Worcestershire Acute Hospitals NHS Trust

Guideline for The Training of Registered Nurses to Competently Act as a First Assistant with a Registered Medical Practitioner During the Placement of Percutaneous Endoscopic Gastrostomy Tubes (PEG)

This guidance does not override the individual responsibility of health professionals to make appropriate decision according to the circumstances of the individual patient in consultation with the patient and /or carer. Health care professionals must be prepared to justify any deviation from this guidance.

Introduction

This guidance is specifically for use on the Endoscopy Unit. It must be used in conjunction with a training schedule agreed by a consultant Endoscopist.

An Endoscopist and another doctor have traditionally undertaken the insertion of Percutaneous Endoscopic Gastrostomy tubes (PEG). Within this trust nursing staff have been trained to act as the assistant to the Endoscopist. This training package has been devised to formalise the training offered to staff who wish to undertake this role.

The patients covered by this guidance are patients undergoing Percutaneous Endoscopic Gastrostomy tube insertion to assist with feeding. Procedure to be carried out on the Endoscopy unit.

This guideline is for use by the following staff groups:

This role should only be undertaken by Endoscopy trained nurses who have completed their basic Endoscopy competencies. These nurses would be expected to be a band 5 with a minimum of 3 year's experience.

Lead Clinician(s)

Jennifer Dutton — Practice Development Sister, Countywide Endoscopy

Approved by Endoscopy Directorate Governance Meeting on: 24th February 2025

Review Date: 24th February 2028

This is the most current document and should be used until a revised version is in place

Key amendments to this guideline

Date	Amendment	Approved by:
April 2022	New document approved	Endoscopy Directorate Governance

March 2025	Introduction of use of Avanos CORFLO PEG's	Jennifer Dutton Natalie Tayler

GUIDELINE

Rationale

- Percutaneous Endoscopic Gastrostomy (PEG) Tubes are currently placed, for the purpose of long term feeding by two registered practitioners or with the assistance of a registered nurse. This can often result in a delay to the patient waiting for this procedure if there is not an adequate number of staff trained in performing this procedure.
- It is now appropriate for the registered nurse, whose client group includes patients requiring this procedure, to expand their role to include becoming a first assistant to a doctor at PEG placement
- This will allow for improved quality and continuity of care, a potential for reduction in waiting time for this procedure and continued professional development of the Endoscopy Workforce.

Aim

To equip the registered nurse with the knowledge, skills and attitude to be able to competently act as a first assistant during Percutaneous Endoscopic Gastrostomy tube placement.

Objectives

Following training and assessment the registered nurse will be able to:

- *Discuss reasons for placement of PEG tube*
- *Demonstrate knowledge of selection criteria for PEG placement including contraindications.*
- *Discuss issues surrounding PEG tube placement, including obtaining valid consent.*
- *Be aware of the need for counselling of patients and / or their relatives prior to tube placement and identify personnel available to do this.*
- *Demonstrate skill in acting as first assistant during PEG tube placement*
- *Identify the specific nursing care for patients receiving PEG tube feeding*
- *Explain the possible complications of the procedure and methods used to help prevent these*
- *Discuss types of PEG tube available and the rationale behind the choice of each*
- *Discuss the scope of Professional Practice and demonstrate awareness of implications of the development of their practice*

Documentation

Competence achieved to be recorded in:

- Individual's personal file ○ Certificate given to practitioner

- Completion of JETS Workforce where applicable

TRAINING AND ASSESSMENT CRITERIA

Teaching Method

Teaching will be done under the supervision of a Medical Practitioner. This should include some theoretical information about the placement of PEG's and the need for PEG feeding. Theoretical teaching will also be supported by the Practice development team. Some supplementary external courses are available on an annual basis where available but not a necessity to fulfil this role. Practical training will be done on a Supernumerary basis to accommodate the Trainees learning needs until deemed competent.

Learning Outcome

- The nurse will demonstrate an understanding of the Code of Professional Conduct NMC 2018, recognise personal abilities and shortcomings.

