

Having a Radiologically Inserted Gastrostomy (RIG) feeding tube



Information for patients

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1. Introduction

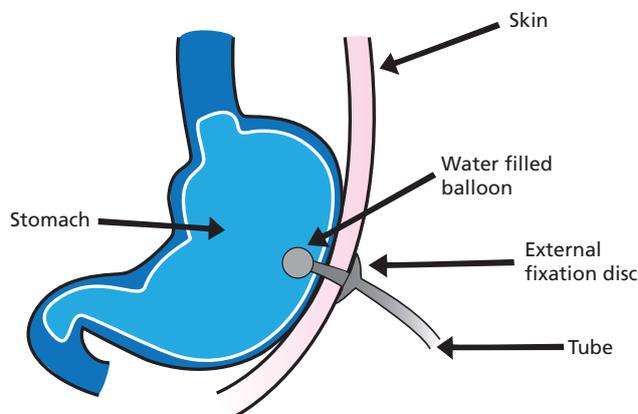
Radiologically Inserted Gastrostomy (RIG) insertion

This booklet has been written to provide you with information about Radiologically Inserted Gastrostomy (RIG).

What is a Radiologically Inserted Gastrostomy (RIG) feeding tube?

A gastrostomy feeding tube is inserted through the skin of the abdomen into your stomach. This allows enteral feed, water and medications to be given directly into the stomach.

RIG feeding tubes are placed in Radiology using X-Rays to guide the insertion of the tube.



Why might I need a RIG feeding tube?

You may require a RIG gastrostomy feeding tube for the following reasons:

- Difficulties swallowing food, fluids or medications
- Being unable to eat or drink enough to meet your needs
- Having an illness or medical treatment which limits how much you can eat or drink
- You have a significant narrowing in the throat or food pipe (oesophagus)

Why do I need a RIG and not a PEG or PIG?

RIG feeding tubes are used when the food pipe is too narrow for the gastrostomy tube to pass through safely.

PEG (Percutaneous Endoscopic Gastrostomy) and PIG (Per-oral Image guided Gastrostomy) feeding tubes can only be placed when the food pipe is wide enough for the gastrostomy tube to pass.

How long will I need a feeding tube for?

Your healthcare team will be able to discuss how long the feeding tube may be needed. These tubes can be used for a few months up to many years. In most cases the feeding tube is required until you are able to eat and drink enough to maintain a healthy weight or until you choose to have it removed.

Do I still need to brush my teeth if I am not having an oral diet?

It is important to maintain good oral hygiene even if you are not eating and drinking.

Can I eat and drink if I have a feeding tube?

If you have a feeding tube you can still eat and drink unless you have been advised not to do so by your healthcare team.

Your healthcare team will be able to discuss whether it is safe to eat and drink, and the reasons why. This can be different for each person.

2. How do I make a decision?

Your healthcare team will ensure that you have all the relevant information you need to make an informed decision about having a feeding tube placed. It is important that you understand the risks, benefits and alternatives so that you can make a decision that is best for you.

You should be given time to make your decision and are encouraged to discuss your options further with your healthcare team, family or carers if you wish to. It may be helpful to write down any questions or concerns you have.

What questions might I ask?

The following link contains a list of relevant questions:

<http://www.peng.org.uk/pdfs/hcp-resources/having-an-enteral-feeding-tube-faqs.pdf>

What if I am unable to make a decision or I am the carer of someone needing a feeding tube?

A person who lacks the capacity to make a decision about their treatment due to an impairment or disturbance of the mind or brain (whether temporary or permanent) will need to have the decision made through the best interest (BI) process. This is done within the framework of the Mental Capacity Act.

The decision maker will be the person who is undertaking the procedure on the patient, unless there is a Lasting Power of Attorney (LPA) for health and welfare decisions in which case they would make the decision. This decision can be challenged if it is considered the LPA is not acting in the best interests of the patient.

