Nasal bridle policy

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Ratified by: NMAC
Date Issued: November 2016
Next review date: November 2018
Target Audience: All staff
Impact Assessment Carried Out by: Nina Cron, Nutrition Support Nurse
                               Dee Bousfield, Stroke Specialist Dietitian
                               Caroline Goodger, Nutrition Support Dietitian
Policy Owner: Dee Bousfield, Stroke Specialist Dietitian
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INTRODUCTION

One of the most common complications of enteral tube feeding is tube dislodgement. Studies suggest that between 40-80% of Enteral Feeding Tubes (EFTs) – both Naso-Gastric Tubes (NGTs) and naso-jejunal tubes (NJTs) become dislodged due to a variety of patient and staff-related factors.

Placement of both NGTs and NJTs is a time, resource, and labour intensive process, especially when undertaken repeatedly following frequent tube displacement. This results in feeding delays and decreased calorific intake, which can affect a patient’s outcome. In addition, repeated tube replacement increases the risk of potential complications related to tube insertion and results in increased referral rates for Percutaneous Endoscopic Gastrostomies (PEG) and parenteral nutrition. Both carry inherent risks and complications and may not be appropriate.

Nasal bridles (also known as nasal loops) are devices which fix EFTs in place to prevent accidental removal. The bridle loops around the nasal septum and vomer bone and is fixed to the EFT. It can be placed at the patient’s bedside, usually but not exclusively, at the time of insertion of the EFT. The nasal bridle can stay in for the lifespan of the EFT and can be removed when required.

Nasal bridles are designed to reduce the rate of EFT dislodgement and thus avert risks and costs associated with repeated tube placement and help ensure ongoing nutrition is provided.

The decision to use a nasal bridle should, where possible, involve the patient and family/carers. Where the patient does not have capacity to make an informed decision, a decision must be made in their best interest under the Mental Capacity Act 2005. This policy has been written to enable practitioners to follow an agreed decision making, assessment and procedure process.

PURPOSE

This clinical policy describes how Ashford and St Peter’s Hospitals NHS Foundation Trust (ASPH) will manage the use of nasal bridles in adult patients.
3 DEFINITIONS

Nasal Bridle: is a method of preventing inadvertent displacement or removal of EFTs in patients requiring enteral administration of feed, fluid or medication. It comprises of a rigid probe and a flexible probe with ribbon attached. The flexible probe has a removable guide wire. Each probe has a magnet at the end. The probes are inserted into each nostril until the magnets join at the back of the nose. The rigid probe is then pulled out of the nostril bringing the flexible probe and the loop of ribbon around the nasopharynx and exiting each nostril. The ribbons from each nostril are then secured to the EFT with a clip, reducing the risk of inadvertent removal. The standard nasal bridle stocked by ASPH fits a 10 fg diameter feeding tube (although larger sizes are available to order if required)

Enteral Feeding Tube (EFT): most commonly a NGT but may be a NJT. A 10fg diameter tube is usually recommended for feeding and must be used if a bridle is required. If an alternative sized tube is required please discuss with your ward dietitian or the Nutrition Support Team. The ITU may use nasal bridles for securing other types of tubes and should follow their own protocol.

4 PROCESS

In all cases where a nasal bridle is considered there must already exist a clinical need for an EFT to be sited. Staff will work to increase the chances of EFT being tolerated by clear explanation, and reassurance and in the case of stroke patients, where appropriate inserting the EFT on the side of hemi-sensory neglect.

Mittens must be considered as first line for prevention of EFT removal as this is the least restrictive alternative for these patients (see Trust Mittens Policy). However if the use of mittens has not prevented EFT removal then nasal bridles should be considered for use in:

A. patients that require enteral tube access, usually for the purpose of feeding but also for the administration of other treatments including medicines

AND

B. whose ETF has been inadvertently dislodged on at least three occasions

OR

C. in instances where it has been particularly difficult to place the first EFT tube and the tube has inadvertently dislodged on at least one occasion

OR

D. where the tube has been sited either endoscopically, radiologically or during surgery

In most instances, cases of repeated EFT dislodgement are due to a patient-related factor, the most common of which is confusion. Where possible the cause of confusion should be investigated and treated, as this may allow the EFT to remain in situ without the need for placement of a nasal bridle.