The nurse will be able to:

- Demonstrate a knowledge in the reasons for placement of PEG tubes Discuss the ethical issues surrounding tube placement.
- Describe the nursing care of the patient pre and post procedure
- Explain the possible complications from the procedure and methods employed to help prevent these
- Discuss types of PEG tube available, the PEG tube of choice for the trust and the reasons behind the choice of each type.
- Demonstrate skill in acting as first assistant at the placement of PEG tubes

Theory

- Theoretical knowledge:
- Anatomy of stomach in relation to tube placement
- Indications and contraindications of insertion of PEG tubes
- Risks involved in tube placement and measures incorporated to reduce such risks
- Describe the procedure for insertion of PEG tubes
- Patient care Pre and Post procedure

Practical Assessment

Recognised assessor must be a Registered Medical Practitioner of Consultant level, skilled in this procedure.

- Observation of PEG Tube placement
- Supervised practice, by recognised trainer, for at least 10 procedures

- Trainee to be Supernumerary during supervised practice Assessed as competent according to defined criteria

PROGRAMME OF RECORDED EDUCATION

THEORETICAL SESSION:

DATE: / / /

NAME OF TRAINER:…… (BLOCK CAPITALS)

TITLE OF TRAINER:…… (BLOCK CAPITALS)

SIGNATURE OF TRAINER:……

NAME OF NURSE:…….... (BLOCK CAPITALS)

SIGNATURE OF NURSE:……

STANDARD STATEMENT TO COMPETENTLY ACT AS A FIRST ASSISITANT, WITH A REGISTERED MEDICAL PRACTIONER, DURING THE PLACEMENT OF PERCUTANEOUS ENDOSCOPIC GASTROSTOMY TUBES

Criteria: 1. Minimal knowledge and understanding 2. Need supervision to perform effectively 3. Perform some skills effectively without supervision 4. Confident in performing identified skills. 5. Can facilitate knowledge and understanding effectively.

KNOWLEDGE, SKILLS & ATTITUDE	Competency Level DATE/SIGN	Competency Level DATE/SIGN	Competency Level DATE/SIGN	Competency Level DATE/SIGN	Competency Level DATE/SIGN
DEMONSTRATE KNOWLEDGE OF THE ANATOMY OF THE STOMACH IN RELATION TO PEG PLACEMENT					

DESCRIBE TYPES OF PEG TUBES AVAILABLE AND RATIONALE FOR CHOICE OF EACH					
DEMONSTRATE UNDERSTANDING OF COUNSELLING OFFERED TO PATIENTS AND/OR RELATIVES PRIOR TO TUBE PLACEMENT					
IDENTIFY RISK INVOLVED IN PROCEDURE AND METHODS TAKEN TO REDUCE THESE					
SELECT AND PREPARE THE APPROPRIATE EQUIPMENT					
EFFECTIVELEY PREPARE THE PATIENT FOR THE PROCEDURE					
PLACE A PEG TUBE DEMONSTRATING SAFETY AND SKILL IN THE PROCEDURE					
DEMONSTRATE A KNOWLEDGE OF PATIENT CARE POST PROCEDURE					

KNOWLEDGE OF PATIENT CARE POST PROCEDURE					
DISCUSS RESOURCES AVAILABLE FOR ADVICE OVER PEG CARE					
DISCUSS RESOURCES AVAILABLE FOR ADVICE OVER PEG CARE					

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST CERTIFICATE OF COMPETENCE

This is to Certify that……..

Has been instructed and assessed and that he/she is competent in the principles and practice of *Acting as a First Assistant to a Registered Medical Practitioner during the placement of Percutaneous Endoscopic Gastrostomy Tubes*.

Date Competence approved: / / /

Signature of Assessor……..

Signature of Trainer……

Signature of Matron……

Signature of Medical Practitioner……..

GUIDELINES FOR PLACEMENT OF PERCUTANEOUS ENDOSCOPIC GASTROSTOMY TUBES WITH A REGISTERED NURSE AS FIRST ASSISTANT DEFINITION

The placement of a gastrostomy Feeding Tube under intravenous sedation, with the assistance on an Endoscope using the 'pull technique', with the Registered Nurse acting as a first assistant alongside a Registered Medical Practitioner (or other qualified Endoscopist) at all times.

