (NOT NEONATES)



A pH of between 1 and 5.5 is reliable confirmation that the tube is not in the lung, however it does not confirm gastric placement as there is a small chance the tube tip may sit in the oesophagus where it carries a higher risk of aspiration. If this is any concern, the patient should proceed to x-ray in order to confirm tube position.

Where pH readings fall between 5 and 6 it is recommended that a second competent person checks the reading or retests.

www.npsa.nhs.uk/alerts

NPSA Reducing Harm



Patient Safety Alert

NPSA/2011/PSA002
10 March 2011



Reducing the harm caused by misplaced nasogastric feeding tubes in adults, children and infants

This Alert updates and strengthens Patient Safety Alert 05 (*Reducing the harm caused by misplaced nasogastric feeding tubes*) and is based on national learning since then. It does not replace *Reducing the harm caused by misplaced naso and orogastric feeding tubes in babies under the care of neonatal units*, issued in August 2005.

Patient Safety Alert 05 provided guidance for the NHS on checking and confirming that a nasogastric tube had been inserted into the right place, i.e. the stomach.

This followed reports to the NPSA's National Reporting and Learning System (NRLS) of patient death as a result of feeding into the lung through misplaced nasogastric tubes.

Since the completion date for that Alert's actions (1 September 2005), the NRLS has received reports of a further **21 deaths** and **79 cases of harm** due to feeding into the lungs through misplaced nasogastric tubes. The main causal factor leading to harm was misinterpretation of x-rays. This was found in 45 incidents, 12 of which resulted in the death of the patient. The focus for this new Alert therefore supports safe x-ray interpretation.

Other causes of harm related to failure to follow the guidance in Patient Safety Alert 05 including: feeding despite obtaining aspirate between pH6 and pH8 (seven incidents including two deaths), instilling water down the tube before obtaining aspirate (two incidents), no checking of tube placement by any method (nine incidents including one death). A repeated finding in local investigations was that no written record was made of pH obtained or of x-ray interpretation before feeding commenced^{1,2,3}.

This Alert does not change the advice given in Patient Safety Alert 05 that pH testing remains the first line test, and x-ray checking remains the second line test.

For the purpose of this Alert the definition of 'to feed' and 'feeding' includes the introduction of any feed, liquid or medication through the nasogastric tube.

This Alert must be read in conjunction with the Supporting Information, available at www.nrls.npsa.nhs.uk/alerts

Action for the NHS

For action by all organisations in the NHS and independent sector where nasogastric feeding tubes are placed and used for feeding patients.

An executive director, nominated by the chief executive, working with relevant medical and nursing staff should ensure, through reviewing policies, procedures and staff training that by **12 September 2011**:

1. A named clinical lead is assigned to have responsibility for implementing all actions in this Alert.
2. All policies, protocols, and bedside documentation are reviewed to ensure compliance with steps (a) to (j) outlined on page 2 every time a nasogastric tube is inserted and used to administer medication, fluids or feed.
3. An ongoing programme of audit is put in place to monitor compliance.
4. Staff training, competency frameworks and supervision are reviewed to ensure that all healthcare professionals involved with nasogastric tube position checks have been assessed as competent. Competency training should include theoretical and practical learning. An example eModule training tool for x-ray interpretation of nasogastric tube position is available at www.esrsupport.co.uk/nlms/login.html
5. Purchasing policies are revised and old stock systematically removed to ensure all nasogastric tubes used for the purpose of feeding are radio-opaque throughout their length and have externally visible length markings.
6. Purchasing policies are revised and old stock systematically removed to ensure all pH paper is CE marked and intended by the manufacturer to test human gastric aspirate⁴.

1. National Patient Safety Agency. Reducing harm caused by the misplacement of nasogastric feeding tubes. Patient Safety Alert 05, Feb. 05. www.nrls.npsa.nhs.uk/resources

2. National Patient Safety Agency. Misplaced naso or orogastric tube not detected prior to use. www.nrls.npsa.nhs.uk/resources

3. National Patient Safety Agency. Never Events Annual Report 2009-2010. www.nrls.npsa.nhs.uk/resources

4. Medicines and Healthcare products Regulatory Agency. Medical Device Alert: Medical devices in general and non-medical products (MDA/2010/010). www.mhra.gov.uk/Publications/SafetyWarnings/MedicalDeviceAlerts/COM65571

5. Metheny NA, Meert KL, Clouse RE. Complications related to feeding tube placement. *Curr Opin Gastroenterol*. 2007 Mar; 23(2):176-82

6. Hanna G. Improving the safety of nasogastric feeding tube insertion. Developing guidelines for the safe verification of feeding tube position - a decision analysis approach. A Report for the NHS Patient Safety Research Portfolio, July 2010.