The use of a nasal bridle does not remove the requirement for the routine tube insertion and placement checks prior to and during use of EFT as per Trust Enteral Feeding Policy.
4.1 CONSENT

The practitioner inserting the nasal bridle should discuss the rationale for its use with the patient and give an explanation of the procedure. Verbal consent must be obtained and documented in the patient’s medical notes prior to placing a nasal bridle. If there is a question about the patient’s ability to give informed consent the managing clinical team need to complete a mental capacity assessment and if the patient lacks capacity, the team are required to make a best interest decision and complete a best interest checklist (Appendix 1). This should be placed in the patient’s medical notes. All efforts should be made to discuss the rationale for siting a nasal bridle with the patient’s relatives or next of

4.2 CONTRAINDICATIONS TO NASAL BRIDLE

A patient must have a patent airway on both sides of the nasal septum for nasal bridle insertion to be safe.

Nasal bridle insertion is not appropriate in:
- extremely confused patients who may continue to pull at the EFT and cause trauma to the nasal septum
- patients with known facial or basal skull fractures
- patients with a grossly deviated or perforated nasal septum
- patients with any structural deformity of the nose or naso-pharynx
- patients with abnormal clotting e.g. raised INR, low platelets

Pacemakers

The magnets in the two introducers of the nasal loop insertion kit are likely to be too weak to cause any disruption to permanent pacemakers. However, ideally they should be kept at least 6 inches away from any pacemaker at all times.

4.3 REFERRAL PATHWAY

Once the decision to place a nasal bridle has been made the clinical team should complete the nasal bridle request form (Appendix 2). The ward dietitian will countersign the request form and provide a nasal bridle. This will be charged to the ward directly. The dietitian will assist in locating suitably trained staff to insert the nasal bridle.

Intensive Care Unit and Cedar ward hold their own supply of nasal bridles and have their own staff trained in insertion of a nasal bridle on the units.
## 5 PROCEDURE

1. First ensure that the decision to use the nasal bridle has been clearly documented by the medical team and relevant forms are completed i.e. MCA/Best Interest Checklist.

2. Ensure the EFT tube has been inserted, and if possible the position of the tube confirmed as per Trust policy (if the position has not yet been confirmed, the nasal bridle can be inserted to secure the tube and the position changed by repositioning of the tube and clip if required – **the tube must not be used to administer any feed, fluids or medication until the tube position has been confirmed**).

3. Note the cm marking at the nose of the inserted tube and document on care plan.

4. Explain the nasal bridle and procedure to the patient, gain verbal consent and agree on a stop sign.

5. Using a clean procedure, wear apron and gloves – check the bridle is the correct size for the inserted tube and then open the nasal bridle pack.

6. Lubricate both of the probes and bridle ribbon with lubricating gel, and place the blue probe of the insertion kit into the nostril to the marked ridge. Use the nostril opposite to the NG tube.

7. Place the white probe of the insertion kit into the other nostril. The “click” as the magnets attach should be heard or felt. If not, then gently manipulate the probes.

8. Remove the orange stylet from the bridle probe.

9. Gently pull on the blue probe to pull the white probe and the attached bridle ribbon around the septum. The patient should have equal lengths of ribbon from each nostril.

10. Cut the bridle ribbon to remove the white probe.

11. Ensure that the EFT is correctly positioned. Place the EFT and both lengths of bridle ribbon into the channel on the clip and then clip it tightly shut. The clip should be 1cm from the nose to prevent pressure damage.

12. Tie a double knot in the bridle ribbon just distal to the clip. Trim off any excess bridle ribbon with the scissors.

13. Securely fix the EFT to the patient’s upper cheek using adhesive tape to prevent the extra weight of the bridle from putting traction on the bridle ribbon.

14. Clear away all equipment and dispose of as per Trust policy.

15. Document in the medical notes and the nasal bridle care plan (Appendix 3) that the bridle has been inserted, any difficulties or complications and any epistaxis related to the procedure. Complete the EFT tube care plan and nasal bridle care plan as usual.
5.1 POTENTIAL COMPLICATIONS

Anterior Epistaxis
During insertion of the nasal bridle, if a blood vessel in the nasal passage is ruptured, an anterior epistaxis can occur. Any bleeding lasting longer than 15 minutes or blood loss greater than 100mls should be discussed with the medical team.

