POLICY FOR THE ADMINISTRATION OF EPIDURAL ANALGESIA (excluding maternity services)

Author: Harriet Barker Lead Nurse Pain Service

Executive Lead: Sue Tranka Chief Nurse

Status: Approval date: 30th November 2017

Ratified by: Drugs and Therapeutics Committee

Review date: November 2020
## History

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<tr>
<th>Issue</th>
<th>Date Issued</th>
<th>Brief Summary of Change</th>
<th>Author</th>
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<tr>
<td>1</td>
<td>August 2011</td>
<td><strong>New Policy</strong></td>
<td>Harriet Barker</td>
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<td>2</td>
<td>August 2012</td>
<td>Change throughout the document from ‘Yellow Pre-printed epidural analgesia chart’ to ‘Pre-printed analgesia chart for Epidural and IV PCA’&lt;br&gt;Clarified that opioids should not be given via any other route whilst the epidural is in progress unless part of a pre agreed analgesia plan&lt;br&gt;Clarified that therapeutic anticoagulants should not be administered whilst the epidural catheter is in-situ without first discussing with Inpatient Pain Service/On call Anaesthetist</td>
<td>Harriet Barker</td>
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<td>3</td>
<td>October 2014</td>
<td>Changed to new format Guidance for prescribing / administering oxygen with an epidural has been updated to reflect the current Oxygen Policy&lt;br&gt;Reflect the change in epidural pumps by stating Smiths medical CADD Solis pumps.&lt;br&gt;Reference made to pumps not being interchangeable between maternity and acute pain.&lt;br&gt;Pump key to be kept on CD keys&lt;br&gt;References and hyperlinks updated throughout the document</td>
<td>Harriet Barker</td>
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<td>4</td>
<td>November 2017</td>
<td>Executive Lead updated Hyperlinks updated Title clarified to show this policy is not including maternity services Clarification regarding anticoagulant doses at request of DTC</td>
<td>Harriet Barker</td>
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For more information on the status of this document, please contact:

Policy Author | Harriet Barker
Department/Directorate | Inpatient (Acute) Pain Service/TASCC
Executive summary

This policy sets out the framework for the safe and effective delivery of epidural analgesia via an infusion device for patients requiring this method of analgesia within a surgical setting. It covers the expectations and standards required from the different groups of staff who will be involved in this process.

This policy does not cover the use of epidurals within maternity or the administration of single shot epidurals.
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1. Introduction

Epidural analgesia is an established method of post-operative analgesia across the Trust. It is normally delivered using a patient controlled epidural analgesia (PCEA) system which enables the patient to give themselves a bolus (under predefined parameters) in addition to the background infusion. Patients with epidural analgesia are nursed on the St Peter’s Hospital site in the Post Anaesthetic Recovery Unit (PACU), Intensive Care Unit (ICU), Surgical Dependency Unit (SDU), the Medical High Dependency Unit (MHDU), and the Surgical Wards. Nursing staff working in these areas receive training, are competent to care for patients with epidurals and are encouraged to pass the epidural competency.

The orthopaedic ward rarely has patients requiring epidural analgesia and as such the staff are no longer competent to care for these patients. Ideally they should be cared for in an area where staff are competent. Advice from the Inpatient Pain Service should be sought on a case by case basis.

Maternity also provide an epidural service using the same pumps but work from their own policies and are therefore not included in this policy. The protocols on the pumps in Maternity are significantly different from those used for acute pain management and are therefore not interchangeable between these two areas.

Patients from the above areas who are receiving epidural analgesia may occasionally need to be transferred to Coronary Care Unit (BACU). The patient may be managed on BACU with the epidural but must not be moved to a medical ward whilst receiving epidural analgesia.

There is no post-operative epidural infusion service at Ashford Hospital as there is no longer an anaesthetist on site 24 hours a day and the infrequency of this mode of analgesia being used. Epidural injections are still carried out as a stand-alone procedure for chronic pain and are not covered by this policy.