The best interest (BI) process involves consultation with all the relevant people and needs to take in all circumstances/factors relevant to the patient. If a patient has no family etc, to advocate for them an Independent Mental Capacity Advocate (IMCA) may be required.

What are the benefits of having a feeding tube?

The benefits of having a feeding tube may be different for each person.

Having a feeding tube can:

- allow you to take fluid and nutrition if you are unable to take enough orally
- allow you to take medications if you are unable to take them orally
- reduce the risk of choking on food and fluids
- reduce the risk of food or fluids entering your lungs, which can cause chest infections
- reduce the time and stress caused by mealtimes taking longer if you have swallowing problems

What are the risks of having a gastrostomy feeding tube placed?

Placing a gastrostomy is a relatively safe procedure which means it can be used for patients who are frail, elderly or ill for other reasons. As with any surgical procedure there are risks related to the insertion of a gastrostomy feeding tube. Your healthcare team takes a number of steps to reduce these risks.

Here are some definitions to help you:

- Common – More than 10 in every 100 (>10%) people will develop this complication
- Occasional – Between 1 and 10 in every 100 (1-10%) people will develop this complication
- Rare – Less than 1 in 100 (<1%) people will develop this complication

Below is a list of complications along with how likely they are to occur.

Major complications

Major complications are more serious but occur less often:

Complication	Description	Risk
Bowel perforation	Injury to the bowel (intestines) during the procedure. This may heal itself, need antibiotics or require surgery if more serious.	Rare Less than 1%
Peritonitis	The inflammation of the inside lining of the abdomen. This may heal itself, need antibiotics or require surgery if more serious.	Occasional 2 to 3%
Haemorrhage	Injury to a blood vessel surrounding the stomach wall. This may heal itself or may require further procedures such as a gastroscopy (a flexible tube used to look inside a person's stomach).	Occasional 2 to 3%
Aspiration	This is when saliva or stomach contents (food or liquid) enters the lungs. This can cause a chest infection.	Rare Less than 1%
Risk of death	The above complications can lead to death if severe and the appropriate treatment is not effective.	Rare Less than 1%
Sedation related	Short term problems with breathing, heart rate and blood pressure related to sedation. Older people and those with significant health problems (for example people with serious breathing difficulties) may be at higher risk.	Rare Less than 1%

Minor complications

Minor complications are less serious and can usually be resolved.

Complication	Description	Risk
Abdominal pain	It is common to have some discomfort after a gastrostomy tube has been placed. Pain relief is provided as part of the procedure and can be given on the ward after the procedure until any pain settles.	Common 40%
Local infection of the stoma site	A gastrostomy tube is placed through the skin into your stomach. This means that the natural skin barrier has been broken and infections can develop at the stoma site. Infections usually respond well to medications where required.	Common 25%
Tube dislodgement after insertion	Gastrostomy tubes can become displaced after placement. Being aware of the Danger Signs (on the back page of the booklet) will help manage a tube displacement if it should occur.	Occasional 1-5%
Stoma leakage	The stoma tract is where the gastrostomy tube enters the body. This is an unnatural tract and therefore leakage can occur.	Common 10%
Granulation tissue	A granuloma is soft tissue that can grow at the stoma site over a period of time. Granulomas usually respond well to treatment such as tube replacement and medications where required.	Common 12%

What are the alternatives to having a gastrostomy feeding tube?

The nasogastric tubes (NGT) are narrow plastic feeding tubes which is passed through the nose into the stomach. This tube can be used for short term feeding, usually for up to six weeks, and do not require an operation to be inserted.

They are used as a temporary way of feeding when you are unable to eat and drink enough to maintain your health.

Benefits:

- NG tubes allow you to take water, liquid feed and medications if you are unable to take them orally
- NG tubes do not require any surgery to be placed

Disadvantages:

- You may see and feel the tube coming out of your nose
- The position of these tubes needs to be checked each time they are used
 - This is done by drawing up some stomach contents (an aspirate) with a syringe and testing it with pH paper and/or noting the length of the tube
- These tubes are thin and are more likely to block than a gastrostomy feeding tube
- These tubes can become displaced
- It is likely that you will need to attend hospital to have it replaced

Are there any other alternatives to having a feeding tube?