Pressure ulcers/Necrosis
If the nasal loop is secured too tightly, or becomes twisted as a result of having been fixed too loosely, pressure necrosis of the nasal septum may occur. This may manifest as pain or as epistaxis. If suspected, the nasal bridle must be removed.

Sinusitis/Rhinitis
Infection may occur and this may require treatment with antibiotics or removal of nasal bridle.

Nasal trauma
Damage to the nasal septum may occur either on insertion or because of pressure necrosis or rupture of the septum from patients pulling on the bridle. In practice this is very rare.

Dislodged EFT
Although the nasal bridle reduces the incidence of EFT’s becoming dislodged, it is still possible for this to occur. Correct position of the EFT should be confirmed prior to commencing feeding and daily as per Trust enteral feeding policy.

5.2 REMOVAL OF THE NASAL BRIDLE

If the patient has previously consented to the bridle and then withdraws consent, or if the patient becomes distressed by the bridle then it MUST be removed whether the bridle has been assessed as being in the patient’s best interest or not. If epistaxis occurs then medical advice should be sought about the continued use of the bridle.

If the patient continues to pull on the EFT tube despite the use of the nasal bridle then it should be removed. The bridle is placed to prevent the EFT tube from being accidentally removed, not to prevent the patient from deliberately removing it.

When removal of the nasal bridle is required cut one side of the bridle ribbon (between the nose and the clip) and gently pull both the bridle and the feeding tube out at the same time.
6 RESPONSIBILITIES

- Ashford and St Peter’s Hospitals Trust is responsible for providing optimal treatment for patients and ensuring appropriate training is available to those involved in the selection, fitting and use of nasal bridles.

- Clinical Nurse Leaders and ward managers are responsible for ensuring the implementation of this policy and that all staff inserting nasal bridles have completed the relevant training. Ward managers will hold a list of all staff competently trained in nasal bridle insertion within their own clinical area.

- The decision to insert a nasal bridle will only be undertaken after discussion with the clinical team and following a mental capacity assessment. The decision to use a nasal bridle must be clearly documented in the medical notes in accordance with the Mental Capacity Act 2005. The least restrictive option must always be considered. The intervention required and rationale for use must be identified and documented. Restraint must be proportional to patient needs and a best interest decision under the Mental Capacity Act 2005.

- A family member does not have the authority to consent to the insertion of a nasal bridle on their relative unless they have lasting power of Attorney for Health and Welfare or a Deputyship for Health and Welfare. They should, however, be consulted as part of the best interest decision making process with the doctor or nurse or health professional.

- Ashford and St Peter’s Hospitals NHS Foundation Trust Nutrition Steering Group will ensure that evidence based practice is followed and national recommendations are disseminated to all staff involved in nasal bridle management.

- Each clinical area is responsible for monitoring compliance with this guideline.

7 RATIFICATION

The policy will be reviewed by the Nutrition Steering Group. Ratification will be by the Nursing Documentation Group and Senior Nursing and Midwifery and Leadership Committee.
8 DISSEMINATION AND IMPLEMENTATION

- Staff must be able to demonstrate competence prior to insertion of a nasal bridle. Ward managers are responsible for ensuring competence.

- Notification of the policy will be put onto Aspire and training can be arranged by the dietitian or NST for specific staff groups.

- The nutrition support nurse/stroke nurse/dietitian will be responsible for helping staff to identify patients who may be appropriate for insertion of a nasal bridle.

- The use of this policy will be included into the mental capacity act training, the feeding older people teaching sessions and in one to one discussions with individual members of staff after a decision is made about the use of the nasal bridle.

