

Ref: FOI/GS/ID 6774

Please reply to:
FOI Administrator
Trust Management
Maidstone Hospital
Hermitage Lane
Maidstone, Kent
ME16 9QQ
Email: mtw-tr.foiadmin@nhs.net
www.mtw.nhs.uk

15 September 2021

Freedom of Information Act 2000

I am writing in response to your request for information made under the Freedom of Information Act 2000 in relation to the adult elective patient pre-operative nil by mouth (or fasting or fluids and feeding) guideline.

You asked:

Please would it be possible for you to share a copy of your trusts adult elective patient pre-operative nil by mouth (or fasting or fluids and feeding) guideline.

Trust response:

Please find below the requested policy.

Nil-by-Mouth policy for Adults and Children

Target audience:	All clinical staff
Author:	Clinical Coordinator (Theatres)
Other contributors:	Clinical Manager for Nutrition and Clinical Manager Consultant Gastroenterologist Consultant Anaesthetists Consultant Surgeon Consultant Orthopaedic Surgeon Deputy Chief Nurse Head of Pharmacy Consultant Ophthalmologist Clinical Manager for Speech and Language Therapy

Thanks to East Kent Hospitals University Trust

Executive lead:	Medical Director
Directorate:	Theatres
Specialty:	Anaesthetics
Supersedes:	Nil-By-Mouth policy for adults and children version 1.0
Approved by:	Trust Clinical Governance Committee, 12 th October 2017
Ratified by:	Policy Ratification Committee, 8 th December 2017
Review date:	December 2021

Disclaimer: Printed copies of this document may not be the most recent version.
The master copy is held on Q-Pulse Document Management System
This copy – REV1.1

Document history

Requirement for document:	<ul style="list-style-type: none"> • Risk of harm to patients who are nil by mouth – Signal Ref 1309 <i>National Patient Safety Agency (NPSA)</i> • <i>Royal College of Nursing – Preoperative Fasting in Adults and Children 2005</i> 		
Cross references (external):	<ol style="list-style-type: none"> 1. The Cochrane Collaboration (August 2014) Preoperative carbohydrate treatment for enhancing recovery after elective surgery (review) 2. Fearon KCH et al. Enhanced recovery after surgery: A consensus review of clinical care for patients undergoing colonic resection. <i>Clin Nutr</i> 2005;24:466-477 3. Nygren J et al. Preoperative gastric emptying. Effects of anxiety and oral carbohydrate administration. <i>Ann Surg</i> 1995, Vol 222, No 6; 728-734 4. Hausel J et al. A carbohydrate-rich drink reduces preoperative discomfort in elective surgery patients. <i>Anest Analg</i> 2001;93(5); 1344-50 5. Yuill KA et al. The administration of an oral carbohydrate containing fluid prior to major elective upper-gastrointestinal surgery preserves skeletal muscle mass postoperatively - a randomised clinical trial. <i>Clin Nutr</i> 2005;24:32-37 6. Ljungqvist et al. Preoperative nutrition – elective surgery in the fed or in the overnight fasted state. <i>Clinical Nutr</i> 2001;20(1);167 – 171 7. Nygren J, Soop M, Thorell A et al. Pre-operative oral carbohydrates and postoperative insulin resistance. <i>Clin Nutr</i> 1999 18(2):117-20 8. Rothman D, Magnusson I, Katz D L et al. Quantification of hepatic glycogenolysis and gluconeogenesis in fasting humans with ¹³C-NMR. <i>Science</i> 1991; 254: 573-6 9. APA Consensus Statement on updated fluid fasting guidelines, 2018 https://www.apaqbi.org.uk/sites/default/files/paragraphs/files/Fasting%20Consensus%20statement%20signatures%20Word.pdf 		
Associated documents (internal):	<ul style="list-style-type: none"> • Consent to Examination or Treatment, Policy and Procedure for [RWF-OPPPES-C-SM5] • Enteral Feeding Policy and Procedure, Adult Hospital [RWF-OPG-CSS10] • Parenteral Nutrition in adults, Policy and procedure for the use of [RWF-OPPPCSS-C-THP3] • Refeeding syndrome in adults, Guidelines for the prevention and management of the [RWF-OPG-CSS12] • Medicines Policy and Procedure [RWF-OPPPCSS-C-PHAR1] • Patient Group Directions (PGDs): Policy and Procedure for Development and Implementation [RWF-OPG-CSS6] 		
Keywords:	nasogastric	naso-jejunal	endoscopic
	parenteral feeding	enteral feeding	fasting
	Nil By Mouth	fasting state	oral
	nutritional status	theatres	surgical
	paediatrics	carbohydrate	emergency