It is important to remember that choosing not to have any treatment is an option for you. You should understand what the consequences of not having a feeding tube are, so that you can make an informed decision about this option.

3. Before the procedure

Do I need to change my medications?

You should continue to take your medications unless the healthcare team advise otherwise.

Blood thinners are usually stopped before a gastrostomy insertion.

If you are taking any of the following blood thinners you should let your healthcare team know before your admission as they may need to be stopped:

- Warfarin
- Direct oral anticoagulants (DOACS) (Rivaroxaban, Apixaban, Dabigatran, Edoxaban)
- Anti-platelets (Clopidogrel, Ticagrelor, Prasugrel, Dipyridamole)

If you are taking Aspirin it is safe to continue this.

What happens if I decide to have a gastrostomy feeding tube placed?

If you are not already in hospital, you will be contacted to arrange an admission date.

You may be admitted before the procedure or sometimes on the day of the procedure.

It is important to let your healthcare team know if you take any blood thinners (anti-coagulants) as soon as possible.

On the day of the procedure you will be asked:

- to have a blood test
- to have a cannula (small needle) placed into your arm for medications
- not to eat, drink or tube feed for six hours before the procedure
- to wear a gown and compression stockings

Will I be awake during the procedure?

1. You will be given sedative medications through a cannula in your arm to make you sleepy and relaxed. This is called conscious sedation. You will not be unconscious and will be monitored throughout the procedure
2. A local anaesthetic throat spray is given to numb your throat
3. A mouth guard will be placed in the mouth

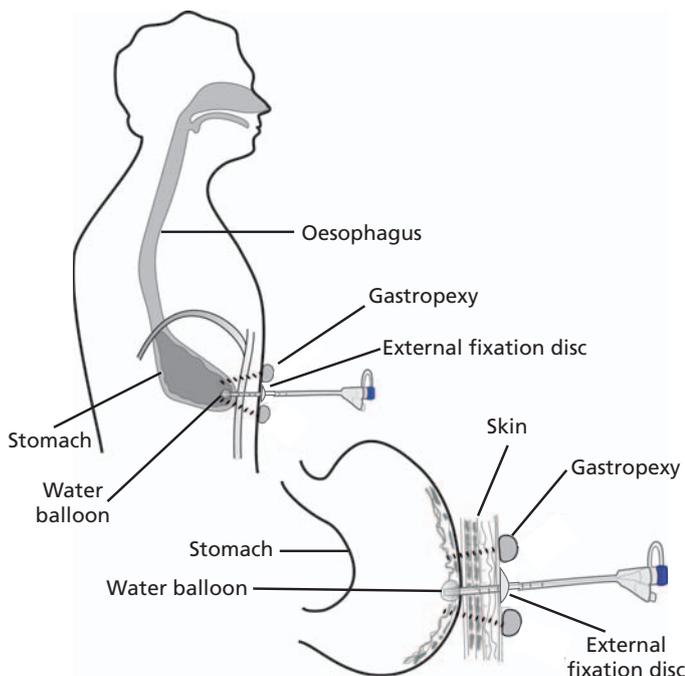
More information relating to conscious sedation is available from the Royal College of Anaesthetists

<https://www.rcoa.ac.uk/sites/default/files/documents/2020-05/12-SedationExplainedweb.pdf>

4. How is a RIG gastrostomy feeding tube inserted?

Radiologically Inserted Gastrostomy (RIG) feeding tubes are placed in Radiology using X-Rays to guide the insertion of the tube.