7. Barthelme R, Boublata J, Branley S, Corliss M, Guether S, Kennedy J, Lyman B, Metheny NA, Mueller C, Robbins S, Wisel J, A.S.P.E.N. Board of Directors. Enteral nutrition practice recommendations. *JPEN J Parenter Enteral Nutr*. 2009; 33(2):122-47



Patient Safety Alert

NPSA/2011/PSA002
10 March 2011

Action for healthcare professionals

Healthcare professionals should ensure that:

- a. Before a decision is made to insert a nasogastric tube, an assessment is undertaken to identify if nasogastric feeding is appropriate for the patient, and the rationale for any decisions is recorded in the patient's medical notes.
- b. Placement is delayed if there is not sufficient experienced support available to accurately confirm nasogastric tube placement (e.g. at night), unless clinically urgent, and that the rationale for any decisions made is recorded in the patient's medical notes.
- c. Nasogastric tubes used for the purpose of feeding are radio-opaque throughout their length and have externally visible length markings.
- d. pH indicator paper is CE marked and intended by the manufacturer to test human gastric aspirate.
- e. Nasogastric tubes are not flushed, nor any liquid/feed introduced through the tube following initial placement, until the tube tip is confirmed, by pH testing or x-ray, to be in the stomach.
- f. pH testing is used as the **first line test method**, with pH between 1 and 5.5 as the safe range, and that each test and test result is documented on a chart kept at the patient's bedside.
- g. X-ray is used only as a second line test when no aspirate could be obtained or pH indicator paper has failed to confirm the position of the nasogastric tube and that:
 - i) X-ray request forms clearly state that the purpose of the x-ray is to establish the position of the nasogastric tube for the purpose of feeding.
 - ii) The radiographer takes responsibility to ensure that the nasogastric tube can be clearly seen on the x-ray to be used to confirm tube position.
 - iii) Documentation of the tube placement checking process includes confirmation that any x-ray viewed was the most current x-ray for the correct patient, how placement was interpreted, and clear instructions as to required actions. Any tubes identified to be in the lung are removed immediately, whether in the x-ray department or clinical area.
- h. Any individual involved with nasogastric tube position checks has been assessed as competent through theoretical and practical learning.
- i. 'Whoosh' tests, acid/alkaline tests using litmus paper, or interpretation of the appearance of aspirate **are never used** to confirm nasogastric tube position as they are not reliable.
- j. A full multidisciplinary supported risk assessment is made and documented before a patient with a nasogastric tube is discharged from acute care to the community^{6,7}.

Further information

For further information visit www.nrls.npsa.nhs.uk/alerts



Patient Safety Alert

NPSA/2011/PSA002
10 March 2011

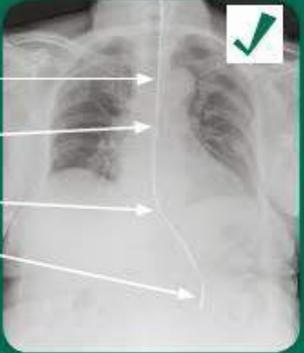
Nasogastric tubes: x-ray interpretation aid

- Is nasogastric tube feeding the right decision for this patient?
- Is this the right time to place the nasogastric tube and is the appropriate equipment available?
- Is there sufficient knowledge/expertise available at this time to test for safe placement of the nasogastric tube?

To confirm gastric position of the nasogastric tube, ask:

- Does the tube path follow the oesophagus/avoid the contours of the bronchi?
- Does the tube clearly bisect the carina or the bronchi?
- Does it cross the diaphragm in the midline?
- Is the tip clearly visible below the left hemi-diaphragm?

Proceed to feed only if all criteria are met. If in any doubt repeat x-ray or call for senior help.



Below are two examples where the nasogastric tube has been incorrectly identified as being in the stomach:



Radiograph 1 shows the tip of the nasogastric tube above the diaphragm and on the right-hand side of the thorax. The presence of ECG leads make interpretation of the radiograph more difficult.



Radiograph 2 shows the tip of the nasogastric tube apparently below the left hemidiaphragm but the tube clearly follows the contours of the left bronchus. In fact, the tube is positioned in the left lower lobe of the lung.

