

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

<b>Key Document code:</b>	WAHT-KD-017	
<b>Key Documents Owner:</b>	Keith Hinton	Principal Pharmacist, Surgery and Critical Care
<b>Approved by:</b>	Nutrition and Hydration Steering Group 17/06/2026	
<b>Date of Approval:</b>	17 <sup>th</sup> June 2026	
<b>Date of Review:</b> <b>This is the most current version and should be used until a revised document is in place</b>	17 <sup>th</sup> June 2029	

### Key Amendments

Date	Amendment	by
January 2024	Complete revision to refer to national and separate specific local guidance	Keith Hinton
17 <sup>th</sup> June 2026	Additional information relating to roles and responsibilities for the provision of nutrition and hydration.	Jonathan Howard

### Introduction

The aim of this document is to ensure no patient remains nil-by-mouth (NBM) for longer than is 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 to ensure the patient's nutritional status is not comprised in the long term.

For adult and paediatric patients presenting for elective surgery at WAHT, staff should refer to the Pre-operative Fasting for Elective Surgery Guidelines (WAHT-KD-017).

**Key Principle**

**Nil By Mouth status does not remove the responsibility to provide hydration, nutrition and medicines.**

**NBM must be time limited, reviewed and clearly planned.**

**Every patient on NBM must have a documented care plan and review timeline, shared at handover and at safety huddles**

**Prolonged or unclear NBM status must trigger escalation**

**Patient safety, comfort and nutritional safety must remain central to care.**

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
- Diabetic 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**

**Nil by Mouth and Sip Till Send Trust-approved signs can be found in the Nutrition and Dietetics section of Trust-wide documents.**

### **Nil By Mouth (NBM): Escalation and Staff Responsibilities**

#### **Purpose**

To ensure patients who are Nil By Mouth do not experience avoidable harm due to unmet hydration, nutrition or medicines needs, and to support compliance with the National Standards for Healthcare Food and Drink.

#### **Staff Responsibilities**

##### **All Clinical Staff**

- All staff involved in the care of a patient who is Nil By Mouth are collectively responsible for ensuring that the patient's hydration, nutrition and medicines needs are assessed, reviewed and with appropriate action plans documented.
- Nil By Mouth status must not be regarded as a passive instruction; it requires active management and ongoing review.

Any concerns regarding a patient's hydration, nutrition or clinical deterioration must be escalated promptly in line with this policy.

### **Escalation Process**

#### **Patients Nil By Mouth for 24 Hours**

If a patient has been Nil By Mouth for **24 hours** and their **hydration, nutrition or medicines needs are not being adequately met**, the following actions must occur: **Immediate escalation to the responsible Consultant** for review and decision-making.

If, following consultant review, the patient's needs **remain unmet**, escalation must occur to

##### **Ward Manager/Matron**

**This escalation is required to ensure senior oversight, timely intervention and patient safety.**

#### **Documentation**

- All decisions, reviews, escalation actions and outcomes must be clearly documented in the patient record.
- Nil By Mouth status must be reviewed at least daily, or more frequently if the patient's condition changes.

### Professional Roles and Responsibilities in Nil By Mouth (NBM) Management

These responsibilities support safe, timely and appropriate management of patients who are Nil By Mouth and ensure compliance with the National Standards for Healthcare Food and Drink, patient safety principles, and professional regulatory expectations.

**Please follow the guidance for pre-operative fasting for elective surgery guidelines,**

**Pre-op Assessment Key Documents WAHT-KD-017**

#### Medical / Nursing staff

- Weigh and assess patients on admission and weekly thereafter
- Ensure NBM status is clearly visible, Trust approved NBM signage available on the intranet, key documents>Nutrition and Dietetics>Nil By Mouth
- Monitor intake status and prevent unintended oral intake
- Ensure NBM status is communicated at handover and safety huddles with planned review time and escalation plan if review does not occur
- Flag patients approaching or exceeding planned NBM timelines
- Refer to therapists if required
- Escalate care acting as patient advocate if patient 's nutritional needs are not being met
- **Monitor and record fluid balance accurately**

#### Theatre and ward staff

As part of the World Health Organisation (WHO) team brief, the order of the operative list should be determined and clear fluid 'drink until' times determined and communicated to wards/admission areas. Patients should be encouraged to drink clear fluids until the time agreed.

#### Dieticians

- Assess the referred patient for nutritional status
- Provision of feeding regimen
- Training and education of patients with feeding tubes/special dietary requirements
- Provide relevant patient information

#### Speech and Language Therapy (SLT)

- Assess referred patients for swallowing safety, communication needs and suitability for oral intake.
- Provide clear, timely recommendations regarding Nil By Mouth status, texture modification, fluid consistency and safe swallowing strategies.
- Support decision-making regarding initiation, continuation or cessation of Nil By Mouth status from a swallowing safety perspective.
- Provide education and training to patients, carers and staff to promote safe eating and drinking practices.
- Ensure all assessment outcomes and recommendations are clearly documented in the patient record.
- Participate in multidisciplinary discussions relating to nutrition, hydration and ongoing care planning.