Fig. 2



1. A small tube is passed down the throat into the stomach.
2. Air is pumped into the stomach and x-ray images are taken.
3. A local anaesthetic is used to numb the area where the tube will be inserted. This may sting initially but will then numb the area.
4. Gastropexy's, are small round buttons on the skin attached to a stitch. These are placed through the skin into the stomach to help secure the stomach to the abdominal wall and to facilitate the feeding tube insertion.
5. A needle is passed through the skin into the stomach and a tract, called a stoma, is created.
6. Hollow tubes, called dilators, are used to make the stoma tract wider enough for a feeding tube to be placed.
7. The feeding tube is pushed through the stoma and into the stomach and water a balloon is inflated to help secure the tube in position.
8. No tubes remain in the mouth or nose after the procedure.

Will I feel anything during the placement of a feeding tube?

You may feel some discomfort during the procedure and may be aware of a small tube in your throat. This may cause some discomfort which should wear off quite quickly. Pain relief medications are provided as part of the procedure and can be given on the ward after the procedure until any pain settles.

After the procedure

1. The sedation will wear off and you will return to the ward.
2. You will need to stay in hospital for at least one night after the procedure.
3. 4 hours after the tube is placed it will be flushed and can then be used to administer water or feed.
4. Your dietitian will provide you with a feeding plan unless you had your feeding tube placed before you need to use it.

5. Routine care

Your healthcare team will show you how to keep the tube clean and in good working order.

Described below is the guidance that people living in Sheffield are advised to follow. If you live outside Sheffield, guidelines may differ slightly. We recommend you speak to your local healthcare team to clarify any local arrangements.

Can I have a bath or shower?

- It is important that you do not submerge the stoma for two weeks after insertion e.g. have a bath or go swimming. The stoma is the tract or hole where the tube enters the abdomen.
- During the first two weeks a stand-up wash or shower is acceptable providing the stoma site is dried thoroughly afterwards.
- After the feeding tube has been in place for two weeks you may have a bath or go swimming.
- Remember to close the caps of your feeding tube prior to submerging your tube in water

How do I use the tube?

- You and any carers will be trained to use the feeding tube before you are discharged from hospital. You will also receive further support when you get home.
- When you use the tube you should be sitting upright at an angle greater than 35 degrees. This is similar to being sat up using two pillows.
- A syringe or giving set (if pump feeding) can be attached to the feeding end of the tube.
- You should flush the tube before and after any feed or medication is given, and when feeding is interrupted.

What type of water should I be putting down the tube?

- In hospital sterile water is used to flush the tube, at home you can use **freshly drawn tap water**.
- You should have a minimum of two water flushes per day.

Do I need to advance and rotate the tube?

No, RIG tubes do not need to be advanced and rotated.

How do I clean the stoma site?

- Clean the stoma site with sterile gauze and sterile water for the first two days after placement. Dry thoroughly afterwards.
- The stoma site should be cleaned at least once a day with a clean cloth or non-woven gauze, using non-perfumed soap and water. Dry thoroughly afterwards.
- Do not use cotton wool or any material that may shed fibres which can get trapped inside tract and cause irritation.
- Keep the feeding end of the tube secured above the level of the stoma using Clinifix tubing fixator dressings. This will prevent the tube from getting pulled and prevent backflow of stomach contents into the tube.

How often does my feeding tube need to be replaced?

RIG gastrostomy tubes are usually replaced every 6 months.

How do I care for my balloon gastrostomy tube?

A balloon gastrostomy tube (Fig. 3) is the name of the tube placed during the RIG gastrostomy procedure.



Fig. 3



Fig. 4

Your balloon gastrostomy:

- has a water balloon inside the stomach and a round disc on the skin. These help to secure the tube in place.
- needs the water balloon to be checked each week starting 14 days after insertion. This is done by removing and replacing the water inside the balloon.
- does not require rotation and advancement.
- can be used with or without an extension set. (Fig. 4)

Extension sets (Fig. 4)

- needs to be replaced every 2 weeks.
- needs to be cleaned with warm soapy water, rinsed with water and dried thoroughly when disconnected or after each use if disconnected.
- will be provided by your healthcare team.