**Epidural analgesia is only to be administered using a yellow Smiths Medical CADD Solis pump and a dedicated yellow stripped administration set.** This equipment is not to be used for any other infusions. No other equipment should be used to administer epidural infusions.
2. Scope

2.1 This guidance is relevant to: Inpatient Pain Service, Registered Nurses, Operating Department Practitioners (ODPs), Anaesthetists, Independent Prescribers, Pharmacy, EBME.

3. Purpose

3.1 The purpose of this policy is to outline the expected care of the patient receiving epidural analgesia. This will assist staff to manage and care for these patients appropriately and safely.

4. Explanation of Terms Used

4.1 POLICY

4.1.1 A policy is a statement of corporate intent that is adopted and followed across the Trust. Policies direct trust practice in fulfilling statutory and organisational responsibilities and are contractually and legally binding on all employees.

4.2 EPIDURAL

4.2.1 An epidural is a method of delivering analgesia to a patient via their epidural space. For the purpose of this policy the term epidural relates to the administration of drugs via a catheter inserted into the epidural space utilising a dedicated infusion device.

5. Duties and responsibilities

In order to implement the above statement, specific people have certain duties and responsibilities as outlined below.

5.1 INPATIENT PAIN SERVICE

The Inpatient Pain Service is responsible for the provision of Acute Pain across Ashford & St Peter’s Hospitals NHS Foundation Trust.

Specifically the Inpatient Pain Service will:-

1. Provide teaching to all appropriate registered nursing staff, anaesthetic staff and operating department practitioners (ODPs) as required which incorporates the principles of epidural analgesia, pharmacology of the analgesics available as well as the appropriate use and management of the epidural equipment.

2. Support the ward staff in the management of patients who have epidural, either through ward visits or through verbal advice as necessary. If out of hours advice is required, the on-call anaesthetist may be asked to review patients who have epidurals by the registered nurse responsible for their care or by the patient’s own team.
3. Communicate any changes regarding the patient’s pain management to the registered nurse responsible for that patient and document their visit and/or actions in the patient healthcare records.

4. Provide the dedicated documentation required to support the safe administration and monitoring of epidural analgesia.

5. Ensure that staff working across the Trust, are aware of who to contact to request advice regarding the care of patients with epidural analgesia.

6. Provide a timely and appropriate response to requests for assistance with managing epidural analgesia.

7. Work in conjunction with EBME and PACU to maintain pump function and safety

8. Ensure that information for staff relating to managing epidural infusions will be kept up to date and can be accessed on the TrustNet

9. The Inpatient Pain Service or the registered nurse may intervene to stop the patient using the demand button at any time if they feel that the patient is at risk or is not receiving optimum pain relief using this method. The patient would then be reviewed and may be changed to continuous epidural analgesia

5.2 ANAESTHETIST

Out of working hours on the St Peter’s hospital site the anaesthetic registrar covering maternity will co-ordinate acute pain support provided for the wards, working alongside their on call anaesthetic colleagues and the ward teams.

The Anaesthetist will:-

1. Assess patient suitability for epidural analgesia pre-operatively and all 'non post-operative' patients requiring epidural analgesia as a primary procedure (i.e. for fractured ribs or pancreatitis)

2. Give all patients the opportunity to discuss the use of epidural analgesia for their pain management.

3. Liaise with the Inpatient Pain Service as needed if a patient has complex needs relating to epidural analgesia

4. As part of their on call duties, provide out of hours advice for staff to help them manage patients with epidural analgesia safely and effectively. Also to provide telephone advice to patients who may ring with a suspected epidural haematoma

5.3 PRESCRIBER
Epidural analgesia is initially prescribed by the anaesthetist sitting the epidural. Other doctors can alter or rewrite epidural prescriptions as required. The prescriber must:

1. Prescribe epidural analgesia, naloxone and anti-emetics on the Trust’s pre-printed analgesia prescription chart for Epidural and IV PCA. The prescriber must ensure that this chart is then secured in the PRN section of the patients inpatient prescription chart.