Version control:		
Issue:		
1.0	Policy developed to reduce and manage the risk of harm to patients who are nil by mouth.	December 2017
1.1	Amendments to reflect changes to how patients flow through the admission and perioperative pathway Amendments approved by Trust Clinical Governance Committee, 18 th April 2019 and ratified by Policy Ratification Committee, 26 th April 2019	April 2019

Summary for

Nil-by-Mouth Policy for Adults and Children

The aim of this document is to ensure no patient remains nil-by-mouth (NBM) for longer than is absolutely necessary.

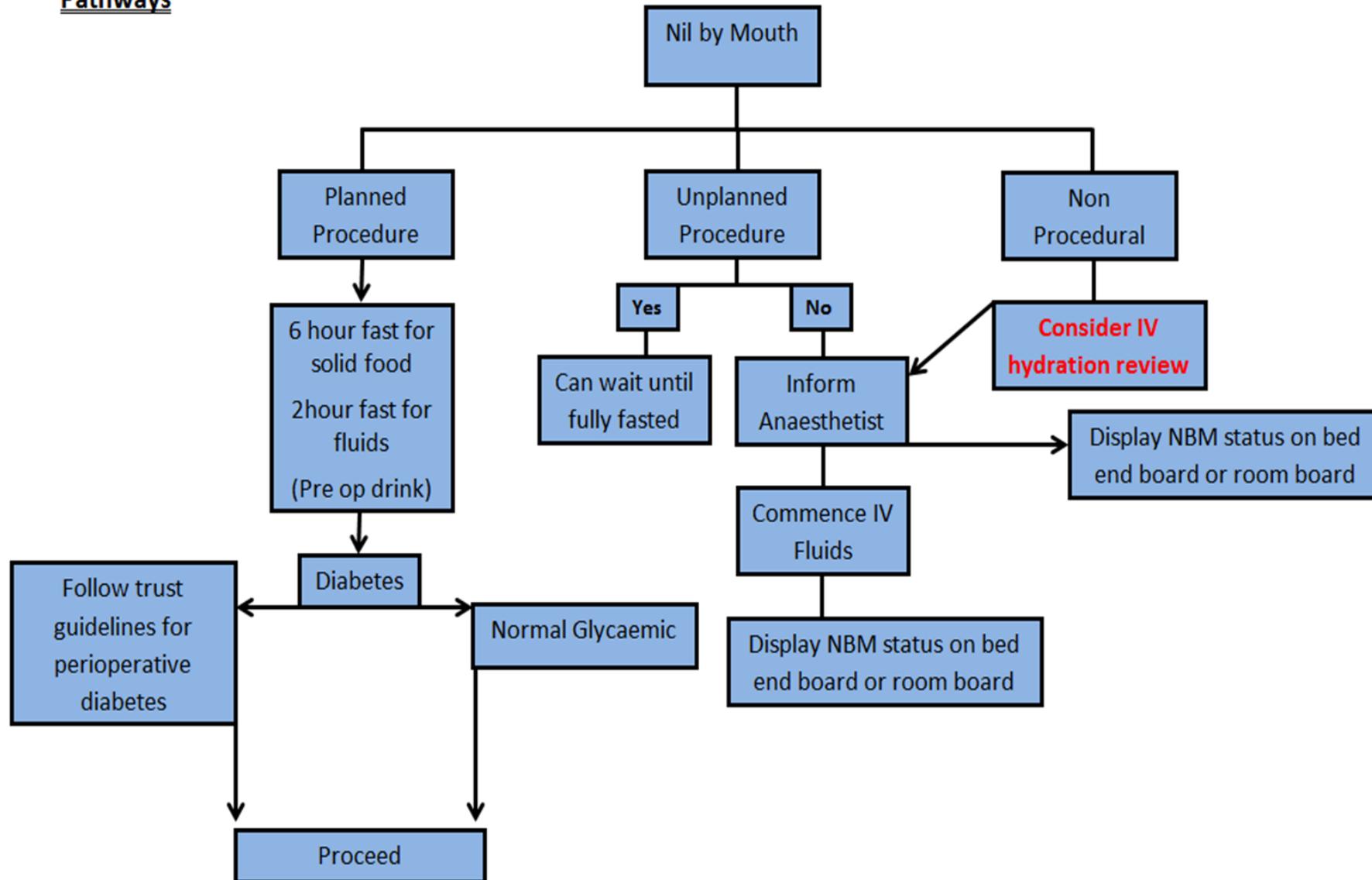
This policy covers all adult and paediatric patients admitted for elective and emergency procedures (surgical/non-surgical), and other circumstances requiring the patient to be in a fasting state, unable to take any food, drink or medication via the oral route