How do I replace the balloon water?

Replacing the water in the balloon each week reduces the risk of the balloon failing and the tube falling out. To replace the balloon water:

1. Hold or tape the tube in place during the procedure.
2. Attach a luer slip syringe to the inflation valve and draw back on the plunger until no more fluid can be removed.
3. Discard this water and attempt to remove any water remaining in the balloon.
4. Check the colour and volume of the balloon water removed from the inflation valve (the recommended amount is written on the inflation valve)
5. Stop and seek advice if any concerns such as:
 - no water or you have an under filled water balloon.
 - the water removed from the balloon is not clear.
6. Fill a new luer slip syringe with the required volume of water and inflate the balloon (the recommended amount is written on the inflation valve).
7. Keep thumb on plunger when removing syringe from the inflation valve to prevent backflow into the syringe.

Your healthcare team will provide training for this task.

You should stop using the tube and contact your healthcare team if you have any pain during or following this procedure.

Gastropexys

The Gastropexys are small round buttons on the skin which are attached to a stitch inside the stomach. Gastropexys help secure the feeding tube in place while the stoma heals. After 2-3 weeks the Gastropexys will drop off.

Contact your healthcare team if a gastropexy drops off outside of the timescales described above.

6. Troubleshooting

What should I do if my feeding tube falls out?

- If your tube falls out less than the **first 4 weeks** after insertion you need to seek urgent medical attention.
- If you are at home then this will mean you need to attend your local emergency department.

- If your tube falls out **more than 4 weeks** after insertion then you still need to seek urgent medical attention but it may be possible for your local healthcare team to replace the tube in your own home.
- If the water balloon securing the tube has failed then the tube should be taped in place but not used until you receive urgent medical attention.
- Your local healthcare team will provide further information on who you can contact.

What should I do if my stoma is sore or red?

If you notice any redness, soreness, breaks in the skin, swelling, discharge, leakage or bleeding around the stoma, then please contact your local healthcare team.

Can parts of the tube be replaced?

No, a balloon gastrostomy tube may need replacing if a part of it becomes damaged.

7. Further questions

What happens when I go home?

Before leaving hospital you will be provided with:

- Contact details for your local healthcare team
- Written information about how to care for your feeding tube
- A feeding plan to follow (if required)
- Enough feed to use until you receive your first feed delivery (delivered monthly)
- All the equipment you will need to use the tube, which may include:
 - Feeding pump
 - Feed connectors (giving sets)
 - Syringes

Will I need support when I have a feeding tube?

If you are unable to use and care for the tube independently then care may be required. This might be in the form of friends and family, a local healthcare team arranged by the hospital, or a nursing home.

When can the feeding tube be removed?

Your healthcare team will be able to discuss how long you are likely to need the gastrostomy feeding tube. They are not usually removed for the first 2-3 months after insertion.

Feeding tubes are usually removed for one of the following reasons:

- You choose to have it removed
- You have recovered from a period of ill health or medical treatment
- You can eat and drink enough to maintain your health
- You no longer have swallowing problems

8. My tube passport

Date of tube insertion:	
Tube type	
Tube French Gauge (Fr)	
Bumper to skin measurement (cm)	
Water balloon volume (ml)	
Subsequent bumper to skin measurements or when a new tube is inserted	

9. Contact details

For patients who live in Sheffield:

Community Home Enteral Feeding (HEF) Team

For any queries or problems with a tube when you're at home.

- 07817 017 190

Sheffield Teaching Hospitals Enteral Nutrition Team

For any queries or problems with a tube when you are in hospital.

- 0114 226 9573

Nutricia Homeward Nurse Service

The Nutricia Homeward Nursing Service provides specialist support to patients with enteral feeding tubes.

- Mon-Fri 8am-6pm: 03457 623 637
- Weekends and bank holidays 9am-5pm: 0800 093 3672

For patients who live outside of Sheffield:

Chesterfield & Derby:

- Mon-Fri: 03457 623 644
- Excluding weekends or bank holidays.

