NIL BY MOUTH (NBM) AND PERI-OPERATIVE MEDICINES USE GUIDELINE

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Approved by:	TACCSS Clinical Governance:	
Date of Approval:	17th January 2024	
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Key Amendments

Date	Amendment	by
January 2024	Complete revision to refer to national and separate specific local guidance	K Hinton

Introduction

The term 'Nil By Mouth' is often used inappropriately and therefore can be misleading. Patients may be labelled 'Nil By Mouth' for several reasons and this may put the patient at risk of dehydration, malnutrition and the omission of essential regular medicines. Some patients are kept nil by mouth repeatedly for various investigations. As hospital in patients are often either malnourished or at risk of malnutrition even before admission it is essential that interference with nutritional intake be kept to a minimum. Careful consideration must be given to the use of the term. Examples of why patients may be nil by mouth:

- Pre or post surgery
- When the bowel is non-functional e.g. gastric outlet obstruction
- The patient is unable to swallow safely e.g. after a stroke, head injury, myasthenia gravis or reduced level of consciousness.
- Nausea or vomiting may also inhibit the intake of fluids, nutrition and oral medicines.

No patient should be without fluid input (either enteral or intravenous) for more than 10 hours. Certain groups of patients are particularly vulnerable and should not be left for long periods without hydration, correcting serum electrolytes as necessary:

- Elderly patients
- Patients who have undergone bowel preparation
- Acutely ill patients
- Breast feeding mothers
- Infants and children

If patients need to be kept NBM for longer (days) consider other methods of feeding such as nasogastric, naso-jejunal, PEG or parenteral feeding. This needs to involve multi-disciplinary team (medical and nursing staff, dieticians, pharmacists and speech and language therapists) including patients and relatives. Patients should be re-assessed at least daily to determine

when regular feeding can be re-instated. Specific guidance on enteral and parenteral feeding can be found on the Trust intranet.
The National Confidential Enquiry into Peri-Operative Deaths (NCEPOD) report for 2001-02 (1) found that many patients were not being given essential regular medicines before operations. The report entitled 'Functioning as a team' says 'Of concern is the information on antianginal, bronchodilator and steroid treatment. These drugs should be given throughout the operative period and when the patient cannot take their oral drugs, there are simple topical, inhaled or parenteral replacement preparations readily available'. This recommendation is supported by an observational study by Kennedy et al (2) of over 1000 admissions for general and vascular surgery that found that a high number of patients scheduled for inpatient surgery took medicines unrelated to surgery, the majority of which (53%) were for cardiovascular problems. There was a higher incidence of peri-operative complications among patients who took such medicines and there was a significant association between abstinence from their regular medication and adverse outcomes. This guideline, produced as a result of a recommendation by The Royal College of Anaesthetists helps define which medicines should be administered pre and post-operatively and which should be discontinued. (3)

- It is not appropriate to simply omit an oral medicine without first clarifying the instruction with the relevant team. It may be appropriate to give the oral medicine or to change to an alternative product using an alternative route. Failure to continue a patient's usual medication can potentially cause an exacerbation of their chronic condition or adverse effects from abrupt drug withdrawal to occur.

- When changing the route of administration of a drug care should be taken to ensure that the appropriate dose and frequency is prescribed, as these may not be the same as for the oral route. Please check with the ward pharmacist, anaesthetist or the on-call pharmacist (available via switchboard).

- For advice on pre-operative fasting, please follow the link below:

Pre-Operative Fasting for Elective Surgery Guidelines

- Ideally required prescribed medicines should be taken up to two hours before surgery. However, as water leaves the stomach quickly, a small amount (30ml) of water to take oral medicines is permitted.

- Patients who have chewed gum pre-operatively should not have their surgery/procedure cancelled for this reason.

- There are a few significant interactions between drugs used during surgery and routine medications that require the drugs not to be administered concurrently. The anaesthetist will usually manage this, by their choice of anaesthetic technique but the advice given in this document will help limit potential problems

- This guideline is intended to supplement advice on drug therapy that should be continued or discontinued for patients who are 'nil by mouth' available from:

  UKCPA - Handbook of Perioperative Medicines

- For advice regarding the alteration to the preparation, formulation or alternative medicine choice for specific therapies please contact your ward pharmacist.

Adjustment to routine medication during the peri-operative period

Routine medicines should wherever possible, be reviewed *prior* to surgery for:

1. Medicines that should be continued throughout the perioperative period to prevent relapse of the treated condition or to avoid the effects of drug withdrawal.
2. Medicines that should be withheld before surgery to reduce the risks that they may impose upon the procedure.

