Patient Controlled Analgesia (PCA) Using Morphine Sulphate or Fentanyl Citrate for the Management of Acute Pain in Adults.

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Additional author(s) Angela Leonard; Rhiannon Vernon-Hunt – Specialist Nurses Pain Management

Division/ Department:: Pain Team, Neurosurgical Directorate

Applies to: (Please delete) Salford Royal Care Organisation

Approving Committee Medicines Management committee

Date approved: 15/07/2019

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<td>Document Control Information</td>
</tr>
<tr>
<td>12</td>
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</tr>
</tbody>
</table>
Patient Controlled Analgesia (PCA) Using Morphine Sulphate or Fentanyl Citrate for the Management of Acute Pain in Adults.

[TWCG16(13) Issue 5]

- PCA is a useful technique for the management of severe acute pain only.
- PCA allows patients to receive opioids (Morphine Sulphate or Fentanyl Citrate) intravenously on demand within set parameters via a dedicated pump.
- Careful patient selection and education is key to successful outcome with PCA.
- Patients requiring PCA should only be cared for in designated clinical areas by fully trained and up to date staff. (appendix 1)
- PCA is administered via CME 575 Bodyguard pumps with designated giving sets and lines should be labelled ‘PCA’.
- PCA must be plugged in at the mains to enable the pump to be charged sufficiently to allow continuous uninterrupted use. If unplugged, the pumps will work from a battery.
- PCA lines should be changed as per intravenous policy after 72 hours of use. These are supplied by pharmacy.
- Morphine PCA is recommended for patients under the age of 70 years unless contraindicated such as in renal impairment.
- Fentanyl PCA is recommended for patients of 70yrs and over or where pre-existing renal impairment exists.
- The cumulative dose (mg/mcg) used should be documented alongside clinical observations on the Adult Observation Chart (CCU) and PCA flow chart on EPMAR.
- Clinician delivered bolus doses may be given by trained staff to supplement PCA doses. The total hourly dose administered should be charted on the clinical observation chart and on EPMAR.
- In the event of on-going pain, refer to troubleshooting guidelines. (Section 5.6)
- A qualified nurse should accompany any patient who is leaving the ward with PCA attached.
- PCA analgesia should be reviewed by the parent team on a daily basis to assess suitability to step down to oral analgesia.
- On discontinuation of the PCA, the remaining infusing solution should be discarded as per medicines policy.
- The pump must not be used on another patient until infusion information has been downloaded by pharmacy and the pump reset.
1. Overview

Patient Controlled Analgesia is a technique which facilitates the intravenous delivery of Opioid Analgesia for the management of severe acute pain. Patients can self-administer analgesia in response to their pain levels using specific delivery systems and within prescribed protocol parameters. The PCA device is programmed to deliver a pre-determined dose when triggered by the patient. The pump has a lockout period of 5 minutes, during which time no further doses can be administered. This policy outlines the set up and management of these systems for inpatients in an acute pain setting.

If you have any concerns about the content of this document please contact the author or advise the Document Control Administrator.

2. Scope

This policy applies to all adult patients within SRFT who are receiving opioids via Patient Controlled Analgesia (PCA). It is expected that all staff involved in the setting up, connection, management and discontinuation of Patient Controlled Analgesia are trained and perform care in line with this policy. This includes Medical and Nursing Staff, and some AHPs such as Operating Department Practitioners working in Operating Theatres.

Specific wards and departments who have been authorised by the pain team to manage patients with PCA should ensure that there are adequately trained staff on duty during each shift to manage these patients safely and effectively.

Associated Documents This policy should be read in conjunction with:

- Opioid Analgesia for Acute Pain Management
- Opioid Loading Dose Patient Controlled Analgesia IV Titration Protocol for the Administration of QRG

3. Background

Patient harm has been associated with this intervention in the absence of standardised policy/protocols. There is evidence that outcomes are improved by standardised practice in this area.