2. Ensure that any medicines prescribed on the Trust’s pre-printed analgesia prescription chart for Epidural and IV PCA do not duplicate any existing prescriptions.

3. Be aware that the solution used for epidural analgesia contains Levobupivacaine 0.1% with Fentanyl 2 micrograms/mL and Epinephrine (adrenaline) 2 micrograms/mL. This is supplied in prefilled bags of 500mL volume (i.e. prepared by the manufacturer or pharmacy). Occasionally, a patient may be prescribed an epidural solution that contains only a local anaesthetic agent with no fentanyl or adrenaline. If this is prescribed for a patient then this must be used for continuous epidural analgesia ONLY, not for PCEA.

4. Ensure that no other opioid analgesia is prescribed whilst the epidural is in progress unless the patient has an existing opioid requirement. The patient should ideally be discussed with both the Inpatient Pain Service and the anaesthetist so that a safe and effective analgesia plan can be provided.

5. Prescribe oxygen 2-4L/minute on a PRN basis so that it is only delivered during the day if oxygen saturations fall outside the target parameters (88-92% or 94-98%) as per the Trust’s Oxygen Policy. Oxygen will be delivered continuously at night when the risk of episodes of hypoxaemia is increased, due to the increased risk of upper airway obstruction. Caution should be exercised in patients with chronic lung disease. Advice may be sought from the Inpatient Pain Service, responsible clinician or physiotherapist in this instance.

### 5.4 REGISTERED NURSE IN CHARGE

In ward areas where patients with epidural analgesia are nursed, the nurse in charge of the ward must:

1. Ensure that there is at least one member of staff on duty at all times who has received education in the management of epidural analgesia.

2. Ensure that epidural analgesia bags are replaced by registered nurses who are competent in intravenous drug administration and who have received the appropriate training from the Inpatient Pain Service.

5.5 REGISTERED NURSE CARING FOR PATIENT RECEIVING EPIDURAL ANALGESIA

The registered nurse who cares for a patient receiving epidural analgesia must:

1. Be aware of and demonstrate their accountability, including their own abilities and limitations when caring for a patient who is receiving epidural analgesia.

2. Be able to educate the patient on the medicines contained within the epidural solution and about how to use epidural analgesia effectively.

3. Ensure that epidural analgesia is administered using the Smiths Medical CADD Solis epidural analgesia pump and that a dedicated epidural analgesia administration set is used.

4. Ensure that the epidural system between the pump and the patient remains a ‘closed’ system wherever possible. A prefilled epidural infusion bag may be left in place until it is empty. A single epidural administration set and filter can be left in place for the duration of the epidural infusion if the system is not broken.

5. Ensure if there is a break in the epidural system through disconnection of the epidural catheter from the antibacterial filter, the correct action is taken to either reconnect or remove the epidural catheter. An epidural may be reconnected by the Inpatient Pain Service, a nurse with the ‘Reconnecting an Epidural Catheter’ competency or an anaesthetist if:

   a. the disconnection happened less than 8 hours before the reconnection takes place
   b. the fluid volume in the catheter remains static when raised above the level of the patient
   c. the fluid meniscus in the catheter is within 12.5cm of the disconnection
   d. a minimum of 20cm is cut off the epidural catheter distal to the disconnection before reconnection takes place. The cutting and reconnection must be an aseptic procedure

6. Be aware of the possible side effects of opioids and be able to explain the rationale for the use of naloxone

7. Assess and record on the Epidural Analgesia Observation Chart (for the duration of epidural analgesia):

   a. pain on movement
   b. sedation level
   c. nausea and vomiting score
   d. motor block
   e. sensory block
   f. that pressure areas have been visibly checked
   g. the amount of epidural solution used
8. In addition, assess and record all vital signs as per the Epidural Analgesia Observation Chart on the Trust observation chart.

