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Royal Cornwall Hospitals NHS Trust

Acute Post-Operative Patient Controlled Analgesia Clinical Guideline

V2.0

August 2019

1. Aim/Purpose of this Guideline

1.1.Patient Controlled Analgesia (PCA) has been shown to provide a safe and effective technique for the administration of intravenous opioids for the relief of pain both post operatively and for severe acute pain which requires repeated doses of parenteral opioids.

1.2.The use of PCA refers to a method of pain relief that allows a patient to self-administer small doses of intravenous analgesic agents, most commonly opioids, from a computerised pump.

1.3.This technique enables pain management to be tailored to patient need, providing the patient with control and minimising delay in administration of analgesia.

1.4.The patient is able to communicate a requirement for analgesia via a hand held button connected to the pump which is programmed to deliver a fixed bolus dose when the demand button is pressed. Immediately following the demand a lock out period commences which allows control of total maximum dose delivered within a set period thereby preventing the potential risk of overdose.
1.5.A continuous background infusion can be added if required for any patient with particular pain needs but should only be undertaken in areas where there is sufficient monitoring and skill in observing and treating signs of overdose.

1.6. Nurse Controlled Analgesia (NCA) refers to a technique by which nurse may press the button. This is not commonly practiced in this Trust.

1.7.Occasionally, when patients may not be able to operate the button e.g. those with severe arthritics, or undergoing bilateral hand surgery they would not be suitable for this PCA technique and other methods of analgesia should be considered such as percutaneous, iv bolus or oral opioids.

1.8..PCA should not be considered appropriate in patients with diminished comprehension e.g. dementia and used with caution in the very frail or very elderly.

1.9.Morphine is considered to be the ‘gold standard’ for intravenous analgesia is the most commonly used opioid drug of choice.

1.10. This version supersedes any previous versions of this document.

1.11. Data Protection Act 2018 (General Data Protection Regulation – GDPR) Legislation

The Trust has a duty under the DPA18 to ensure that there is a valid legal basis to process personal and sensitive data. The legal basis for processing must be identified and documented before the processing begins. In many cases we may need consent; this must be explicit, informed and documented. We can’t rely on Opt out, it must be Opt in.

DPA18 is applicable to all staff; this includes those working as contractors and providers of services.

For more information about your obligations under the DPA18 please see the 'information use framework policy', or contact the Information Governance Team rch-tr.infogov@nhs.net

2. The Guidance

2.1. To provide information to all clinical and ward based staff involved in the management of patients prescribed a PCA technique.

2.2. To ensure all patients with a PCA receive appropriate and continuous analgesia.

- Patients should have a pain score of 1 or less following surgery. If not, acute pain should be treated appropriately within 30 minutes within the immediate recovery area.
- Patients should not return to the ward with uncontrolled pain.
- Pain should be managed so that any increase in levels is detected and treated within 2 hours

2.3. To ensure patients with PCA receive appropriate and effective antiemetic therapy and whilst not recorded on the NEWS chart.

- Patients should have nausea and vomiting assessed regularly
- Patients should have anti emetics prescribed according to guidelines

2.4. To ensure all patients are educated on the use of the PCA system prior to leaving recovery

2.5. To ensure that all patients pre operatively are provided with written information regarding available analgesia post operatively in a booklet issued at time of pre op assessment - 'Pain After Surgery'

2.6. A lack of opportunity to counsel a patient pre operatively should not prevent suitable cases from receiving PCA. No patient should leave recovery until competent use of PCA is established.

2.7. These guidelines provide information about the prescribing, patient care and the maintenance of PCA systems for adults within RCHT and is applicable to all health care staff.

2.8. RCHT refers to Royal Cornwall Hospital Trust at the three main sites of West Cornwall Hospital, Penzance (WCH), St Michael's Hospital, Hayle (SMH) and Royal Cornwall Hospital, Treliske.

2.9. PCA is intended for use by the patient only and no one else

2.10. Clinical areas that accept patients with PCA should have staff suitably trained in patient care for PCA and have completed the Trust or equivalent training package.

2.11. There should always be, as an absolute minimum, an appropriately trained

nurse at every shift available to supervise the care of these patients.

2.12. **Definitions**

- PCA Patient Controlled Analgesia
- RCHT Royal Cornwall Hospital Trust (WCH, St M and Treliske)
- CD Controlled Drug
- NSAID Non-Steroidal Anti Inflammatory Drug
- APT Acute Pain Team
- PONV Post Operative Nausea and vomiting
- HDU High Dependency Unit
- ICU Intensive Care Unit

2.13. Roles and Responsibilities

2.14. Anaesthetists

2.14.1. PCA's are normally prescribed by anaesthetists who are expected to follow the accepted standards of care for selecting the appropriate patients, infusion and pump, safe prescribing and following the monitoring guidelines.