4. What is new in this version?

- PCA Pumps are now supplied in dedicated lock boxes which should be securely clamped to drip stands during use.
- Each pump should be used with a dedicated electrical lead and kept on charge during use to prevent failure of the pump and analgesia. It takes 6 hours to fully charge a flat pump.
- PCA lines are now supplied with no side arm. These should be attached to the patient via a dedicated port of a central line or iv cannula. Bionectors and Octopus should be used as per Trust policy. Three way taps should not be used.
- During pump set up, the patient’s hospital number should be inserted when requested during programming to improve traceability.
• PCA Fentanyl prescription has been adjusted. The dose choices are now 10mcg, 20mcg and 30mcg.
• PCA Fentanyl 40mcg dose will not be routinely available except under the direction of the Pain Team.

5. Policy

Indications for PCA:

• For the management of severe acute pain following trauma or surgery.
• Other acute pain situations where the oral route has been unreliable or contraindicated—Please discuss with pain team.

5.1 Standards

• PCA may only be considered with patient’s full consent and the agreement of the clinical team responsible for the care of the patient.
• PCA must be prescribed on EPMAR prior to initiation
• PCA systems can only be used in designated clinical areas where staff have been trained in the management and monitoring of patients receiving PCA. (Appendix 1)
• PCA is delivered via CME 575 Bodyguard pump with dedicated infusion line via intravenous cannula access port using dedicated giving set with integrated anti-syphon and non-return valve as per iv opioid titration policy
• PCA Morphine for patients under the age of 70yrs (available as 1mg/ml in 100ml bags and 250ml bags)
• PCA Fentanyl for patients 70yrs and over (available as 20mcg/ml, 250ml bag)
• PCA Fentanyl is also available for patients with reduced renal function or true allergy to morphine.
• PCA should only be considered for pain management if the patient can physically use the handset and can understand instruction on how to use device.

Example of prescription

<table>
<thead>
<tr>
<th>Morphine Sulfate (1mg/ml) PCA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bolus: 1 - 2 mg; LOCKOUT 5 minutes</td>
</tr>
<tr>
<td>IV Infusion</td>
</tr>
<tr>
<td>CONTROLLED DRUG</td>
</tr>
<tr>
<td>LOADING DOSE: Up to 20mg hourly, titrated by approved staff as per SRFT protocol</td>
</tr>
</tbody>
</table>
PCA should not be initiated where

- Simultaneous use of other forms of immediate release Opioid- oral or parenteral are being administered, except under direction of pain team or consultant anaesthetist.
- Patient nursed in an area where staff do not hold competencies using PCA pumps.
- Where patients do not possess the cognitive or physical ability to comply with PCA instructions.
- Where the patient is haemodynamically unstable (senior review is required should PCA be considered).

5.2 Patient preparation and education

It is the clinician’s responsibility to ensure that patients know how to use the PCA and explore their expectations of how effective the PCA will be.

- Patient preparation should be commenced when PCA is being considered as a treatment option, usually:
  - Pre op assessment clinic
  - Post Anaesthetic Care Unit (PACU)
  - Ward/Unit

Contents of education should include as a minimum:

- How pain will be assessed by the clinical team (Appendix 2)
- How the PCA works
- Patient-only activated. Green light on button displays when dose is available.
- How quickly it takes effect
- PCA safety mechanisms with a 5 minute lock out.
- It should be reinforced that a dose demand should be made only if pain is present and not just because the button is lit green.
- Visitors should not press the button for the patient
- Common side effects and their management
- Optimising effectiveness- after sleeping and for physiotherapy
- Aim to reduce level of pain to facilitate comfort and rehabilitation, not to take away completely
- Frequent observations are recorded to ensure safety
- Longstanding modified release opioids/patches can continue.

Clinical staff should regularly check patients’ understanding and reinforce messages delivered to improve effectiveness of PCA use.
Patients receiving PCA opioids must not leave the ward with the infusion in situ unless this is to attend another clinical area for investigations or treatment (such as x-ray). If the patient insists on leaving the wards whilst having a PCA in situ, ensure PCA is stopped, disconnected from patient and convert to alternative analgesia, this should be oral analgesia if this route is available.