EQUIPMENT

- Fresenius Kabi Freka PEG kit 15Fr or Avanos CORFLO PEG kit 16fr (mostly for patients on Head and Neck cancer pathway)
- Chlorhexidine 3ml applicator
- Sterile gloves
- Bupivacaine Hydrochloride 0.25% 10mls
- 10ml Syringe
- Green Needle x1 Blue Needle x 1
- Lubricating Jelly (Optional dependant on Endoscopist)
- Sterile Scissors
- Sterile Drapes x 2
- Sterile Galipot
- Sterile Gauze swab

PROCEDURE

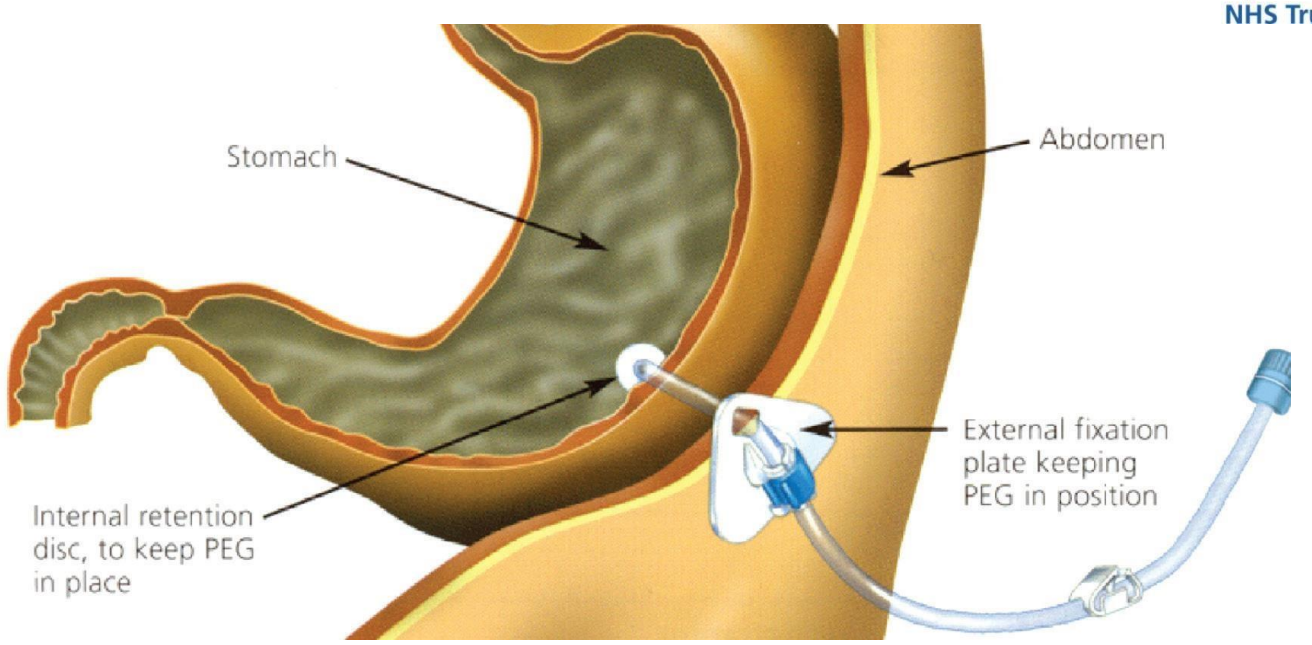
ACTION	RATIONALE
1. Ensure patient is still suitable for procedure and all relevant pre- procedure checks have been completed in line with local policy. Ensure that the patient has a current INR and that a dietician referral has been put in place. Ensure doctor gives a full explanation of the procedure to the patient and any family members. Ensure that the patient has been nil by mouth and any naso-gastric feed has been discontinued for 6 hours. Ensure consent form has been signed / Consent form 4 if necessary. Endoscopist/ Ward to administer IV antibiotics.	There is a possibility of bleeding if the patients INR is over the recommended therapeutic levels- refer to guidelines. Oral anticoagulants with need to be omitted in line with current guidance. Dietician needs to be involved to provide plan of patient's dietary needs. To alleviate any fears or anxieties. To prevent aspiration of Stomach contents To ensure written consent obtained. Prophylactic antibiotics are given to help prevent infection at PEG site, as this is a known complication of the procedure.