#### Pharmacists

- Provide specialist advice on the safe and effective use of medicines for patients who are Nil By Mouth.
- Identify and advise on appropriate alternative formulations or routes of administration (e.g. intravenous, transdermal, enteral).
- Support clinical teams to prevent omitted or delayed medicines due to Nil By Mouth status.
- Review medication regimens to minimise risk related to hydration status, renal function and altered absorption.
- Document advice provided and escalate concerns where medication, hydration or electrolyte needs are not being adequately met.

#### Medical and Surgical Staff

- Assess patients for clinical suitability and fitness to proceed with anaesthetic or surgical intervention.
- Ensure decisions to make a patient Nil By Mouth are clinically justified, clearly documented and regularly reviewed.
- Clarify the Nil by Mouth status relating to nutrition, hydration or medicines e.g. is it for food and fluids but essential medicines may be taken orally?
- Specify the anticipated duration of Nil By Mouth status and outline a clear plan for hydration, nutrition and medicines management.
- Review patients who remain Nil By Mouth for prolonged periods and take action to reduce unnecessary fasting.
- Initiate and respond to escalation where hydration, nutrition or medicines needs are unmet, in line with the Trust's escalation process.
- Communicate Nil By Mouth status and management plans during ward rounds, handovers and safety huddles.

### Multidisciplinary Responsibility and Advocacy

- Nil By Mouth status does not remove the responsibility to provide hydration, nutrition and medicines.
- All members of the multidisciplinary team share responsibility for advocacy, escalation and patient safety.
- Concerns raised by patients, carers or staff must be taken seriously and escalated appropriately.
- Systems and processes (including EPR prompts and hydration risk assessments) should be used to support timely review and escalation.

### Medicines

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

**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: <i>(Responsible for also ensuring actions are developed to address any areas of non-compliance)</i>	Frequency of reporting:
	<b>WHAT?</b>	<b>HOW?</b>	<b>WHEN?</b>	<b>WHO?</b>	<b>WHERE?</b>	<b>WHEN?</b>
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)	Sunrise report	Annual	Informatics	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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Dr Harsha Mistry	Consultant Anaesthetist
Jonathan Howard	Practice Educator

**Circulated to the following individuals for comments**

Name	Designation
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 James Hutchinson	Clinical Director, Theatres and Anaesthetics
Dr Jo Marriott	Divisional Director, Surgery
Alison Robinson	Deputy Chief Nursing Officer and Chair of the Nutrition and Hydration Committee

## Supporting Document 1 - Equality Impact Assessment Tool

## Equality and Health Inequalities Impact Assessment (EHIA) Tool

**Herefordshire & Worcestershire STP - Equality and Health Inequalities Impact  
Assessment (HEIA) Form**

**Please read HEIA 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)	

<b>Name of Lead for Activity</b>	<b>Keith Hinton</b>		
<b>Details of individuals completing this assessment</b>	<b>Name</b>	<b>Job title</b>	<b>e-mail contact</b>
	Keith Hinton	Countywide Lead Clinical Pharmacist for Critical Care, Surgery and Anaesthetics	Keith.hinton1@nhs.net
<b>Date assessment completed</b>	17/06/2026		

**Section 2**

Activity being assessed (e.g. policy/procedure, document, service redesign, policy, strategy etc.)	<b>Title: Nil by Mouth and perioperative medicines use Guideline</b>		
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?	<input type="checkbox"/> Service User <input checked="" type="checkbox"/> Patient <input type="checkbox"/> Carers <input type="checkbox"/> Visitors	<input checked="" type="checkbox"/> Staff <input type="checkbox"/> Communities <input type="checkbox"/> Other _____	
Is this:	X Review of an existing activity		

	<input checked="" type="checkbox"/> New activity <input type="checkbox"/> 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		
Race including Traveling Communities		X		

Equality Group	Potential <u>positive</u> impact	Potential <u>neutral</u> impact	Potential <u>negative</u> impact	Please explain your reasons for any potential positive, neutral or negative impact identified
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?				


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<p><b>When will you review this EIA?</b> (e.g in a service redesign, this EIA should be revisited regularly throughout the design &amp; implementation)</p>	
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**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.

<p><b>Signature of person completing EIA</b></p>	
<p><b>Date signed</b></p>	<p>18/06/2026</p>
<p><b>Comments:</b></p>	
<p><b>Signature of person the Leader Person for this activity</b></p>	
<p><b>Date signed</b></p>	
<p><b>Comments:</b></p>	



**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.

	<b>Title of document:</b>	<b>Yes/No</b>
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