5.3 Equipment and set up

- PCA should be delivered via CME Bodyguard 575 infusion pump, which has been programmed with set protocols for this purpose in SRFT.
- Dedicated giving sets are provided with each pump; with indwelling anti-syphon and non-return valve.
- These should be changed after 72 hours as per Trust policy.
- The patient must have a dedicated patent IV cannula or access port via a central line for the administration of PCA opioids.
- Three way taps must NOT be used.
- PCA opioids are provided by pharmacy ready for use. These should NOT be prepared locally in clinical areas.
- The PCA opioids are supplied using controlled drug orders, and their use should be documented in the local CD register as per controlled drug policy
- PCA Opioid infusion bags are very similar to other I.V. infusions. In order to minimise risk, they should be stored separately in the controlled drug cabinet away from any other infusion.
- When setting up PCA or replacing an opioid bag, 2 independent checkers should check and witness the whole process as per CD policy.
- Staff should ensure that replacement bags of Morphine or Fentanyl are ordered from pharmacy when ward stocks are diminished to ensure that bags are available when bag changes are indicated.

5.4 Establishment of Analgesia

Staff who have undergone further training in the enhanced role and have been assessed as competent to deliver boluses of IV opioids may facilitate more rapid achievement of analgesic levels by delivering opioid boluses in increments via the PCA system as per policy (Opioid loading dose protocol)

In the absence of a suitably trained clinician, the pain team can facilitate this if contacted by pager (07623 623107) during normal working hours.

Patient assessment and observations should be repeated during an opioid titration process as per IV opioid loading dose protocol.

The total amount of clinician delivered bolus given should be documented on the patient’s chart and on EPMAR in the dedicated PCA flow sheet (Appendix 3) This should also be signed on completion of the bolus on the patients EPMAR.

5.5 Maintenance of Therapy, Pain Assessment and Monitoring

It is the nurse’s responsibility to ensure that patients using PCA are assessed and monitored regularly.
Minimum pain observations should be observed and frequency of observations increased if pain is inadequately controlled or there are concerns regarding adverse effects. At nurse handover, it is the responsibility of the nurse to check all relevant details and obtain an up to date assessment of the patient. These include:

- Prescription matches pump settings and infusion solution
- Check correct set up and attached to correct I.V. access point
- Volumes used documented as a cumulative total on the PCA flow chart on EPR.
- Record PCA use on EPMAR 4 hourly
- Assess patient is competent in use
- Pain assessment (see Appendix 2)
- Consider if step down to oral analgesia is appropriate

**Frequency of PCA observations**

Every 15 minutes for 1 hour when commenced
Hourly for 4 hours
4 hourly thereafter

These are the **MINIMUM** frequency for observations

### 5.6 Management of Ineffective Analgesia and PCA Troubleshooting

If a patient reports high pain score or that PCA is not working

- Reassess and check source of pain- Rule out acute complication such as surgical complication or acute abdomen. If high suspicion of complication, seek urgent Medical review.
- Check PCA prescription, set up and delivery via IV access port. Rule out disruption to system such as leak, occlusion, cannula dislodgement.
- Check PCA button function. If broken or uncertainty re function, obtain replacement immediately from Pharmacy or theatres.
- Check pump function and manage alarms (see below)
- Note PCA use by accessing PCA history and note demands made and doses delivered. If infrequent demands made, re-educate patient.
- Check patient understanding of technique and re-educate if appropriate
- Give analgesic adjuvants if able such as paracetamol +/- NSAID
- If pain severe, consider clinician delivered PCA boluses as per policy if trained to do so (bleep pain team as above if necessary).
- Reassess regularly until pain is adequately managed.

**Machine alarms**

- **Missing key** • Check line insertion in pump
- **Air in line** • Disconnect and prime line
- **Occlusion** • Check line, clamps and cannula site
- **End of infusion** • Change bag
5.7 Opioid Side Effects or Adverse Effects and their Management

Nausea and vomiting
- Is a common side effect of anaesthesia, surgery and analgesia. The PONV guidelines should be implemented for symptomatic management

Pruritus
- Symptomatic management with Chlorphenamine

Constipation
- Local guidelines should be followed depending upon surgical intervention

Hallucinations
- Reassure patient and consider opioid rotation to another formulation
- Consider reduction in bolus dose
- Rule out other causes such as sepsis

Sedation and respiratory depression
- Presenting as sedation score VPU
- Respiratory rate of 8 or less
- Pinpoint pupils (miosis) are a confirmatory sign only
- Remove PCA button out of reach
- Seek medical review
- Apply oxygen and repeat ABCDE assessment frequently until stable
- Check PCA set up and function is appropriate
- Review analgesic prescriptions and adjust if necessary