This policy sets out the principles to manage this process and the steps for managing the medicine regimen and also for ensuring the patient's nutritional status is not compromised in the long term.

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Pathways



1.0 Introduction and scope

This policy is intended for all non-diabetic adult and paediatric patients admitted for procedures (either unplanned or planned) requiring a period of fasting or when oral intake is not possible.

This policy sets out the steps on managing the period of time a patient cannot eat or drink and how, if appropriate, their medicine administration is to be managed.

Patients may be labelled nil by mouth (NBM) for several reasons other than awaiting surgery, e.g. unconsciousness, gut rest, not safe to swallow. The period of time NBM is enforced must be kept to a minimum to reduce unnecessary distress and the risk of dehydration and malnutrition. No patient should be without fluid input (either enteral or intravenous) for more than 10 hours. Patients should not be left for long periods without hydration, correcting serum electrolytes as necessary.

If patients need to be kept NBM for long periods (>2 days) alternative methods of feeding such as nasogastric, naso-jejunal, gastrostomy or parenteral feeding must be considered; this needs to involve the multi-disciplinary (MD) team, patients and relatives. See the Adult Hospital Enteral Feeding Policy and Procedure. This policy excludes patients undergoing pain relief procedures, ophthalmological procedures and patients with Type 1 and Type 2 diabetes (see Adult Guidelines for perioperative diabetes).

This policy is intended to ensure minimal deterioration in the nutrition and hydration status of the patient in both short and long term periods of deprivation.

2.0 Definitions / glossary

- **Clear fluid:** includes water, very diluted squash, and the juice-based oral nutrition supplement used within the Trust.
- **Enhanced recovery programme** (after surgery): a programme that looks at all areas of surgical preparation and post-surgical care; this will include the provision of specific fluids pre-surgery and a process to speed the reintroduction of eating and drinking post-procedure.
- **Enteral nutrition:** liquid feed delivered via a tube into the patient's stomach and/or duodenum/jejunum
- **Naso gastric tube (NGT):** a tube that passes into the stomach to either aspirate stomach contents, decompress or provide enteral feed.
- **Nil by mouth (NBM):** not to take food or fluid either via the oral route or via a feeding tube.
- **Oral route:** (orally) a route of administration where a substance is taken through the mouth.
- **Patient Group Direction (PGD):** A specific written instruction for the supply or administration of named medicines in an identified clinical situation. It is drawn up locally by doctors, pharmacists and other appropriate professionals, and approved by the employer, advised by the relevant professional advisory committees. It applies to groups of patients or other service users who may not be individually identified before presentation for treatment.
- **Pre-operative drink:** a high carbohydrate (energy) drink with added electrolytes provided to elective surgical patients to drink the night before

their procedure and 2 hours prior to the operation. Evidence shows that these drinks help avoid nausea for the patient, and reduce the incidence of post-operative insulin resistance and thus improving the surgical stress response.

3.0 Duties

- **Medical staff/Nursing staff** (Outpatients, Pre-Operative Assessment, ICU, Recovery and Inpatients)
 - Weigh and assess patients
 - Refer to Therapists if required
 - Provide instructions on use of pre-operative high energy drinks
 - Issue carbohydrate drinks at pre-operative assessment
- **Theatre staff**
 - Inform the admission lounge/ward the day before the operative list of arrangements, in order for patients to be contacted via the admissions officer to be advised of the NBM time
 - As part of the WHO pre-list huddle, the order of the adult/paediatric surgical list must be determined, and clear fluid “drink-until” times determined; this information must then be relayed to the paediatric ward/admission lounge, and patients encouraged to drink water until the time agreed
- **Dietitians**
 - Assess the referred patient for nutritional status
 - Highlight re-feeding to nursing staff and patients
 - Provision of feeding regimen
 - Education and training of patients with feeding tubes/special dietary requirements
 - Provide relevant patient information
- **Speech and Language Therapists**
 - Assess the referred patient
 - Education and training for the patient
- **Pharmacists**
 - Provide information on oral medication and pre-operative drinks
 - Provide guidance on appropriate use of PGDs “Patient Information Policy and Procedure, Development and Production of Written” [RWF-OPPPCS-NC-CG28
- **Medical and Surgical staff** (Anaesthetists, Surgeons, Physicians and Radiologists)
 - Assess patient for suitability and fitness to proceed to an anaesthetic or surgical intervention
 - Consent process- inform patient via informed consent of the risks and benefits to surgical intervention and anaesthetic risks
- **Catering staff**