9. Check and document on the Epidural Analgesia Observation Chart the epidural analgesia pump settings whenever they take over responsibility for the care of a patient receiving epidural analgesia.

10. Ensure no other opioid analgesics are administered whilst the epidural is in progress unless the patient has an existing opioid requirement and is part of an agreed analgesia plan discussed and agreed by the anaesthetist and inpatient pain service.

11. Ensure therapeutic anticoagulants or high dose prophylactic anticoagulants (e.g. doses above 40mg od) are not prescribed or administered whilst the epidural catheter is in-situ without consulting with the Inpatient Pain Service or out of hours the on call Anaesthetist on 5011. Prophylactic anticoagulants can be administered as long as the guidance for removing the epidural catheter is followed (see Epidural Analgesia Observation Chart).

12. Have attended epidural training and completed the relevant IV competency before administering epidural analgesia by connecting a prefilled infusion bag to an existing epidural infusion.

13. Ensure oxygen 2-4L/minute is prescribed on a PRN basis so that it is only delivered during the day if oxygen saturations fall outside the target parameters (88-92% or 94-98%). Oxygen will be delivered continuously at night when the risk of episodes of hypoxaemia is increased, due to the increased risk of upper airway obstruction. Caution should be exercised in patients with chronic lung disease. Advice may be sought from the Inpatient Pain Service, responsible clinician or physiotherapist in this instance.

14. Ensure that the epidural analgesia is only discontinued following discussion with the patient and when alternate regular and ‘as required’ analgesia has been prescribed.

15. Ensure that any unused solution from an epidural analgesia bag is recorded in the Controlled Drug Register as per Trust guidelines and that disposal is carried out in accordance with the Trust ‘Medicines Management Policy’.

16. Ensure that the epidural catheter is removed as per the guidelines on the Epidural Analgesia Observation Chart. Epidural catheters can be removed by the Inpatient Pain Service, an anaesthetist or a registered nurse who has completed the Epidural competency, ensuring that the patient is given a copy of the ‘Epidural Haematoma Letter’.
17. Understand the potential infection control risks relating to epidurals and when to send the epidural tip to microbiology for microscopy, culture and sensitivity (MC&S). Any pyrexia must be recorded and reported to the patient’s team. The epidural site must be checked by the registered nurse at least once during the time period for which they are responsible for that patient in addition to regular assessment of the motor power. The site must be covered with a clear occlusive dressing to allow checks for redness, swelling, oozing and pain/tenderness. All checks must be documented on the trust epidural observation chart. The development of an epidural abscess is rare but the following may increase this risk
   a. Patients with compromised immunity including diabetes, cancer, HIV infection, alcoholism.
   b. Length of hospital stay prior to surgery and length of time that the epidural is actually in situ may also increase risk particularly if epidurals are in situ for more than four days
   c. Existing respiratory, urinary or soft tissue infections, patients who are intravenous drug abusers
   d. Unwitnessed disconnection of the epidural line, particularly if disconnected proximally to the filter
   e. Patients with lumbar epidurals
If any of the above symptoms are noted, then the Inpatient Pain Service or the on call anaesthetist must be informed

18. Be able to identify and detect complications such as an epidural haematoma, and understand what action to take if such a complication is suspected (as per Epidural Analgesia Observation Chart).

19. Be able to identify the various alarms on the Smith Medical CADD Solis epidural analgesia pump and take the appropriate action.

20. Ensure that epidural analgesia pumps are cleaned after use and labelled as clean, before the pump is returned to the PACU with the bolus cord and mains lead/powerpack

5.6 PACU STAFF (in addition to the responsibilities of REGISTERED NURSE)
PACU staff will:-

1. Keep records of patients currently using epidural analgesia.

2. Work in association with the Inpatient Pain Service to maintain safe and effective storage of epidural analgesia pumps and to maintain correct date and time function on same.