2.14.2. If the anaesthetist cannot ensure safe nursing care for the patient in an appropriate environment then it becomes their responsibility to provide alternative analgesic techniques more suitable to the environment in which they may be nursed.

2.14.3. However, where it is obviously in the best interest of the patient to receive patient controlled analgesia, it would be expected that senior nurses and managers become involved to allow this to occur without detriment to other patients.

2.15. Medical Prescribers

2.15.1. Prescribers are encouraged to prescribe in line with local opioid guidelines as well as the current edition of the BNF, unless there are justified clinical reasons not to do so.

2.15.2. Prescribing teams should review all analgesic prescriptions on a daily basis or more frequently if clinically indicated.

2.16. Nursing Staff

2.16.1. Nursing staff are responsible for the timely administration of PCA drugs in line with RCHT guidelines.

2.16.2. Nursing staff are responsible for the ongoing monitoring of pain scores on rest and movement, motor power and sensation and signs of local anaesthetic toxicity along with vital signs of pulse, respiratory rate, BP, oxygen saturation and urine output on a NEWS chart.

2.16.3. Adverse reactions to analgesics should be reported to the prescribing tem and further action on administration confirmed.

2.16.4. Nurses should contact the Acute Pain team for further advice when necessary (bleep 3233.)

2.17. Pharmacists

2.17.1. As part of regular monitoring, pharmacists should ensure adherence to the local opioid guidelines with regards to appropriateness, accuracy, safety and clarity of prescribing.

2.17.2. Pharmacists should challenge any inappropriate prescribing of analgesics, such as the use of combination therapy.

2.17.3. Pharmacists should contact the acute pain team for further advice when necessary.

2.18. The PCA Pump

Table 1 Glossary of Terms

Term	Meaning
Loading Dose	The Loading dose is an initial dose of a drug given rapidly to achieve a therapeutic concentration in the body. Loading doses in PCA are usually administered to a patient before the initiation of the PCA to ensure that the patient has reached an acceptable level of analgesia
Bolus	The amount of drug the patient receives intravenously when the demand button is pressed
Lock out interval	A pre determined time period during which the patient cannot access doses
Dose Duration	The time the pump will take to deliver each bolus
Demands	Each time the demand button is pressed it is recorded as a demand
Good Demands	Each time the demand button is pressed and the patient receives a bolus it is recorded as a good demand
Background Infusion	A continuous infusion that can be prescribed to maintain a steady blood concentration of analgesic. Can be used for patients reporting severe pain on waking or for patients with a strong history of strong opioid use.
Total amount of drug	The pump will record the total amount of drug a patient has received in milligrams within a set time period. This includes bolus doses and a background infusion.

2.19. Programming Pumps

2.19.1. All wards that accept patients with PCA systems should have an acute pain link nurse

2.19.2. Pumps are available from each of the theatre recovery areas or by bleeping the equipment technician

2.19.3. At the commencement of each PCA episode details should be recorded on a pink audit form which also records the pump number

2.19.4. All wards/units must have a key for the IVAC PCAM syringe pump which must be kept with the ward/unit controlled drug(CD) keys

2.19.5. Pumps can be programmed by authorised personnel who have been appropriately trained and may include:

- Recovery nurses
- Acute Pain Team
- Anaesthetists
- Intensive Care nurses
- Night site coordinators

2.19.6. The settings should be checked by 2 authorised staff

2.19.7. Pump reprogramming must be done by authorised personnel if a prescription is changed

2.19.8. If a pump is started in ITU,HDU, or on the ward then the appropriate pink form should be completed and the Acute Pain Team informed.

2.20. Indications

Any patient requiring analgesia for severe pain either post operatively or for other reasons which cannot be achieved by other routes satisfactorily to a consistently low level. This may be as a sole method of analgesia or as part of a multi modal approach.

2.21. Contraindications

Patient related factors including age, psychological characteristics, concurrent disorders, opioid dependency may influence the decision as to the safety and suitability of a PCA for particular patients when an alternative method of analgesia should be used.

Table 2 Contraindications for PCA

Absolute Contraindication	Inadequate staffed area Patient/carer refusal Known allergy to opioids Inability to operate the device due to physical or mental disability Severe Cognitive Impairment

Relative Contra Indications	Pregnancy Breast Feeding Known history of iv drug abuse Inability to understand concept of PCA

2.22. Monitoring Care of Patient

2.22.1. Observations

2.22.1.1. All observations should be recorded on the NEWS chart by competent staff

2.22.1.2. All patients should be monitored by nursing staff who have completed their PCA competency or are closely supervised by a member of staff who has completed the training.