Opioid Toxicity
- Caused by the central effects of opioid analgesia
- Presents as sedation V.P.U
- Respiratory rate < 8 breaths per minute.
- Can be reversed by the administration of the opioid antagonist Naloxone. (See Naloxone policy).
  [http://intranet.srht.nhs.uk/policies-resources/trust-policy-documents/trust-wide-clinical/gen/pha606aqrg/]
- Naloxone should be titrated as per APS guidelines.
- If long acting opioids have been administered, an infusion of Naloxone may be required.

5.8 Discontinuation of PCA

Once pain is managed and the oral route is viable, ongoing management of acute pain can be maintained using oral opioids. See Oral Opioid Analgesia for acute Pain Management Policy (2018). Opioid Analgesia for Acute Pain Management

The aim of conversion is to provide a smooth transition to oral analgesia and to 'bridge any analgesic gap'.

The Algorithm below provides guidance
Algorithm for discontinuation of Patient Controlled Analgesia (PCA)

1. Is there an oral route established before removal?
2. Is the patient able to tolerate free fluids or diet?
3. Is the time of day morning or early afternoon (not evening or night time)?
   A dislodged cannula is not a criterion for stopping the PCA.

YES

Check PCA total dose used in previous 24 hours.
Total dose Morphine is less than 30mg or Fentanyl less than 600mcg

YES

Continue PCA
Review again when oral route established

NO

Commence Opioid Post Op Regime:
Oramorph po 10-20mg
Or Oxynorm po 2.5-5mg
Continue Paracetamol 0.5-1g PO qds (weight adjusted).
Consider NSAIDs

Give Codeine Phosphate 60mg PO qds + Paracetamol 0.5-1g PO qds (weight adjusted).
Consider NSAIDs

Continue PCA 30 mins after 1st dose given and then stop.
Review in 1 hour. Is pain controlled?

YES

Continue Codeine/Paracetamol regime

NO

Consider change to oral opioid regime

Patient on high doses of Opioids via PCA or established long term Opioids
Liaise with Pain team re suitable regime

Consider regular pain assessment whilst pain exists and review analgesic need daily
Reduce analgesic dose as pain decreases and step down using analgesic ladder

Pain team Pager: 07623623107

Updated April 2019
5.9 Explanation of terms

PCA- Patient Controlled Analgesia
IV- Intravenous
EWS- Early warning score
EPR- Electronic patient record
EPMAR- Electronic prescribing and Medication Administration Record
APS- Acute Pain Service
PONV- Post Operative Nausea and Vomiting
AVPU- Awake, responds to voice, responds to pain, unconscious

6. Roles & responsibilities

Lead Pain Nurse:
Accountable to the Executive Nurse Director & Trust Board for review and maintenance of this policy.

Pain Management Team:
• Are responsible for checking that their activities comply with the guidance in this policy.
• Are responsible for training and assessing nurses, doctors and other identified staff in the use of this policy.
• Are responsible for monitoring and recording practice to ensure nurses and other identified staff comply with this policy.
• Are responsible for reviewing this protocol and making staff aware of any updates.

Clinical staff setting up and managing PCA in clinical areas:
• Are responsible for complying with the protocol and reporting to the pain management team.
• Should attend initial training and then be responsible for maintaining their competency annually.
• Modern Matrons and Ward Managers are responsible for ensuring compliance with policy.

7. Monitoring document effectiveness

Pain team review of patients when needed with PCA will monitor adherence
Datix feedback will provide information regarding any deviation from policy
Link nurse/pain team will monitor staff training for PCA management

8. Abbreviations and definitions

PCA- Patient Controlled Analgesia
IV- Intravenous
EWS- Early warning score
EPR- Electronic patient record
EPMAR- Electronic prescribing and Medication Administration Record
APS- Acute Pain Service
PONV- Post Operative Nausea and Vomiting
9. References


Opioid analgesia for acute pain policy (2018) [Opioid Analgesia for Acute Pain Management](http://intranet.srht.nhs.uk/policies-resources/trust-policy-documents/trust-wide-clinical/gen/345tdc85qrg/)