3. Connect a premixed infusion bag (i.e. prepared by the manufacturer or pharmacy) of an epidural solution to an epidural line providing there is written evidence that a test dose of epidural analgesia has already been administered by the anaesthetist and that the registered nurse has attended appropriate training and have their epidural competency
4. Ensure no other opioid analgesia is administered whilst the epidural is in progress unless the patient has an existing opioid requirement and is part of a analgesia plan discussed and agreed with the anaesthetist and Inpatient pain service

5. Ensure that the patient does not leave the PACU until they have a pain score of 1 (mild pain) or less using the Trust pain assessment scale of 0 – 3.

6. Ensure that the algorithm ‘Management of leg weakness with epidural analgesia in recovery areas’ is followed (as per the Epidural Analgesia Observation Chart)

7. Safely hand over care of the patient receiving post-operative epidural analgesia to the ward nurse assuming responsibility upon discharge from PACU. The handover must include checking the epidural analgesia pump settings, the total amount of drug administered and the inpatient drug chart including the epidural analgesia prescription, with the ward nurse before the patient leaves the PACU (or on arrival in the ward if the patient is escorted back to the ward by a PACU Nurse). This is recorded by both nurses signing the Theatre Integrated Care Pathway (ICP) document.

5.7 PHARMACY
The pharmacy department will:-

1. Supply prefilled bags of epidural analgesia solution to the wards and recovery areas where epidural analgesia is used.

2. Alert and liaise with the PACU at St Peter’s if there is a supply problem with epidural bags and ensure that alternative supplies of epidural solution can be obtained to avoid a gap in the provision of the epidural analgesia service. The Inpatient Pain Service should also be made aware of any supply problem

3. Check epidural analgesia prescriptions in accordance with their normal procedure for reviewing inpatient drug prescriptions in ward areas.

5.8 EBME
The electronic biomedical engineers will:-

1. Liaise with Smiths Medical to arrange the service and maintenance for all Smiths Medical CADD Solis epidural analgesia pumps, consulting with the Inpatient Pain Service as required.

6. Training

6.1 All staff involved with caring for patients with an epidural delivered via a Smiths Medical CADD Solis Pump will receive training on how to use it. This will be provided either by the Smiths Medical Clinical Trainer or by Trust staff who have undergone a programme of training and are designated ‘CADD Solis Train the Trainers.’
6.2 In addition to this all registered nursing staff caring for patients with epidural analgesia will receive dedicated epidural training from the Inpatient Pain Service or a member of staff who is deemed competent by the Inpatient Pain Service to deliver such as session. This training should be undertaken every 2 years in line with the guidance set out by the Royal College of Anaesthetists.

6.3 All registered nurses caring for patients with epidural analgesia should complete the competency ‘Care of the Patient with Epidural Analgesia’ within 12 months of starting in the Trust.

7. **Stakeholder Engagement and Communication**

7.1 This policy has been consulted on and reviewed by a variety of staff including: members of the Inpatient Pain Service, nurses, divisional pharmacists for surgery, orthopaedics and critical care/theatres, respiratory physiotherapy specialists, consultant anaesthetists, EBME

8. **Approval and Ratification**

8.1 Ratification will be sought from the Drugs and Therapeutics Committee.

9. **Dissemination and Implementation**

9.1 The policy will be disseminated through the Aspire global email.

9.2 This policy will be published on the trust intranet and internet sites.

9.3 Any changes to practice arising from this policy will be disseminated to the appropriate staff by the Inpatient Pain Service.

10. **Review and Revision Arrangements**

10.1 This policy will be reviewed by the author in October 2020, or before if necessary

10.2 The review will be sooner if there is a change in legislation, or if a NHS England Patient Safety Alert which directly affects this policy is issued, or if new national guidance from a body such as the Royal College of Anaesthetists or the Royal College of Nursing is issued.

11. **Document Control and Archiving**

11.1 This is a trust-wide document and archiving arrangements are managed by the Head of Regulation & Accreditation and Information Content Manager who can be contacted to request master/archived copies.
11.2 On the internet site, the document will be highlighted as green, when in date, amber 3 months prior to review date, and red if expired.