2. Position Patient lying Supine, head slightly elevated. 3. Wash hands and Don appropriate PPE 4. Place equipment onto a cleaned dressing trolley. Open kit, put on sterile gloves, open internal packaging and prepare equipment using strict aseptic technique . 5. Draw up 5 mls Bupivacaine solution or other selected local anaesthetic. 6. Assistant to expose patient's abdomen and lower rib cage, shave if necessary. 7. **Clean Abdomen from Umbilicus to Xiphisternum and left lateral rib cage Chlorhexidine applicator. Allow to dry.**	To facilitate procedure To help prevent infection during placement. To reduce risk of infection from skin flora into Gastrostomy site.
Endoscopist to administer intravenous sedation and analgesia, if indicated, via an indwelling intravenous cannula. Endoscopist to pass Endoscope and perform examination of Stomach and Duodenum. *Then to tensely inflate Stomach and keep it inflated throughout the procedure.*	*To facilitate the Endoscopic procedure* *To provide Analgesia/ sedative for the procedure* *To observe for any abnormality that may hinder placement or may require treatment* *To ensure contact of the Gastric and Abdominal walls.*
8. Depress a finger within the triangle of the Xiphisternum, Umbilicus and left lateral rib cage until indentation Endoscopically visualised within Stomach, in a suitable position of the Abdomen. Should this prove difficult then trans illumination of Stomach will be performed.	To ensure correct position of the tube, which will facilitate feeding Trans-illumination allows positive positioning of the Stomach to be confirmed.
9. Infiltrate the selected site, subcutaneously with 0.25% Bupivacaine solution; withdraw gently on the syringe before injecting. **If blood is visible withdraw syringe**	To act as a local anaesthetic to prevent discomfort from the procedure. Blood flashing back into the syringe means that the needle is in a blood vessel and must be withdrawn and rechecked before

10. Insert needle in anaesthetised area until tip is visible within the Stomach by the Endoscope. The plunger must be withdrawn when inserting the needle and air aspirated as the tip of the needle is seen to enter the Stomach withdraw needle. 11. Make a small incision (up to 1 cm) in the skin at the exit site with the scalpel to facilitate the 'Pull through' 12. Introduce the Trocar and cannula unit down the needle tract into the Stomach until the tip is visible to Endoscope.	Bupivacaine solution is injected. Air aspiration at an earlier stage suggests that the needle is in the Transverse Colon. To ensure the correct positioning of the trocar and cannula
Endoscopist to place snare loop via endoscope and place around the trocar sheath, to grab placement thread when it is passed.	*In readiness to snare the placement thread*