Sickle Cell in the adult patient guidelines(2017) [SICKLE CELL CRISIS IN THE ADULT PATIENT GUIDELINES](http://intranet.srht.nhs.uk/policies-resources/trust-policy-documents/trust-wide-clinical/gen/pha606aqrg/)
## 10. Appendices

### Appendix 1

**Wards Authorised to Manage PCA (April 2019)**

<table>
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<tr>
<th>Ward</th>
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<td>B5</td>
<td>YES</td>
</tr>
<tr>
<td>B6</td>
<td>YES</td>
</tr>
<tr>
<td>B7</td>
<td>YES</td>
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<td>B8</td>
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<td>C3</td>
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<td>H4</td>
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<td>H6</td>
<td>YES</td>
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<tr>
<td>H7</td>
<td>YES</td>
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<tr>
<td>H8</td>
<td>Contact Pain Team</td>
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<tr>
<td>Neurosurgical HDU</td>
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<td>Surgical Triage Unit</td>
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<td>Theatres</td>
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<td>Emergency Assessment Unit</td>
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<td>M2/M3</td>
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</tr>
<tr>
<td>Medical Wards/Units Ladywell</td>
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</tr>
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</table>
Appendix 2 Pain Assessment

Pain Assessment Tools

1. **Verbal Descriptor Scale** - this is a self-report tool
   
   - Ask the patient ‘do you have any pain’?
   - Assess at rest and on Movement/Deep breathing/ Coughing
   - Ask if pain is mild moderate or severe
   - Score as below

<table>
<thead>
<tr>
<th>No Pain</th>
<th>0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mild Pain</td>
<td>1</td>
</tr>
<tr>
<td>Moderate Pain</td>
<td>2</td>
</tr>
<tr>
<td>Severe pain</td>
<td>3</td>
</tr>
</tbody>
</table>

*Note Patients who cannot self-report pain should not be given PCA to manage their pain*
Appendix 3  PCA Flow sheet on EPR
## 11. Document Control Information

All sections must be completed by the author prior to submission for approval

<table>
<thead>
<tr>
<th>Lead Author:</th>
<th>Fionn Murison, Lead Nurse, Acute Pain Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lead author contact details:</td>
<td>Ext 64248  <a href="mailto:Fionn.murison@srft.nhs.uk">Fionn.murison@srft.nhs.uk</a></td>
</tr>
</tbody>
</table>

### Consultation

List the persons or groups who have contributed to this policy. (please state which Care Organisation)

<table>
<thead>
<tr>
<th>Name of person or group</th>
<th>Role / Department / Committee (Care Org)</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angela Leonard</td>
<td>Specialist Nurse Pain Management, SRFT</td>
<td>April 2019</td>
</tr>
<tr>
<td>Rhiannon Vernon-Hunt</td>
<td>Specialist Nurse Pain Management, SRFT</td>
<td>April 2019</td>
</tr>
</tbody>
</table>

### Endorsement

List the persons or groups who have seen given their support to this policy. (please state which Care Organisation)

<table>
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<tr>
<th>Name of person or group</th>
<th>Role / Department / Committee (Care Org)</th>
<th>Date</th>
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<tbody>
<tr>
<td>DR Richard Makin</td>
<td>Clinical Lead Acute Pain</td>
<td>17/6/19</td>
</tr>
<tr>
<td>Dr Richard Cooper</td>
<td>Chair Medicines Management Committee</td>
<td>15/7/19</td>
</tr>
</tbody>
</table>

### Keywords / phrases:

Patient controlled Analgesia (PCA), Post-operative, pain, Morphine, Fentanyl, Pain team policies, Intravenous, Acute pain.

### Communication plan:

Via regular training sessions
Nurses, Doctors and Anaesthetists (at Induction)
Link Nurse Meetings

### Document review arrangements:

This document will be reviewed by the author, or a nominated person, at least once every three years or earlier should a change in legislation, best practice or other change in circumstance dictate.