If adjustments to therapy cannot be made e.g. for emergency admissions, ensure the surgeon and anaesthetist are aware of the patient's medication history**.**

Protocol for managing anticoagulants when operation cancelled following temporary cessation of oral anticoagulants

When a patient who is taking oral anticoagulants is listed for planned surgery this information must be clear on the booking form so that cancellation of surgery after cessation of oral anticoagulants is avoided unless on clinical grounds.

When a patient who is taking oral anticoagulants is listed for planned surgery clear advice will be given to the patient at the time of the pre-operative assessment regarding cessation of medicines. In the event their surgery is cancelled the patient should contact the consultant for their care should advice not be given at the time of cancellation.

On the rare occasion where the patient has ceased taking their oral anticoagulants in preparation for surgery and their operation is cancelled it is the responsibility of the consultant or operating surgeon to give appropriate advice to the patient, this will depend on the indication for the anticoagulation and the date if the rescheduled surgery. Advice can be sought by the consultant or operating surgeon from cardiology or haematology.

GUIDANCE	LINK
PERI-OPERATIVE MEDICINES USE GUIDANCE	UKCPA - Handbook of Perioperative Medicines
PERI-OPERATIVE ORAL ANTOCOAGULANT BRIDGING	Peri-operative oral anticoagulant bridging
PRE-OPERATIVE MANAGEMENT OF ANTIPLATELET MEDICATIONS	Pre-operative Management of Antiplatelet Medications
GUIDELINE FOR THE PERIOPERATIVE MANAGEMENT OF DIABETES FOR ADULT PATIENTS UNDERGOING SURGERY	Guideline for the Perioperative Management of Diabetes for Adult patients Undergoing Surgery
PRE-OPERATIVE FASTING FOR ELECTIVE SURGERY	http://whitsweb/KeyDocs/KeyDocs/DownloadFile/2963 http://whitsweb/KeyDocs/KeyDocs/DownloadFile/1756

MONITORING TOOL

Page/ Section of Key Document	Key control:	Checks to be carried out to confirm compliance with the policy:	How often the check will be carried out:	Responsible for carrying out the check:	Results of check reported to: *(Responsible for also ensuring actions are developed to address any areas of non-compliance)*	Frequency of reporting:
	WHAT?	**HOW?**	**WHEN?**	**WHO?**	**WHERE?**	**WHEN?**
1	No patient will be without fluid input (enteral or parenteral) for more than 10 hours	Care and comfort rounds	Hourly	Nursing staff	Nurse manager	Daily
2	Essential regular medicines will not be omitted pre-operatively from surgical patients (unless there is a clinical reason to do so)	Audit	Annual	Pharmacy	Medicines Safety Committee	Annual

References:

1. The 2002 Report of the National Confidential Enquiry into Perioperative Deaths. Functioning as a team? London; NCEPOD 2002
2. Kennedy JM, van Rij AM, Spears GF, Pettigrew RA, Tucker IG. Polypharmacy in a general surgical unit and consequences of drug withdrawal. Br J Clin Pharmacol 2000; 49:353-362
3. Kennedy JM, van Rij AM, Spears GF, Pettigrew RA, Tucker IG. Polypharmacy in a general surgical unit and consequences of drug withdrawal. Br J Clin Pharmacol 2000; 49:353-362
4. Smith I, Kranke P, Murat I, Smith AF, O'Sullivan G, Søreide E, Spies C, in't Veld B. Perioperative Fasting in Adults and Children: Guidelines from the European Society of Anaesthesiology. *European Journal of Anaesthesiology* 2011; 28: 556-69.
5. The United Kingdom Clinical Pharmacy Association. The Handbook of perioperative Medicines. Third edition. Accessed online May 2021 via https://www.ukcpa-periophandbook.co.uk/

CONTRIBUTION LIST

Key individuals involved in developing the document

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Circulated to the following individuals for comments

Name	Designation
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Linzi Wright	Senior Sister – Pre-Operative Assessment Countywide and TAU

Circulated to the chair of the following committee's / groups for comments

Name	Committee / group
Dr Rob Glasson	Clinical Director Anaesthetics
Dr Nick Purser	Clinical Governance lead Surgery

Supporting Document 1 - Equality Impact Assessment Tool

To be completed by the key document author and included as an appendix to key document when submitted to the appropriate committee for consideration and approval.