9 MONITORING AND COMPLIANCE

Compliance will be monitored by regular audit undertaken by the Nutrition Support Nurse and the Dietetic Department. Audits will include the number of nasal bridle requests made, resultant placements, outcome and compliance with completion of relevant documentation and care plans. These findings will be used to identify any further training needs and may be used in updating future guidelines.
10 REFERENCES


g. Seder, C., Stockdale, W., Hale, L. and Janczyk, R. (2010). Nasal bridling decreases feeding tube dislodgement and may increase caloric intake in the surgical intensive care unit: A randomized, controlled trial. Critical Care Medicine. 38(3) p797

APPENDIX 1

Mental Capacity Act 2005 - Checklist for assessing mental capacity/best interest in the trust

The following check-list should be completed for all patients requiring a mental capacity assessment, in relation to a significant decision i.e. about health or social care. This check-list must be completed by registered practitioners (Drs, RN – Senior Staff Nurses; Band 6 and Band 7 Nurses; Therapists, Care Managers, Midwives)

<table>
<thead>
<tr>
<th>Date of Assessment:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name and Designation of Assessor:</td>
</tr>
<tr>
<td>Name of Person being assessed:</td>
</tr>
<tr>
<td>Hosp No:</td>
</tr>
<tr>
<td>DOB:</td>
</tr>
<tr>
<td>Address:</td>
</tr>
<tr>
<td>Consultant / SpR:</td>
</tr>
<tr>
<td>NOK/Carer contact details:</td>
</tr>
<tr>
<td>Ward / Unit:</td>
</tr>
</tbody>
</table>

NB: Once completed the check-list must be filed in the patients notes

For further guidance please see Code of Practice – Trust Guidelines (trust.net)
**NB:** For Adults 18 years & over
1. Is there a:

   1. Lasting Power of Attorney (LPA) – finance?
   2. Lasting Power of Attorney -welfare?
   3. Written Statement?
   4. If there is an Advance Decision to refuse treatment (in relation to this decision at this point in time) & is it valid & applicable?
   5. Court Appointed Deputy?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
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</table>

2. Detail of the SPECIFIC treatment / care for which decision is required:

When (date) specific treatment or care required: ________________

**

1. If decision required for more than one issue, please use additional sheets for each specific treatment

3. For the above specific issue / decision, does the person have an impairment or disturbance in the functioning of, the mind or brain,

Evidence/Details: (ie, diagnostic tests, functional assessments)

AND can the person:

(functional test)

   1. Understand the information relevant to the decision? and
   2. Retain the information (in their mind long enough to use it to make an effective decision)? and
   3. Use or weigh the information to arrive at a choice? and
   4. Communicate the decision (in any manner)?

(Yes to all 4 questions 1-4 would indicate the person does have capacity)

NB: Attempts must be made to reiterate the information at appropriate intervals if short term retention of information is impaired

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
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</table>
4. If the person is believed to lack capacity on this specific issue/decision?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
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</thead>
</table>

Is the lack of capacity likely to be Temporary?

Is the lack of capacity likely to be permanent?

**NB:** Is treatment/decision considered urgent or can it be deferred?

Please comment:

5. (If the person lacks capacity)

**Who will be the decision maker?** (This will normally be the person responsible for the treatment/action)

Name .................................................................

designation & contact details .................................................................

**NB:** Is there a personnel welfare Lasting power of Attorney which gives a donee specific power?

This must be checked via the Court of Protection

6. Views of interested others (family, friends, carers IMCA. Give names & roles) including; contact details & relevant supporting information:

7. If there are any conflicts of interest amongst family/carer, health or social care professionals please outline
8. Independent Mental Capacity Advocate

<table>
<thead>
<tr>
<th>Is there an existing Independent Mental Capacity Advocate?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is there a requirement for an Independent Mental Capacity Advocate (IMCA)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If Yes, IMCA was contacted on ................................................................. by whom (inc contact details)........................................................................</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Name &amp; Contact details of IMCA.................................................................</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IMCA report being received &amp; considered?</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