X-rays must always be interpreted by someone assessed as competent to do so, and the decision to feed a patient must be documented in the patient's medical notes, dated, timed and signed by that person.

Document Control Information

This is a controlled document and should not be altered in any way without the express permission of the author or their representative.

Please note this document is only valid from the date approved below, and checks should be made that it is the most up to date version available.

If printed, this document is only valid for the day of printing.

This guidance has been registered with the Trust. The interpretation and application of guidance will remain the responsibility of the individual clinician. If in doubt contact a senior colleague or expert. Caution is advised when using clinical guidance after the review date, or outside of the Trust.

Ref No:	2439		
Document title:	Care and Management Of A Nasogastric Tube		
Purpose of document:			
Date of issue:	11 November 2019	Next review date:	11 November 2022
Version:	1	Last review date:	
Author:	Service Lead		
Directorate:	Child Health		
Equality Impact:	The guidance contained in this document is intended to be inclusive for all patients within the clinical group specified, regardless of age, disability, gender, gender identity, sexual orientation, race and ethnicity & religion or belief		
Committee(s) approving the document:	Head of Service, Children with Additional Needs		
Date approved:	6 November 2019		
Links or overlaps with other policies:			

Have you identified any issues on the Rapid (E)quality Impact Assessment. If so please detail on Rapid (E)QIA form.	Yes <input type="checkbox"/>	
	Please select Yes No	
Does this document have implications regarding the Care Act? <i>If yes please state:</i>	<input type="checkbox"/>	<input type="checkbox"/>
Does this document have training implications? <i>If yes please state:</i>	<input type="checkbox"/>	<input type="checkbox"/>

Does this document have financial implications? <i>If yes please state:</i>	<input type="checkbox"/>	<input type="checkbox"/>
Is this document a direct replacement for another? <i>If yes please state which documents are being replaced:</i>	<input type="checkbox"/>	<input type="checkbox"/>

Document Amendment History

Date	Version no.	Amendment summary	Ratified by:
11 November 2019	1	New	Head of Service, Children with Additional Needs

The Mental Capacity Act 2005

The Mental Capacity Act provides a statutory framework for people who lack capacity to make decisions for themselves, or who have capacity and want to make preparations for a time when they lack capacity in the future. It sets out who can take decisions, in which situations, and how they should go about this. It covers a wide range of decision making from health and welfare decisions to finance and property decisions

Enshrined in the Mental Capacity Act is the principle that people must be assumed to have capacity unless it is established that they do not. This is an important aspect of law that all health and social care practitioners must implement when proposing to undertake any act in connection with care and treatment that requires consent. In circumstances where there is an element of doubt about a person's ability to make a decision due to 'an impairment of or disturbance in the functioning of the mind or brain' the practitioner must implement the Mental Capacity Act.

The legal framework provided by the Mental Capacity Act 2005 is supported by a Code of Practice, which provides guidance and information about how the Act works in practice. The Code of Practice has statutory force which means that health and social care practitioners have a legal duty to have regard to it when working with or caring for adults who may lack capacity to make decisions for themselves.

“The Act is intended to assist and support people who may lack capacity and to discourage anyone who is involved in caring for someone who lacks capacity from being overly restrictive or controlling. It aims to balance an individual's right to make decisions for themselves with their right to be protected from harm if they lack the capacity to make decisions to protect themselves”. (3)

All Trust workers can access the Code of Practice, Mental Capacity Act 2005 Policy, Mental Capacity Act 2005 Practice Guidance, information booklets and all assessment, checklists and Independent Mental Capacity Advocate referral forms on iCare

http://icare/Operations/mental_capacity_act/Pages/default.aspx

Infection Control

All staff will have access to Infection Control Policies and comply with the standards within them in the work place. All staff will attend Infection Control Training annually as part of their mandatory training programme.