Doncaster & Bassetlaw:

- Mon-Fri: 03457 623 670
- Weekends and bank holidays 10am-2pm: 0800 0933672

Nutricia Out of Hours advice line:

- 24 hours 0800 093 3672

10. Danger signs

Immediate action required:

It is important to be aware of the danger signs which require you to seek immediate medical attention within the first 72 hours (3 days) after the gastrostomy insertion or replacement.

Danger signs include:

- New bleeding at the stoma site (tract or hole where the tube enters the abdomen)
- Leakage of fluid from the around the tube
- Pain during or after feed, medication or fluids is put down the tube
- Painful or swollen abdomen
- Vomiting
- High temperature

If you experience any of the above symptoms:

1. Stop feed/medication/water delivery immediately
2. Seek urgent medical advice by contacting 111 and/or attend your local Emergency Department



To help support your local hospitals visit
sheffieldhospitalscharity.org.uk

Registered Charity No. 1189762



Alternative formats can be available on request. Email: sth.alternativeformats@nhs.net

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Consent Form 1

Patient agreement to: Having a Radiologically Inserted Gastrostomy (RIG) feeding tube

Name:
DoB:
Hosp. no. (Affix Patient Label here)
NHS no.

Responsible healthcare professional:

Name:
.....
Job title:
.....

Does this patient have any special requirements? (e.g. other language / other communication method)

Yes No

If Yes, details to be provided here:

Does this patient have an advanced decision to refuse treatment? (e.g. Jehovah's Witness form)

Yes No

If Yes, has the advanced decision been included within the consent discussions? Yes No

Statement of healthcare professional (to be filled in by healthcare professional with appropriate knowledge of proposed procedure, as specified in consent policy)

In particular, I have explained to the patient the:

1. Name of the proposed treatment or procedure (or course of treatment or procedures - include brief explanation if medical term is not clear):

Radiologically Inserted Gastrostomy (RIG) insertion

A gastrostomy feeding tube is inserted through the skin of the abdomen into your stomach. This allows enteral feed, water and medications to be given directly into the stomach.

2. The intended benefits, for this patient, being to:

Having a feeding tube can:

- allow you to take fluid and nutrition if you are unable to take enough orally
- allow you to take medications if you are unable to take them orally
- reduce the risk of choking on food and fluids
- reduce the risk of food or fluids entering your lungs, which can cause chest infections
- reduce the time and stress caused by mealtimes taking longer if you have swallowing problems

3. I have also discussed:

- what the procedure is likely to involve
- the benefits and risks of any available alternative treatments
- the benefits and risks of no treatment

In particular, I have explained to and discussed with the patient the:

4. Recognised risks and/or complications for this particular procedure or treatment:

4.1 What are the known risks for this treatment or procedure? In particular the recognised significant, serious, frequently occurring or other risks this patient should be made aware of:

Placing a gastrostomy is a relatively safe procedure which means it can be used for patients who are frail, elderly or ill for other reasons. As with any surgical procedure there are risks related to the insertion of a gastrostomy feeding tube. Your healthcare team takes a number of steps to reduce these risks.

Here are some definitions to help you:

- Common – More than 10 in every 100 (>10%) people will develop this complication
- Occasional – Between 1 and 10 in every 100 (1-10%) people will develop this complication
- Rare – Less than 1 in 100 (<1%) people will develop this complication

Below is a list of complications along with how likely they are to occur.