This section will be completed following committee approval

### Policy Approval:

Name of Approving Committee: Medicine’s Management Committee

Chairperson: Richard Cooper

Approval date: 15/07/2019

Formal Committee decision (tick) ✓  Chairperson’s approval (tick) ✓
**12. Equality Impact Assessment (EqIA) screening tool**

Legislation requires that our documents consider the potential to affect groups differently, and eliminate or minimise this where possible. This process helps to reduce health inequalities by identifying where steps can be taken to ensure the same access, experience and outcomes are achieved across all groups of people. This may require you to do things differently for some groups to reduce any potential differences.

1a) Have you undertaken any consultation/involvement with service users, staff or other groups in relation to this document? | Yes | Please state: Multidisciplinary peer review
---|---|---
1b) Have any amendments been made as a result? | Not significant- only to phrasing rather than policy content

2) Does this policy have the potential to affect any of the groups below differently or negatively?  This may be linked to access, how the process/procedure is experienced, and/or intended outcomes. Prompts for consideration are provided, but are not an exhaustive list.

<table>
<thead>
<tr>
<th>Protected Group</th>
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<th>No</th>
<th>Unsure</th>
<th>Reasons for decision</th>
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<tbody>
<tr>
<td>Age (e.g. are specific age groups excluded? Would the same process affect age groups in different ways?)</td>
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<td></td>
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<td>Children excluded</td>
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<td>Sex (e.g. is gender neutral language used in the way the policy or information leaflet is written?)</td>
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<td>x</td>
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<tr>
<td>Race (e.g. any specific needs identified for certain groups such as dress, diet, individual care needs? Are interpretation and translation services required and do staff know how to book these?)</td>
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<td>Religion &amp; Belief (e.g. Jehovah Witness stance on blood transfusions; dietary needs that may conflict with medication offered.)</td>
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<td>x</td>
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<tr>
<td>Sexual orientation (e.g. is inclusive language used? Are there different access/prevalence rates?)</td>
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<td>x</td>
</tr>
<tr>
<td>Pregnancy &amp; Maternity (e.g. are procedures suitable for pregnant and/or breastfeeding women?)</td>
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<td></td>
<td></td>
<td>Would liaise with Pharmacist or Consultant in Pain Management</td>
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<tr>
<td>Marital status/civil partnership (e.g. would there be any difference because the individual is/is not married/in a civil partnership?)</td>
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<td>Gender Reassignment (e.g. are there particular tests related to gender? Is confidentiality of the patient or staff member maintained?)</td>
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<td>Human Rights (e.g. does it uphold the principles of Fairness, Respect, Equality, Dignity and Autonomy?)</td>
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<tr>
<td>Carers (e.g. is sufficient notice built in so can take time off work to attend appointment?)</td>
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</tr>
<tr>
<td>Socio/economic (e.g. would there be any requirement or expectation that may not be able to be met by those on low or limited income, such as costs incurred?)</td>
<td></td>
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<td>x</td>
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</table>
Disability (e.g. are information/questionnaires/consent forms available in different formats upon request? Are waiting areas suitable?) Includes hearing and/or visual impairments, physical disability, neurodevelopmental impairments e.g. autism, mental health conditions, and long term conditions e.g. cancer. x

Are there any adjustments that need to be made to ensure that people with disabilities have the same access to and outcomes from the service or employment activities as those without disabilities? (e.g. allow extra time for appointments, allow advocates to be present in the room, having access to visual aids, removing requirement to wait in unsuitable environments, etc.) x

3) Where you have identified that there are potential differences, what steps have you taken to mitigate these?
Alternative analgesia: oral or IV can be administered by staff.

4) Where you have identified adjustments would need to be made for those with disabilities, what action has been taken? N/A.

5) Where the policy, procedure, guidelines, patient information leaflet or project impacts on patients how have you ensured that you have met the Accessible Information Standard – please state below:

EDI Team/Champion only: does the above ensure compliance with Accessible Information Standard
   o Yes

If no what additional mitigation is required:

Will this policy require a full impact assessment? No

Please state your rationale for the decision:

(a full impact assessment will be required if you are unsure of the potential to affect a group differently, or if you believe there is a potential for it to affect a group differently and do not know how to mitigate against this - Please contact the Inclusion and Equality team for advice on equality@pat.nhs.uk)

Author: Type/sign: Fionn Murison Date: 17/6/2019

Sign off from Equality Champion: A Dwyer, Divisional Director of Nursing, Neurosurgery Date: 1/07/19