Rapid (E)quality Impact Assessment (EqIA) *(for use when writing policies)*

Policy Title (and number)	Nasogastric tube feeding	Version and Date	01/11/19
Policy Author	Service Lead		
An (e)quality impact assessment is a process designed to ensure that policies do not discriminate or disadvantage people whilst advancing equality. Consider the nature and extent of the impact, not the number of people affected.			
Who may be affected by this document?			
Patients/ Service Users	<input checked="" type="checkbox"/>	Staff	<input type="checkbox"/>
Other, please state...			<input type="checkbox"/>
Could the policy treat people from protected groups less favourably than the general population? PLEASE NOTE: Any 'Yes' answers may trigger a full EIA and must be referred to the equality leads below			
Age	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Gender Reassignment	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
Race	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Disability	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
Gender	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Pregnancy/Maternity	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
Sexual Orientation			Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
Religion/Belief (non)			Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
Marriage/ Civil Partnership			Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
Is it likely that the policy could affect particular 'Inclusion Health' groups less favourably than the general population? (substance misuse; teenage mums; carers ¹ ; travellers ² ; homeless ³ ; convictions; social isolation ⁴ ; refugees)			Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
Please provide details for each protected group where you have indicated 'Yes'.			
VISION AND VALUES: Policies must aim to remove unintentional barriers and promote inclusion			
Is inclusive language ⁵ used throughout?			Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA <input type="checkbox"/>
Are the services outlined in the policy fully accessible ⁶ ?			Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA <input type="checkbox"/>
Does the policy encourage individualised and person-centred care?			Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA <input type="checkbox"/>
Could there be an adverse impact on an individual's independence or autonomy ⁷ ?			Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> NA <input type="checkbox"/>
EXTERNAL FACTORS			
Is the policy a result of national legislation which cannot be modified in any way?			Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
What is the reason for writing this policy? (Is it a result in a change of legislation/ national research?)			
Support clinical practice			
Who was consulted when drafting this policy?			
Patients/ Service Users	<input type="checkbox"/>	Trade Unions	<input type="checkbox"/>
Protected Groups (including Trust Equality Groups)		<input type="checkbox"/>	
Staff	<input type="checkbox"/>	General Public	<input type="checkbox"/>
Other, please state...		<input type="checkbox"/>	
What were the recommendations/suggestions?			
Does this document require a service redesign or substantial amendments to an existing process? PLEASE NOTE: 'Yes' may trigger a full EIA, please refer to the equality leads below			Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
ACTION PLAN: Please list all actions identified to address any impacts			
Action	Person responsible	Completion date	
AUTHORISATION: By signing below, I confirm that the named person responsible above is aware of the actions assigned to them			

Name of person completing the form	Service Lead	Signature	
Validated by (line manager)	Head of Service, Children with Additional Needs	Signature	

Please contact the Equalities team for guidance:

For South Devon & Torbay CCG, please call 01803 652476 or email marisa.cockfield@nhs.net

For Torbay and South Devon NHS Trusts, please call 01803 656676 or email pdf.sdhct@nhs.net

This form should be published with the policy and a signed copy sent to your relevant organisation

Consider any additional needs of carers/ parents/ advocates etc, in addition to the service user

² Travelers may not be registered with a GP - consider how they may access/ be aware of services available to them

³ Consider any provisions for those with no fixed abode, particularly relating to impact on discharge

⁴ Consider how someone will be aware of (or access) a service if socially or geographically isolated

⁵ Language must be relevant and appropriate, for example referring to partners, not husbands or wives

⁶ Consider both physical access to services and how information/ communication is available in an accessible format

⁷ Example: a telephone-based service may discriminate against people who are d/Deaf. Whilst someone may be able to act on their behalf, this does not promote independence or autonomy

Clinical and Non-Clinical Policies – Data Protection

Torbay and South Devon NHS Foundation Trust (TSDFT) has a commitment to ensure that all policies and procedures developed act in accordance with all relevant data protection regulations and guidance. This policy has been designed with the EU General Data Protection Regulation (GDPR) and Data Protection Act 2018 (DPA 18) in mind, and therefore provides the reader with assurance of effective information governance practice.

The UK data protection regime intends to strengthen and unify data protection for all persons; consequently, the rights of individuals have changed. It is assured that these rights have been considered throughout the development of this policy. Furthermore, data protection legislation requires that the Trust is open and transparent with its personal identifiable processing activities and this has a considerable effect on the way TSDFT holds, uses, and shares personal identifiable data.

Does this policy impact on how personal data is used, stored, shared or processed in your department? Yes No

If yes has been ticked above it is assured that you must complete a data mapping exercise and possibly a Data Protection Impact Assessment (DPIA). You can find more information on our [GDPR](#) page on ICON (intranet)

For more information:

- Contact the Data Access and Disclosure Office on dataprotection.tsdf@nhs.net,
- See TSDFT's [Data Protection & Access Policy](#),
- Visit our [Data Protection](#) site on the public internet.