Major complications

Major complications are more serious but occur less often:

Complication	Description	Risk
Bowel perforation	Injury to the bowel (intestines) during the procedure. This may heal itself, need antibiotics or require surgery if more serious.	Rare Less than 1%
Peritonitis	The inflammation of the inside lining of the abdomen. This may heal itself, need antibiotics or require surgery if more serious.	Occasional 2 to 3%
Haemorrhage	Injury to a blood vessel surrounding the stomach wall. This may heal itself or may require further procedures such as a gastroscopy (a flexible tube used to look inside a person's stomach).	Occasional 2 to 3%
Aspiration	This is when saliva or stomach contents (food or liquid) enters the lungs. This can cause a chest infection.	Rare Less than 1%
Risk of death	The above complications can lead to death if severe and the appropriate treatment is not effective.	Rare Less than 1%
Sedation related	Short term problems with breathing, heart rate and blood pressure related to sedation. Older people and those with significant health problems (for example people with serious breathing difficulties) may be at higher risk.	Rare Less than 1%

Minor complications

Minor complications are less serious and can usually be resolved.

Complication	Description	Risk
--------------	-------------	------

Name:

DoB:

(Affix Patient Label here)

Hosp. no.

NHS no.

Abdominal pain	It is common to have some discomfort after a gastrostomy tube has been placed. Pain relief is provided as part of the procedure and can be given on the ward after the procedure until any pain settles.	Common 40%
Local infection of the stoma site	A gastrostomy tube is placed through the skin into your stomach. This means that the natural skin barrier has been broken and infections can develop at the stoma site. Infections usually respond well to medications where required.	Common 25%
Tube dislodgement after insertion	Gastrostomy tubes can become displaced after placement. Being aware of the Danger Signs (on the back page of the booklet) will help manage a tube displacement if it should occur.	Occasional 1-5%
Stoma leakage	The stoma tract is where the gastrostomy tube enters the body. This is an unnatural tract and therefore leakage can occur.	Common 10%
Granulation tissue	A granuloma is soft tissue that can grow at the stoma site over a period of time. Granulomas usually respond well to treatment such as tube replacement and medications where required.	Common 12%

4.2 Do any of the risks discussed carry a greater significance for this patient? For example, existing co-morbidities, patient's concern, patient's work, hobbies, driving or other.

Yes No

If Yes, details to be provided here;

.....

.....

.....

5. Are there any extra procedures which may become necessary during the treatment or procedure?

blood transfusion

6. The following leaflet(s) has been provided: PIL4807, Issue Date: June 2021

Accompanying leaflet accepted by patient: Yes No

I have fully informed this patient about this procedure or treatment to the best of my ability and in a way in which I believe they can understand.

Patient refused information

(NB: If this patient has refused information ensure this is documented in the patients' medical records. Notify the GP of this and send the patient information leaflet to the GP with the letter in case the GP gets the opportunity to discuss this with the patient at a later date.)

Signed (Healthcare professional) **Date**

Name (PRINT) **Job title**

Professional Registration Number

Statement of interpreter

Does this patient require an Interpreter? Yes No

I have interpreted the information above to the patient to the best of my ability and in a way in which I believe they can understand.

Signed (Interpreter) **Date**

Name (PRINT)

Statement of patient (to be signed, printed and dated by the patient)

Please read this form and the accompanying leaflet carefully. The leaflet describes the benefits and risks of the proposed treatment or procedure and possible alternatives. If your treatment or procedure has been planned in advance, you should already have your own copy of the leaflet. If not, you will be offered a copy now. If you have any further questions, do ask – we are here to help you. You have the right to change your mind at any time, including after you have signed this form.

I agree to the procedure or course of treatment described on this form.

I understand that you cannot give me a guarantee that a particular person will perform the procedure. The person will, however, have appropriate experience.

I understand that any procedure in addition to those described on this form will only be carried out if it is necessary to save my life or to prevent serious harm to my health.

Name:

DoB:

(Affix Patient Label here)

Hosp. no.

NHS no.

I have been told about additional procedures which may become necessary during my treatment. I have listed below any procedures **which I do not wish to be carried out** without further discussion.

.....

Signed (Patient)

Date

A witness should provide their signature if the patient is unable to sign but has indicated his or her consent.