- Provide on request snack boxes/ lunch/dinner for those patients having missed a meal

4.0 Training / competency requirements

Nursing and Dietetic staff administering the pre-operative high energy drink are required to have completed the specific PGD in-house training Medicines Policy.

Any training on the implementation of the policy (e.g. PGD training) to be identified by the senior member of staff and actioned accordingly.

5.0 Management of the adult in elective and non-elective surgical pathways

Patients should not have a general anaesthetic or regional anaesthetic without a 6-hour period of starvation and fluid deprivation, and two hour period of deprivation for clear fluids.

Additionally in this Trust, patients admitted for elective surgery will be offered small volumes of water at hourly intervals to minimise the effects of prolonged fasting and improve patient satisfaction.

On arrival to the admissions lounge, patients will be offered a 50ml drink of water by the nursing staff. After each and subsequent hour, patients will be offered a further 50ml drink of water, up until the time they are called for theatre. All adult elective surgical patients will follow this pathway and all adult patients will follow this route unless specific instructions are provided by the anaesthetist.

For emergency and lifesaving procedures (see section 6.0), Anaesthetists must assess whether it is appropriate to take further precautions to prevent regurgitation/aspiration. These include rapid sequence induction of anaesthesia, use of antacids and pro-kinetic agents.

Healthcare professionals must ensure that clear documentation, stating date, times and reasons for NBM (and who is responsible for reviewing NBM status), is included in the patient's healthcare record.

Patients with NBM status must have this clearly written on their bed headboard or whiteboard at the door to their room by the healthcare professional in charge of their care.

5.1 Paediatric patients

Paediatric patients undergoing an elective procedure are permitted to have water and clear fluids up to **one** hour before an anaesthetic.

Nil by mouth times for the following are 4 hours:

- Breast milk

Nil by mouth times for the following are 6 hours:

- Formula milk
- Cow's milk and other milk substitutes
- Food

To reduce nil by mouth times, a cup of water or very diluted squash should be offered to all paediatric patients on arrival to the ward prior to surgery (07.30 for morning elective lists; 12.30 for afternoon elective lists).

Once the theatre list order is finalised, the ward team will be informed of “drink-until” times for individual patients, whereby water should be made available to each patient until the agreed time.

For paediatric patients undergoing local anaesthetic, theatre staff should arrange with the ward sister to inform the parents or guardian to provide a bottle of formula/cow’s/expressed breast milk which may be offered to the child during certain procedures or in recovery.

5.2 Elective surgery for adult orthopaedic patients (hip and knee replacement)

Patients are advised to:

- eat a carbohydrate rich meal on the evening prior to surgery
- stop eating and drinking from 02:00 on the day of surgery
- not chew gum on the day of the surgery

Patients on the morning list should drink two 200ml carbohydrate rich with added electrolyte drinks (pre-operative) before 06:30.

Patients are admitted to the elective surgical ward at 07:00 on the day of surgery or for afternoon lists patients are admitted at 11:00.

Ward staff should give patients on the afternoon list two 200 ml cartons of carbohydrate rich with added electrolyte drinks (pre-op) at 11:00.

Patients should be encouraged to resume a normal diet as soon as possible after surgery.

5.3 Elective surgery for adult gynaecological patients

Patients are advised to

- Eat a carbohydrate rich meal and drink a large glass of water on the evening prior to surgery
- Take four 200ml cartons of carbohydrate rich with electrolyte drinks (pre-op) two for the night prior to surgery night and two on the day of surgery.
- stop eating and drinking from 02:00 on the day of surgery
- not chew gum on the day of the surgery

Patients on the morning list should drink two 200ml carbohydrate rich with electrolyte drinks (pre-op) at 06:00.