Please complete assessment form on next page;

NHS Worcestershire Acute Hospitals NHS Trust

Herefordshire & Worcestershire STP - Equality Impact Assessment (EIA) Form
Please read EIA guidelines when completing this form

Section 1 - Name of Organisation (please tick)

Herefordshire & Worcestershire STP		Herefordshire Council		Herefordshire CCG	
Worcestershire Acute Hospitals NHS Trust	x	Worcestershire County Council		Worcestershire CCGs	
Worcestershire Health and Care NHS Trust		Wye Valley NHS Trust		Other (please state)	

Name of Lead for Activity	**Dr Salim Shafeek**

Details of individuals completing this assessment	**Name**	**Job title**	**e-mail contact**
	Keith Hinton	**Countywide Lead Clinical Pharmacist for Critical Care, Surgery and Anaesthetics**	**Keith.hinton1@nhs.net**
Date assessment completed	**21/06/2021**		

Section 2

Activity being assessed (e.g. policy/procedure, document, service redesign, policy, strategy etc.)	**Title: Nil by Mouth and perioperative medicines use Guideline**			
What is the aim, purpose and/or intended outcomes of this Activity?	To provide guidance and improve preoperative hydration status and perioperative medicines use.			
Who will be affected by the development & implementation of this activity?	❑	Service User	■	Staff
	■	Patient	❑	Communities
	❑	Carers	❑	Other _____
	❑	Visitors	❑	

Is this:	X Review of an existing activity ❑ New activity ❑ Planning to withdraw or reduce a service, activity or presence?
What information and evidence have you reviewed to help inform this assessment? (Please name sources, eg demographic information for patients / services / staff groups affected, complaints etc.	See reference list
Summary of engagement or consultation undertaken (e.g. who and how have you engaged with, or why do you believe this is not required)	See contribution list
Summary of relevant findings	

Section 3

Please consider the potential impact of this activity (during development & implementation) on each of the equality groups outlined below. **Please tick one or more impact box below for each Equality Group and explain your rationale**. Please note it is possible for the potential impact to be both positive and negative within the same equality group and this should be recorded. Remember to consider the impact on e.g. staff, public, patients, carers etc. in these equality groups.

Equality Group	**Potential positive impact**	**Potential neutral impact**	**Potential negative impact**	**Please explain your reasons for any potential positive, neutral or negative impact identified**
Age		X		
Disability		X		
Gender Reassignment		X		
Marriage & Civil Partnerships		X		
Pregnancy & Maternity		X		

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Race including Traveling Communities		X		
Religion & Belief		X		
Sex		X		
Sexual Orientation		X		
Other Vulnerable and Disadvantaged Groups (e.g. carers; care leavers; homeless; Social/Economic deprivation, travelling communities etc.)		X		
Health Inequalities (any preventable, unfair & unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental & economic conditions within societies)		x		

Section 4

What actions will you take to mitigate any potential negative impacts?	Risk identified	Actions required to reduce / eliminate negative impact	Who will lead on the action?	Timeframe
		.		
How will you monitor these actions?				

When will you review this EIA? (e.g in a service redesign, this EIA should be revisited regularly throughout the design & implementation)	

Section 5 - Please read and agree to the following Equality Statement

1. Equality Statement

1.1. All public bodies have a statutory duty under the Equality Act 2010 to set out arrangements to assess and consult on how their policies and functions impact on the 9 protected characteristics: Age; Disability; Gender Reassignment; Marriage & Civil Partnership; Pregnancy & Maternity; Race; Religion & Belief; Sex; Sexual Orientation

1.2. Our Organisations will challenge discrimination, promote equality, respect human rights, and aims to design and implement services, policies and measures that meet the diverse needs of our service, and population, ensuring that none are placed at a disadvantage over others.

1.3. All staff are expected to deliver services and provide services and care in a manner which respects the individuality of service users, patients, carers etc, and as such treat them and members of the workforce respectfully, paying due regard to the 9 protected characteristics.

Signature of person completing EIA	
Date signed	
Comments:	
Signature of person the Leader Person for this activity	
Date signed	
Comments:	

Supporting Document 2 – Financial Impact Assessment

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

	Title of document:	**Yes/No**
1.	Does the implementation of this document require any additional Capital resources	No
2.	Does the implementation of this document require additional revenue	No
3.	Does the implementation of this document require additional manpower	No
4.	Does the implementation of this document release any manpower costs through a change in practice	No
5.	Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programmes or allocated training times for staff	No
	Other comments:	

If the response to any of the above is yes, please complete a business case and which is signed by your Finance Manager and Directorate Manager for consideration by the Accountable Director before progressing to the relevant committee for approval