9. Checklist for making ‘Best Interest’ decisions

<table>
<thead>
<tr>
<th>1. Have all the relevant circumstances been considered?</th>
<th></th>
<th></th>
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<tbody>
<tr>
<td>2. Has the person been encouraged, as far as reasonably practicable, to participate in making the decision affecting them, even when the person is believed to lack capacity?</td>
<td></td>
<td></td>
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<tr>
<td>3. Confirmed that no motivation/desire to bring about the patient’s death if relating to life sustaining treatment?</td>
<td></td>
<td></td>
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<tr>
<td>4. Consideration has been given to the patient’s past and past wishes and feelings without discrimination?</td>
<td></td>
<td></td>
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<tr>
<td>5. Consideration has been given to any relevant written statement made when the person had capacity?</td>
<td></td>
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<tr>
<td>6. Consideration has been given to beliefs and values likely to influence the person’s decision e.g., religious, cultural and lifestyle choices?</td>
<td></td>
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</tr>
<tr>
<td>7. Have other factors that the person is likely to consider (e.g., emotional bonds, family obligations, financial issues, accommodation etc) taken into account?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Consultation carried out with key people as to what would be in the person’s best interests e.g., spouse, civil partner, anyone named by the person, carer, family friends, professional or voluntary services including existing advocate, IMCA any lasting power of attorney or deputy appointed by the Court of Protection?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. If IMCA involved, does the IMCA support the ‘best interest’ decision?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>If Yes, please provide details: NB: If No to any of the above please detail: (eg Is treatment/decision considered urgent)</td>
<td></td>
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</table>

**Best Interests Decision:**
10. Views of Lead Professional (inc name/role):
Details:

11. Views of other professionals (inc names/roles):
Details:

12. Assessment Summary:
(The treatment/decision should be the least restrictive option or intervention possible. Special considerations for life sustaining treatment have been considered or are not applicable. This decision is not based on age, appearance, condition, gender or race. Every effort has been made to communicate with the person concerned).

Signed: ___________________________________________ ______________________
Name: _____________________________________________ _____________________
Designation:  _____________________________________ _______________________
Department: _______________________________________ ______________________
Date: _____________________________________________ ______________________
# NASAL BRIDLE REFERRAL FORM

**Referring Consultant:**

**Ward:**

**Date and time of referral**

<table>
<thead>
<tr>
<th>Diagnosis (please tick):</th>
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<tbody>
<tr>
<td>CVA</td>
<td>Parkinson’s Disease</td>
</tr>
<tr>
<td>Dementia</td>
<td>Head and Neck Cancer</td>
</tr>
<tr>
<td>Acute Confusion (please specify cause)</td>
<td>Other (please specify)</td>
</tr>
</tbody>
</table>

Has the patient been seen by a dietitian?  Yes / No  Date of last review:

Has the patient been seen by SLT?  Yes / No  Date of last review:

Are the named consultant and the nurse in charge of the ward aware of, and in agreement with, this referral?  Yes / No

Does the patient have capacity to consent to placement of a nasal bridle, and if so have they given their informed, verbal consent?  Yes / No

If the patient does not have capacity to consent, is placement of a nasal bridle to secure the enteral feeding tube in place felt to be in the patients best interests and is this documented in the patients notes?  Yes / No

If placement of a nasal bridle is felt to be in the patient’s best interests, has this been discussed with the patient’s relatives and documented in the patient’s notes?  Yes / No

Are there any contraindications to placement of a nasal bridle as described in the nasal bridle policy document?  If yes, please specify.

**Details of medical personal completing this form**

<table>
<thead>
<tr>
<th>Signature:</th>
<th>Designation:</th>
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</table>

<table>
<thead>
<tr>
<th>Name:</th>
<th>Bleep / Pager:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Bridle Given by:</th>
<th>Date:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>idle placed by:</th>
<th>Date:</th>
</tr>
</thead>
</table>
PROBLEM:
Patient has a nasogastric tube in place secured with a Nasal Bridle to prevent accidental removal

GOAL:
• To prevent nasogastric tube being pulled out, accidental dislodgement and subsequent reinsertions

PLAN OF CARE:

Following insertion:
1. Note and document the position of the nasogastric tube at the distal end of the Bridle clip.
2. If no markers are present mark the tube with indelible pen.
3. Ensure tapes are not twisted or applying pressure to the columnella.
4. If required tape the nasal tube to the cheek for comfort and to prevent traction of the bridle.

Daily:
5. Clean external, visible parts of the Nasal Bridle and nostrils with soap and water or hand and face wipes.
6. Check Bridle ribbon used to secure Bridle is not twisted.
7. Inspect the skin around the nostrils for any soreness or pressure damage.
8. Check clip for signs of damage or loose attachment to the Nasal tube.
9. Record Nasogastric tube length every time tube is used and document on NG Care Plan
10. If the patient continues to pull at the naso-tube while the bridle is in situ, causing unreasonable distress, discuss with medical team/dietitian/nutrition nurse and consider removal of bridle.