11.3 Responsibility for archiving trust-wide policies lies with the Head of Regulation & Accreditation.

11.4 Electronic folders are set up to hold master copies.

11.5 Requests for retrieval of documents can be made to the Head of Regulation & Accreditation.

12. Monitoring compliance with this Policy

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<td>Annual</td>
<td>Lead Nurse pain Services</td>
<td>TASCC Clinical Governance Group Drugs and Therapeutics Committee</td>
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13. Supporting References / Evidence Base


Bibliography


Royal College of Anaesthetists, Royal College of Nursing *et al* (2010) *Best practice in the management of continuous epidural analgesia in the hospital setting.*


APPENDIX 1: EQUALITY IMPACT ASSESSMENT

Equality Impact Assessment Summary

Name and title: Harriet Barker Lead Nurse Pain Services
Policy: Policy for the Administration of Epidural Analgesia

Background
This EIA has been compiled by Harriet Barker Lead Nurse Pain services along with other members of the Inpatient Pain Service.

The aim of all guidelines within the Inpatient Pain Service are to support and guide staff in the delivery of safe and effective acute pain management and to ensure that all patients, where possible, have equal access to the most appropriate method of acute pain control. All guidelines developed by the Inpatient Pain Service consider national guidance, frameworks and evidence to ensure that best practice is encouraged and developed.

This EIA is considered as an overarching assessment for current guidelines that are in place for acute pain management for inpatients in the trust as these guidelines have the common aim as stated above. The RADAR principles (Responsibility, Anticipation, Discussion, Assessment, Response) of acute post-operative pain management are encouraged to ensure good communication and forward planning in relation to acute pain wherever possible.

Patients undergoing surgery are seen by an anaesthetist pre-operatively to assess their suitability for the use of specific methods of acute pain control such as patient controlled analgesia, epidural analgesia and local anaesthetic infusions. If for any reason a patient is deemed unsuitable for a particular method of analgesia, then this is communicated by the anaesthetist to other staff caring for the patient. For patients who have acute pain but who are not undergoing surgery, their suitability for specific methods of pain control are assessed by the Inpatient Pain Service or by the wider team caring for them with advice from the Inpatient Pain Service.

Occasionally a patient may not be able to have a particular method of pain control due to the clinical area in which they are being managed but systems are in place to highlight this to the Inpatient Pain Service so that the patient can be moved to enable them to have the most appropriate analgesia.

Methodology

Patients are not excluded in relation to their gender, sexual orientation or religion. A patient’s race or ethnic origin may affect their ability to understand the use of some methods of acute pain control due to language barriers or personal beliefs about the meaning of pain. Information leaflets incorporate advice on how to obtain information in different languages and interpreting services can be accessed if needed.

Patients with a disability may be unable to use particular pieces of equipment and alternatives will be sought for such patients unless a piece of equipment can be adapted for them. Patients with learning disabilities are supported through local guidance and the use of a specific ‘Patient Passport’ where necessary.

Patients who undergo emergency treatment rather than elective treatment may initially require a type of pain control that may not be of their choice as the priority will be to act in...
the best interest of the patient at that time. However, this is reviewed as soon as the patient is able to make a choice. Patients with certain medical conditions may not be able to have some methods of acute pain control which may pose a risk to their overall health.

Examples:
- patients with clotting abnormalities are excluded from having neuraxial blockade methods such as intrathecal and epidural injections
- patients who are physically unable or who are cognitively impaired, may not be able to manage the patient control aspect of a patient controlled analgesia pump and therefore will not be able to utilise this method (but could have a background epidural infusion running)
- patients who do not speak English may also not understand the patient controlled analgesia aspect of the pump and therefore an interpreter who can explain this to the patient needs to be sort at the earliest opportunity to enable them to best use this method of analgesia
- patients for whom pain is something they feel they must endure, be this for cultural or religious reasons, may not get the full benefit of acute pain control methods and this is accepted to be their choice

Key Findings

There may be a group of patients who are identified as being unable to manage particular acute pain methods and this may have an adverse impact on their care and overall recovery. It is estimated that around 2-3 patients per month will not be able to have the most suitable post-operative analgesia method due to disability, cognitive impairment, language barriers or personal/cultural beliefs and this may present a challenge in relation to adverse impacts.