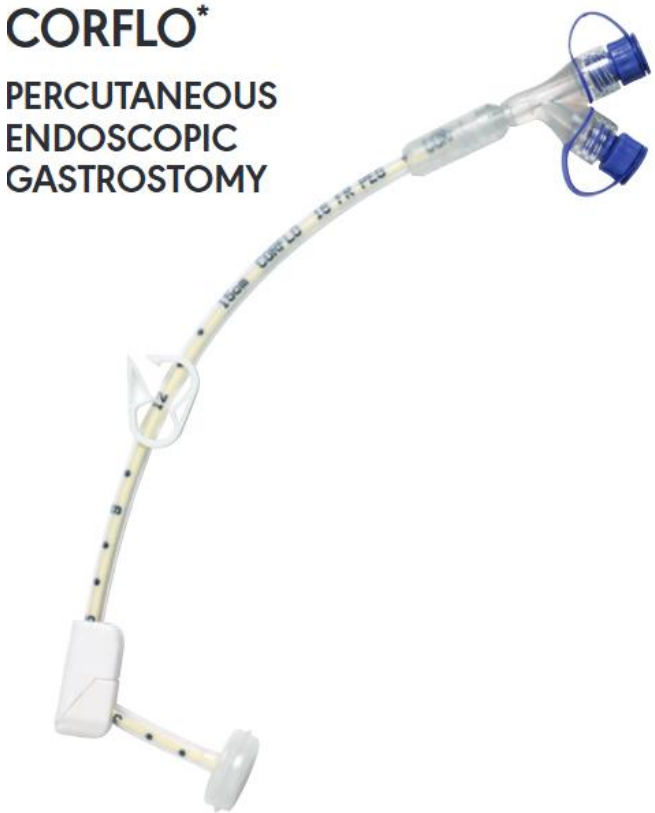
13. Remove the trocar from the cannula and immediately insert looped placement thread. Quickly feed 10-15cm of thread into the Stomach.	To allow passage of the placement thread To prevent the loss of too much air from the Stomach
Endoscopist to use snare loop to grasp thread tightly, then to retract into scope. *Remove scope and snare as a unit.*	
14. Feed thread via Cannula into Stomach as Doctor withdraws scope ensuring that thread is **not pulled** by scope.	Pulling the thread may cause trauma by having a 'cheese wire' effect
Endoscopist to interlock loops of PEG Tube with placement thread and to lubricate tube	*A Water-based jelly e.g. KY Jelly is to be used to prevent damage to the tube. NOT used by all consultants*
15. Gently withdraw placement thread via cannula. Endosocopist to feed PEG Tube into mouth. Keep the trochar sheath in the Abdomen wall until all of the thread is pulled through.	Strong pulling of the thread will cause a 'cheese wire' effect and cause trauma
16. Gently pull tube through the abdominal wall until the retention plate abuts the inner gastric wall. There should be no blanching of the skin. It is not recommended that the patient be re-scoped to view the internal bumper as the length of tube outside the abdomen indicates where the internal bumper has been placed.	Care must be taken not to pull all the tube out via this exit site. Blanching means that the tube is too tight against the gastric mucosa or skin and may lead to necrosis. The risk of re-scoping the patient doubles the risk of the procedure.
17. Cut the guide thread of the tube close to the cone, not the tube Pull the outer end of the tube through the hole in the fixation plate (FREKA triangle or CORFLO rectangular fixation parts) then push the tube clamp onto the tube. Clean and dry puncture site. Attach PEG end – for FREKA slide on white and blue fixator then thread purple and blue ENFIT end to port. Close to parts together. For CORFLO push plastic skirt over tube end, push Y adapter ENFIT end in to tube, screw two parts together. Always unclamp the white tube clamp after fixing end into place.	Prevents any Gastric fluids escaping the tube. To facilitate connection of the adaptors. To ensure secure attachment. To ensure the tension is applied for 1st 24hrs after which the tube should be loosened. To enable the use of the PEG tube

18. After insertion, the fixation device should not indent the skin. If it does readjust the fixation device positioning as necessary.	If the tube is too tight against the skin it may cause skin soreness, hinder cleaning of the site and may lead to skin necrosis.
19. **Do not apply dressing around the tube lumen- unless site is bleeding**	Dressings around the tube lumen increase the pressure on the internal bumper and may lead to unobserved internal blanching or necrosis.
Endoscopist to record procedure and results of diagnostic Endoscopy in the patient's medical notes. Record of insertion sticker to be added to copy of patient report.	*To maintain standards in record keeping.*
20. Record your name and signature in the medical notes as first assistant. Ensure nursing documentation complete. Read and measure length of PEG Tube and document in notes. Ensure the patient Record your name and signature in returns to the ward with the appropriate product literature on PEG Tube care following nurse handover to the ward nurse.	To maintain standards in record keeping To ensure that the correct product information remains with the patient and the ward nurse has a complete handover concerning the procedure and the aftercare required for the patient and their PEG Tube.