Removal of Bridle:
11. Cut one strand of tape.
12. Gently pull both the Bridle and the nasal tube out of the nose.

RN Signature …………………………     Print Name……………………………
Date…………………………

Student Nurse Signature ………………………… (if completed by a Student Nurse, plan must be countersigned by RN)

You are reminded that all record keeping must be in accordance with the NMC Record Keeping Guidelines.
FURTHER ACTIONS

Any care you have given in addition to items in this specific Care Plan, please record below:

RN Signature ....................................  Print Name....................................
Date........................................

Student Nurse Signature .................................... (if completed by a Student Nurse, plan must be countersigned by RN)

RN Signature ....................................  Print Name....................................
Date........................................

Student Nurse Signature .................................... (if completed by a Student Nurse, plan must be countersigned by RN)

RN Signature ....................................  Print Name....................................
Date........................................

Student Nurse Signature .................................... (if completed by a Student Nurse, plan must be countersigned by RN)

References: Enteral  UK AMT Bridle Pocket Guide 2014
APPENDIX 4

EQUALITY IMPACT ASSESSMENT SUMMARY

Name: Dee Bousfield

Policy/Service: Nasal Bridle Policy

<table>
<thead>
<tr>
<th>Background</th>
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<tbody>
<tr>
<td>• Description of the aims of the policy</td>
</tr>
<tr>
<td>• Context in which the policy operates</td>
</tr>
<tr>
<td>• Who was involved in the Equality Impact Assessment</td>
</tr>
</tbody>
</table>

As per introduction.
The policy author led the assessment.

<table>
<thead>
<tr>
<th>Methodology</th>
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<tbody>
<tr>
<td>• A brief account of how the likely effects of the policy was assessed (to include race and ethnic origin, disability, gender, culture, religion or belief, sexual orientation, age)</td>
</tr>
<tr>
<td>• The data sources and any other information used</td>
</tr>
<tr>
<td>• The consultation that was carried out (who, why and how?)</td>
</tr>
</tbody>
</table>

All relevant evidence and data available was considered.
<table>
<thead>
<tr>
<th><strong>Key Findings</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Describe the results of the assessment</td>
</tr>
<tr>
<td>• Identify if there is adverse or a potentially adverse impacts for any equalities groups</td>
</tr>
</tbody>
</table>

This policy does not discriminate against race and ethnic origin, disability, gender, culture, religion or belief, sexual orientation or age.

<table>
<thead>
<tr>
<th><strong>Conclusion</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Provide a summary of the overall conclusions</td>
</tr>
</tbody>
</table>

This policy does not discriminate against race and ethnic origin, disability, gender, culture, religion or belief, sexual orientation or age.

<table>
<thead>
<tr>
<th><strong>Recommendations</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• State recommended changes to the proposed policy as a result of the impact assessment</td>
</tr>
<tr>
<td>• Where it has not been possible to amend the policy, provide the detail of any actions that have been identified</td>
</tr>
<tr>
<td>• Describe the plans for reviewing the assessment</td>
</tr>
</tbody>
</table>

n/a
**Guidance on Equalities Groups**

<table>
<thead>
<tr>
<th>Race and Ethnic origin (includes gypsies and travellers) (consider communication, access to information on services and employment, and ease of access to services and employment)</th>
<th>Religion or belief (include dress, individual care needs, family relationships, dietary requirements and spiritual needs for consideration)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disability (consider communication issues, access to employment and services, whether individual care needs are being met and whether the policy promotes the involvement of disabled people)</td>
<td>Sexual orientation including lesbian, gay and bisexual people (consider whether the policy/service promotes a culture of openness and takes account of individual needs)</td>
</tr>
<tr>
<td>Gender (consider care needs and employment issues, identify and remove or justify terms which are gender specific)</td>
<td>Age (consider any barriers to accessing services or employment, identify and remove or justify terms which could be ageist, for example, using titles of senior or junior)</td>
</tr>
<tr>
<td>Culture (consider dietary requirements, family relationships and individual care needs)</td>
<td>Social class (consider ability to access services and information, for example, is information provided in plain English?)</td>
</tr>
</tbody>
</table>

**Proposed review date**