Patients are admitted to the elective surgical ward 07:00 on the day of surgery or for afternoon lists patients are admitted at 11:00.

Ward staff should give patients on the afternoon list two 200 ml cartons of carbohydrate rich with added electrolyte drinks (pre-operative) at 11:00.

Patients should be encouraged to resume a normal diet as soon as possible after surgery.

5.4 Elective surgery for an adult lower gastrointestinal patient

Patients are advised to

- Eat a carbohydrate rich meal and drink a large glass of water on the evening prior to surgery
- Take four 200ml cartons of carbohydrate rich with electrolyte drinks (pre-op) two for the evening prior to surgery and two on the day of surgery.
- Stop eating and drinking from 02:00 on the day of surgery
- Not chew gum on the day of the surgery

Patients on the morning list should drink two 200ml carbohydrate rich with electrolyte drinks (pre-op) at 07:00.

Patients are admitted to the Admissions Lounge Maidstone at 07:00 on day of surgery for morning lists or for afternoon lists patients are admitted at 11:00.

Ward staff should give patients on the afternoon list two 200 ml cartons of carbohydrate rich with added electrolyte drinks (pre-op) at 11:00.

Patients are advised to consume a light meal 6 hours post-surgery, as tolerated.

5.5 Adult patients receiving a local anaesthetic

There is no restriction for food or drink for patients having local anaesthesia.

5.6 Medicine management during fasting (non-diabetic) see

www.formularywkccgmtw.co.uk

5.7 Oral medications

Regular oral medication can be continued, in most cases, during the fasting period (taken with the smallest amount of water required to swallow)

However, this does not apply to all regular oral medication and changes to usual regimens may be necessary, particular for anticoagulants, antiplatelet, oestrogens and medication taken after food.

Elective surgical patients should be advised on any changes required to their regular medication by the pre-operative assessment/surgical pharmacist or anaesthetists/surgeons

If specific patient advice is required the clinical pharmacist should be contacted.

5.8 Adult inpatient endoscopic procedures

- The referral is received from the ward into the Endoscopy Department where it will be vetted on urgency and discussed with relevant endoscopist if appropriate.
- Once the referral has been authorised the Endoscopy Lead practitioner will liaise with the relevant ward to give them a date and time for the procedure.
- If the procedure is to take place that day the Endoscopy Department will check if the patient is NBM. If the patient is NBM the ward will be given an estimated time of the procedure.
- If the patient has eaten or had something to drink the ward should keep the patient NBM; the Endoscopy Department will give an estimated procedure time e.g. beginning of afternoon list.

- Depending on what the patient has eaten it may not be possible to do the procedure on that day and the ward will be advised accordingly.
- For an upper GI procedure the patients must have had nothing to eat for 6 hours and no fluids for 4 hours.
- Naso gastric and PEG feeds must be stopped for at least 6 hours prior to the procedure.
- For flexible sigmoidoscopy procedures patients can eat and drink normally up until 4 hours before the procedure. The department will liaise with the ward with the approximate time of procedure and when to give the enema. This will be dependent on when the patient last ate or drank.
- If the capacity in the department is such the procedure cannot be carried out that day the ward will be contacted and advised to allow the patient to commence eating and drinking or feeding; further advice will be given regarding procedure date and time.

5.9 Non-compliance from patients

Patients may refuse to fast (see the Policy and Procedure for Consent to Examination or Treatment) if planned surgery is to take place the patient will be cancelled.

Patients may refuse insertion of feeding tubes/ intravenous fluids/parenteral nutrition or may refuse to remain fasted as indicated. Detailed explanation to the patient may help circumvent some of the issues. Despite all explanation if the patient continues to refuse treatment, the patient's wishes should be respected and alternatives should be considered e.g. referral to nutrition team, discussion with family etc.

6.0 Nil by mouth prior to emergency/unplanned procedures in theatres

- The referral is received from the ward into the Theatre Department where it will be vetted on urgency and discussed with the relevant clinicians if appropriate.
- Once the referral has been authorised by the Surgeon, Anaesthetists and the Clinical Coordinator of the theatre department will liaise with the relevant ward to give them an estimated date and time for the procedure.
- If the procedure is to take place that day the anaesthetist will check if the patient is NBM. If the patient is NBM the ward will be given an estimated time of the procedure.
- If the patient has eaten or had something to drink the ward should keep the patient NBM; the Anaesthetist will give an estimated procedure time
- Depending on what the patient has eaten and the urgency of the case it may not be possible to do the procedure on that day and the ward will be advised accordingly.