Fresenius 2016

Avanos 2025:



Worcestershire Acute Hospitals NHS Trust

Record of Training Name:

Date Started: / /

	Date	Trainees Signature	Trainers Signature	PEG DOPS Form Completed Y/N
1				
2				
3				
4				
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6				
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Monitoring

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?**
	To Ensure appropriate use of document and all aspects are adhered to.	Audits, spot checks of documents. Annual PDR	Annually .	Ward managers, Matron, Practice Development team.	Matron, Directorate manager.	Every two years

References

The Code of Professional conduct. NMC 2018

Guidelines for Records and Record Keeping. NMC 2021

The Royal College of Physicians- JAG (JETS) Formative DOPS Percutaneous Endoscopic gastrostomy 2016

Instructions for use – Freka PEG set. Fresenius Kabi

WAHT- CG-122 Investigative procedure information leaflet. Inserting a Percutaneous endoscopic gastrostomy tube insertion

WAHT-CG-123 Investigative procedure information leaflet Removing a Percutaneous endoscopic Gastrostomy tube insertion

WAHT-NUT-006 – Guideline for the identification and management of re-feeding syndrome

WAHT-NUT-008 - Out of Hours Emergency Enteral Feeding Regimen (Including Risk Reduction for Refeeding Syndrome)

WAHT- END-009 - Guideline for Enteral Tube feeding (nasogastric or PEG) in patients with Diabetes Mellitus treated with insulin.

WAHT-NUT- Cut and push technique for removal of PEG (number to be advised)

WAHT-NUT-004- Percutaneous Endoscopic Gastrostomy (PEG) Guideline - Adults

Contribution List

This key document has been circulated to the following individuals for consultation.

Name	Designation
Dr I Gee	Consultant Gastroenterologist
Dr N Hudson	Consultant Gastroenterologist
Dr A Elagib	Consultant Gastroenterologist
Dr G Baker	Consultant Gastroenterologist
Dr J Rees	Consultant Gastroenterologist
Dr T Haldane	Consultant Gastroenterologist
Dr I Ahmad	Consultant Gastroenterologist
Mr J Robinson	Consultant Surgeon
Mr M Wadley	Consultant Surgeon
Lydia Watkins	Matron for Endoscopy
Sally Sykes	Practice Development Sister

Sarah Johnson	Practice Development Sister

It is the responsibility of every individual to ensure this is the latest version as published on the Trust Intranet

Aireen Jalipa	Endoscopy Unit Manager WRH
Alison McCartney	Sister Endoscopy WRH
Emma Smith	Endoscopy Unit Manager AGH
Karen MacPherson	JAG/ Governance lead
Natalie Tayler	Nutrition Specialist Nurse

This key document has been circulated to the chair(s) of the following committee's / groups for comments;

Name	Committee
Mr Richard Lovegrove	Clinical Director - Endoscopy
Lynne Mazzocchi	Directorate Manager Endoscopy
Gina Gill	Directorate Support Manager Endoscopy

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;

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	✓	Worcestershire County Council		Worcestershire CCGs	
Worcestershire Health and Care NHS Trust		Wye Valley NHS Trust		Other (please state)	

Name of Lead for Activity	**J Dutton**

Details of individuals completing this assessment	**Name**	**Job title**	**e-mail contact**
	Jennifer Dutton	**Practice Development Sister**	**Jennifer.dutton1@nhs.net**
Date assessment completed	**1/5/2022** **24/2/2025**		

Section 2

Activity being assessed (e.g. policy/procedure, document, service redesign, policy, strategy etc.)	**Title:** Guideline for The Training of Registered Nurses to Competently Act as a First Assistant with a Registered Medical Practitioner During the Placement of Percutaneous Endoscopic Gastrostomy Tubes (PEG)
What is the aim, purpose and/or intended outcomes of this Activity?	As documented above

Who will be affected by the development & implementation of this activity?	x x ❑	Service User Patient Carers Visitors	x ❑ ❑	Staff Communities Other _____

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 body of document
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 body of document
Summary of relevant findings	See body of document

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		
Religion & Belief		X		

Sex		X		
Sexual Orientation		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**
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**
	N/A	.		
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)	**In a Service redesign**			

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, carer's 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	J Dutton
Date signed	1/5/2022 Reviewed 24/2/25
Comments:	
Signature of person the Leader Person for this activity	J Dutton
Date signed	1/5/2022 Reviewed 24/2/25
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.