Name (PRINT)

Confirmation of consent (to be completed by a health professional when the patient is admitted for the procedure, if the patient has signed the form in advance)

On behalf of the team treating the patient, I have confirmed with the patient that they have no further questions or concerns and consent for the procedure to go ahead.

Signed (Healthcare professional)	Date
Name (PRINT)	Job title
Professional Registration Number	

Withdrawing of consent to proceed with treatment or procedure (to be completed at any stage the patient withdraws consent to proceed with the treatment or procedure).

I, the patient, confirm that I have withdrawn consent and do not want to proceed with the treatment or procedure.

Signed (Patient)	Date
A witness should provide their signature if the patient is unable to sign but has indicated his or her withdrawal of consent.	
Name (PRINT)	

On behalf of the team treating the patient, I have confirmed with the patient that they have withdrawn consent and do not want to proceed with the treatment or procedure.

Signed (Healthcare professional)	Date
Name (PRINT)	Job title
Professional Registration Number	

What a consent form is for

This form documents the patient's agreement to go ahead with the treatment or procedure you have proposed. It is not a legal waiver – if patients, for example, do not receive enough information on which to base their decision, then the consent may not be valid, even though the form has been signed. Patients are also entitled to change their mind after signing the form, if they retain capacity to do so. The form should act as an aide-memoire to health professionals and patients, by providing a check-list of the kind of information patients should be offered, and by enabling the patient to have a written record of the main points discussed. In no way, however, should the written information provided for the patient be regarded as a substitute for face-to-face discussions with the patient.

The law on consent

See the Department of Health's, *Reference guide to consent for examination or treatment*, for a comprehensive summary of the law on consent. Also available at

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/138296/dh_103653_1.pdf

Who can give consent

Everyone aged 16 or more is presumed to be competent to give consent for themselves, unless the opposite is demonstrated, and therefore may sign this form (**Consent form 1**). If a child under the age of 16 has "sufficient understanding and intelligence to enable them to understand fully what is proposed", then they will be competent to give consent for themselves. Young people aged 16 and 17, and legally 'competent' younger children, may therefore sign this form for themselves, but may like a parent to countersign as well. If the child is not able to give consent for themselves, someone with parental responsibility may do so on their behalf and a **separate form (Consent form 2)** is available for this purpose. Even where a child is able to give consent for themselves, you should always involve those with parental responsibility in the child's care, unless the child specifically asks you not to do so. If a patient is mentally competent to give consent but is physically unable to sign a form, you should complete this form as usual, and ask an independent witness to confirm that the patient has given consent orally or non-verbally.

Where an adult patient (18 or over) lacks capacity to give or withhold consent to treatment then **Consent form 4** should be completed.

When NOT to use this form

If the patient is 18 or over and is not legally competent to give consent, you should use **Consent form 4** (form for adults who are unable to consent to investigation or treatment) instead of this form. A patient will not be legally competent to give consent if:

- they are unable to comprehend and retain information material to the decision; and/or
- they are unable to weigh and use this information in coming to a decision.

You should always take all reasonable steps (for example involving more specialist colleagues) to support a patient in making their own decision, before concluding that they are unable to do so. Relatives cannot be asked to sign this form on behalf of an adult who is not legally competent to consent for himself or herself.

Information

Information about what the procedure or treatment will involve, its benefits and risks (including side-effects and complications) and the alternatives to the particular procedure or treatment proposed, is crucial for patients when making up their minds. The courts have stated that patients should be told about 'significant risks which would affect the judgement of a reasonable patient'. 'Significant' has not been legally defined, but the GMC requires doctors to tell patients about 'serious or frequently occurring' risks. In addition if patients make clear they have particular concerns about certain kinds of risk, you should make sure they are informed about these risks, even if they are very small or rare. You should always answer questions honestly.

Sometimes, patients may make it clear that they do not want to have any information about the options, but want you to decide on their behalf. In such circumstances, you should do your best to ensure that the patient receives at least very basic information about what is proposed. Where information is refused, you should document this on the form or in the patient's notes.