Although appropriate fasting is essential prior to surgery, this policy may sometimes need to be overridden in order to expedite surgery in urgent or emergency cases. Anaesthetists are then able to take further precautions to prevent regurgitation/ aspiration. These include rapid sequence induction of anaesthesia, use of antacids and pro-kinetic agents.

If it is possible to delay surgery, the flowchart should be followed.

Prolonged periods without fluid administration should be avoided.

If the patient is dehydrated, or if a delay of several hours is anticipated, the patient's hydration must be maintained either intravenously or orally when appropriate. This will be discussed with the surgeon/anaesthetist involved by the relevant healthcare professional.

6.1 Additional issues to consider

- The patient's routine oral medication should as a rule be given as usual with water on the day of surgery.
- Special consideration for hypoglycemic agents and anticoagulants will be required and should be discussed with the surgeon/anaesthetist.
- Always consider an intravenous infusion if more than a few hours of NBM is unavoidable.
- Diabetic patients have special considerations and the appropriate section of the Perioperative diabetes management guidelines should be read prior to making a NBM decision in such cases.
- It is not appropriate to omit oral medicines for patients who are NBM. Please refer to medicines policy further information. This policy is being revised at present and a link will be inserted as soon as the updated version is available.
- For patients on the ITU with an endotracheal tube or a tracheostomy requiring emergency surgery, it may not be necessary to implement the 'nil by mouth' recommendations.
- A more liberal approach may be considered at the discretion of the surgeon and the anaesthetist. Most importantly, emergency surgery in this group of patients must not be delayed due to presumed inadequate fasting.

7.0 Nil by mouth in non-procedural circumstances

Patients are sometimes NBM because they are unconscious or have significant nausea and vomiting; their gut needs to rest; they have impaired swallow reflex (e.g. stroke/concurrent illness); or they are awaiting an assessment by the Speech and Language Therapists (SLT). Patients awaiting end of life decisions also fall into this category. This also applies to patients with renal disorders who have unique nutritional requirements.

Such patients are particularly vulnerable to prolonged fasting and are thus at risk of developing dehydration, hypoglycaemia and biochemical abnormalities.

A review by either the Specialist Trainee or Consultant is required not later than 24 hours post admission.

Where appropriate, consideration needs to be given to the insertion of NGT for patients who are vomiting or those who are NBM for purposes of gut rest. Such patients should have hydration with intravenous fluids. They may also be considered for parenteral nutrition. A referral to the Nutrition Team is essential.

Patients awaiting SLT assessment may benefit from insertion of a fine bore feeding tube to commence feeding, especially if delay in assessment is anticipated.

Where insertion of feeding tubes is not possible intravenous fluids should be considered to reduce the incidence of prolonged fasting. A referral to the Nutrition Team should be considered.

It is also not appropriate to simply omit oral medicines for patients that are NBM.

Please refer to Medicines policy for further guidance.

7.1 Documentation

- Clear documentation must be included in the patient's healthcare record stating the reason for the fasting and the steps being undertaken to reduce fasting times.
- Patients who are NBM should have a card visibly placed at their bed space, a magnet on the whiteboard clearly stating that the patient is NBM and the date and time fasting commenced. All water jugs etc. should be removed from the patient's view e.g. out of the room.

8.0 Cancelled operations

- The surgeon/anaesthetist should make the decision and must inform the senior member of staff in theatres
- Theatre staff take responsibility for informing the ward/admissions lounge or the patient waiting at home, in order to prevent further NBM
- If the patient is already admitted, the ward staff should inform the patient (on the ward) and provide drinks, high energy drinks, and order a meal or snack box/sandwiches as appropriate

APPENDIX 1

Process requirements

1.0 Implementation and awareness

- Once ratified the Policy Ratification Committee (PRC) Chair will email this policy/procedural document to the Corporate Governance Assistant (CGA) who will activate it on the Trust approved document management database on the intranet, under 'Policies & guidelines'.
- A monthly publications table is produced by the CGA which is published on the Trust intranet under 'Policies & guidelines'; notification of the posting is included on the intranet "News Feed" and in the Chief Executive's newsletter.
- On reading of the news feed notification all managers should ensure that their staff members are aware of the new publications.