Patients who undergo emergency treatment are offered acute pain advice as soon as practically possible.

Conclusion

Guidelines developed by the Inpatient Pain Service for the management of acute pain offer the majority of patients appropriate pain relief. Patients who cannot have easy access to acute pain relief methods are helped to manage their pain with an alternative method of analgesia. Staff are aware of how to access help with pain management from the Inpatient Pain Service and the anaesthetic department and how to access help for specific patient groups such as those with a learning disability.

Inpatient Pain Service guidelines will not have any impact with regards to gender or sexual orientation. Any potential impact relating to race, ethnic origin, culture or religious beliefs will be managed on an individual basis.

Recommendations

No changes need to be made to any guidelines in light of the EIA process but all guidelines will continue to be reviewed after 2 years or sooner if new clinical evidence, risk or equal access emerges and requires action before then.
APPENDIX 2: CHECKLIST FOR THE REVIEW AND APPROVAL OF DOCUMENTS

To be completed (electronically) and attached to any document which guides practice when submitted to the appropriate committee for approval or ratification.

Title of the document: Policy for Administration of Epidural Analgesia
Policy (document) Author: Harriet Barker
Executive Director: Mr John Hadley Divisional Director TASCC

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<td>Is the type of evidence to support the document identified explicitly?</td>
<td>Yes</td>
<td></td>
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<td></td>
<td>Are local/organisational supporting documents referenced?</td>
<td>Yes</td>
<td></td>
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<td>5.</td>
<td>Approval</td>
<td></td>
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<tr>
<td></td>
<td>Does the document identify which committee/group will approve/ratify it?</td>
<td>Yes</td>
<td></td>
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<td></td>
<td>If appropriate, have the joint human resources/staff side committee (or equivalent) approved the document?</td>
<td>NA</td>
<td></td>
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<tr>
<td>6.</td>
<td>Dissemination and Implementation</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Is there an outline/plan to identify how this will be done?</td>
<td>Yes</td>
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<tr>
<td></td>
<td>Does the plan include the necessary training/support to ensure compliance?</td>
<td>Yes</td>
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<td>7.</td>
<td>Process for Monitoring Compliance</td>
<td></td>
<td></td>
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<tr>
<td>Question</td>
<td>Answer</td>
<td>Comments</td>
<td></td>
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<td>-------------------------------------------------------------------------</td>
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<tr>
<td>Are there measurable standards or KPIs to support monitoring compliance of the document?</td>
<td>Yes</td>
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</table>

8. **Review Date**

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
<th>Comments</th>
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</thead>
<tbody>
<tr>
<td>Is the review date identified and is this acceptable?</td>
<td>Yes</td>
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9. **Overall Responsibility for the Document**

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
<th>Comments</th>
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<tbody>
<tr>
<td>Is it clear who will be responsible for coordinating the dissemination, implementation and review of the documentation?</td>
<td>Yes</td>
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</table>

10. **Equality Impact Assessment (EIA)**

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
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<tr>
<td>Has a suitable EIA been completed?</td>
<td>Yes</td>
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**Committee Approval (insert name of Committee)**

If the committee is happy to approve this document, please complete the section below, date it and return it to the Policy (document) Owner.

<table>
<thead>
<tr>
<th>Name of Chair</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Tanya Bernard</td>
<td>30.11.2017</td>
</tr>
</tbody>
</table>

**Ratification by Management Executive (if appropriate)**

If the Management Executive is happy to ratify this document, please complete the date of ratification below and advise the Policy (document) Owner.

**Date:** n/a