When the policy is uploaded to Q-Pulse, a Trust wide memo will be circulated, informing all clinical and management staff.

All clinical Trust staff will be given information on accessing all Trust policies as part of the induction process.

2.0 Monitoring compliance with this document

Monitoring will be undertaken on an adhoc basis on review of the following:

- Adverse incident form – (via the Patient Safety Team)
- Complaints and PALS – (via the Patient Safety Team)

3.0 Review

Nil by mouth policy for adults and children
Author: Consultant Anaesthetist
Review date: December 2021
Version no.: 1.1

This policy and procedure and all its appendices will be reviewed at a minimum of once every 4 years.

4.0 Archiving

The Trust approved document management database on the intranet, under 'Policies & guidelines', retains all superseded files in an archive directory in order to maintain document history.

APPENDIX 2

CONSULTATION ON: Nil by mouth policy for adults and children

Consultation process – Use this form to ensure your consultation has been adequate for the purpose.

Please return comments to: Clinical Coordinator (Theatres)

By date: 24/08/2017

Job title:	Date sent dd/mm/yy	Date reply received	Modification suggested? Y/N	Modification made? Y/N
The following staff MUST be included in ALL consultations:				
Corporate Governance Assistant	18/07/17	20/07/17	Y	Y
Chief Pharmacist	10/08/2017			
Formulary Pharmacist	10/08/2017			
Staff-Side Chair	10/08/2017			
Emergency Planning Team	10/08/2017	07/09/2017	N	N
Head of Staff Engagement and Equality	10/08/2017			
Health Records Manager	10/08/2017			
Complaints & PALS Manager	10/08/2017	07/09/2017	Y	Y
All individuals listed on the front page of this document				
All members of the approving committee: Nutrition Steering Group Committee	10/08/2017		Y	Y
Medicines Management Committee	10/08/2017			
Nursing, Midwifery and Allied Health Professions Group	10/08/2017			
Other individuals the author believes should be consulted				
Local Counter Fraud Specialist	10/08/2017			
Medical Director	10/08/2017			
Director of Infection Prevention and Control	10/08/2017			
Chief Nurse	10/08/2017			
Heads of Nursing and Midwifery	10/08/2017			
Clinical Governance Lead	10/08/2017		Y	Y
Quality and Patient Safety Manager	10/08/2017			
Clinical Director Critical Care	10/08/2017			
Clinical Director Surgery	10/08/2017			
Clinical Director Gynaecology	10/08/2017			
Clinical Director Head and Neck	10/08/2017			

Risk Compliance Manager	10/08/2017			
Lead Matron – Surgery	10/08/2017	26/10/2017	Y	N
Lead Matron Stroke & Elderly Care	10/08/2017			
Lead Matron Medicine	10/08/2017			

APPENDIX 3

Equality impact assessment

This policy includes everyone protected by the Equality Act 2010. People who share protected characteristics will not receive less favourable treatment on the grounds of their age, disability, gender, gender identity, marital or civil partnership status, maternity or pregnancy status, race, religion or sexual orientation. The completion of the following table is therefore mandatory and should be undertaken as part of the policy development, approval and ratification process.

Title of policy or practice	Nil by mouth policy for adult and children
What are the aims of the policy or practice?	To reduce the nil by mouth time for adults and children awaiting procedures.
Is there any evidence that some groups are affected differently and what is/are the evidence sources?	Diabetic patients – will require regular BM monitoring.
Analyse and assess the likely impact on equality or potential discrimination with each of the following groups.	Is there an adverse impact or potential discrimination (yes/no). If yes give details.
Gender identity	No
People of different ages	No
People of different ethnic groups	No
People of different religions and beliefs	No
People who do not speak English as a first language (but excluding Trust staff)	No
People who have a physical or mental disability or care for people with disabilities	No
People who are pregnant or on maternity leave	No
Sexual orientation (LGB)	No
Marriage and civil partnership	No
Gender reassignment	No
If you identified potential discrimination is it minimal and justifiable and therefore does not require a stage 2 assessment?	N/A
When will you monitor and review your EqIA?	Alongside this document when it is reviewed.

Where do you plan to publish the results of your Equality Impact Assessment?	As Appendix 3 of this document
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