2.22.1.3. Observations should include Blood Pressure, pulse rate, oxygen saturation, sedation and respiratory rate as well as the pain scores and mg used as per nursing policy document:

Document	Author	Version	Last review	Reviewed by	Review due
Patient Controlled Analgesia (PCA) Adult Clinical Guideline	Sarah Medlicott	08	01/2019	Pain Services	01/2022

Table 3 Observation frequency

Monitoring parameter	1st hour	Following 2 hours	thereafter
Respiratory Rate	Every 15 mins	Every 30 mins	Hrly for 24 hrs, then 2hrly until cessation
Blood Pressure	Every 15 mins	Every 30 mins	Hrly for 12 hrs if stable then 2hrly until cessation
Heart Rate/sats	Every 15 mins	Every 30 mins	Hrly for 12 hrs then 2hrlyif stable until cessation
Pain score at rest	Every 15 mins	Every 30 mins	Hrly for 24 hrs then 2hrly until cessation
Pain score on movement	Every 15 mins	Every 30 mins	Hrly for 24 hrs then 2hrly until cessation
Sedation	Every 15 mins	Every 30 mins	Hrly for 24 hrs then 2hrly until cessation

2.22.1.4. Monitoring of the respiratory rate is essential to detect complications relating to the use of opioids.

2.22.1.5. If respiratory rate falls below 8 switch off epidural , give oxygen and follow algorithm on NEWS chart.

Table 4 Respiratory observations and actions

Resp Rate	Action to take
≤ 10	Increase frequency of Observations
≤ 8	Stop infusion, give oxygen, observe and consider naloxone
≤ 6	As above and give naloxone immediately

2.22.1.6. Preparation of Naloxone

- 400micrograms of Naloxone should be diluted in 3ml of o.9%NaCl
- Give in 1 ml increments every 5 mins
- Give until resp rate increases to 8 and sedation score greater than 2
- Seek medical advice if resp rate remains low

2.22.1.7. Observations should not enter the red area of the NEWS chart.

2.22.1.8. If patient complains of nausea or vomiting appropriate anti emetics should be given as per RCHT guidelines

2.22.1.9. If Pain score remains at 2 or over and the patient's pain is severe, ensure that the iv access is satisfactory and contact medical staff for additional bolus to be prescribed.

2.22.2. Pump Observations

The following should be observed when monitoring the patient:

- The number of mg used – it should be noted that comparison of no of demands versus good demands will give an indication of patients pain level and their ability to understand and operate the pump effectively
- The pump settings should be checked against the prescription chart.

2.22.3. Post Operative and Opioid Induced Nausea and Vomiting

2.22.3.1. All patients receiving opioids should be prescribed regular or on demands anti emetics and patients should be questioned as to this symptom and early treatment initiated as per RCHT guidelines.

2.22.3.2. Patients may receive more than one type of antiemetic if their symptoms are severe and the Acute Pain team may need to be contacted for advice.

2.22.4. Prescribing

2.22.4.1. Only the medical practitioner (usually the anaesthetist) who has decided that the patient is suitable for a PCA should prescribe the opiates in the accepted format for RCHT

- Total dose in mg in total volume
- Bolus dose

- Lockout time
- Additional loading bolus if required.
- Appropriate reversal agent for respiratory depression (naloxone) and instructions to give at agreed respiratory rate as per RCHT guidelines and algorithms

2.22.4.2. Prescribing will be on the EPMA system, both Morphine and Fentanyl PCA's will be available as standard. .

2.22.4.3. A warning sticker should always be placed on the prescription chart clearly stating that iv opioids are in progress and no other parenteral opioids should be given whilst in progress

2.23. National patient Safety Agency Rapid Response Report

2.23.1. The NPSA received reports of 5 deaths and over 42,000 dose related patient safety incidents between 2005 and 2008, many involved incorrect or unsafe doses of medicines , particularly opioids (not epidural specific)

2.23.2. Every member of the healthcare team has a responsibility for ensuring the prescribed dose is safe for the patient and to take care to avoid errors particularly when dose conversions or a change in formulation is required.

2.23.3. Following analysis of these incidents the NPSA issued a Rapid response report, ***Reducing Dosing Errors with Opioid Medicines, NPSA* 2008**, with recommendations that are applicable to all health professionals involved in prescribing, dispensing or administering opioid medicines:

- Confirm any recent opioid dose, formulation and frequency
- Ensure dose increments are safe and appropriate and the patient is monitored closely
- Ensure they (the staff) are familiar with the correct use of the drug and able to recognise common side effects and symptoms of overdose

2.23.4. The following information gives guidance on prescribing PCA. Morphine is the drug of choice but fentanyl may be used for those patients in whom it is contra indicated.

Table 5 Prescribing Guidance for PCA for Adults >50Kg

Drug	Route	Equipment	Concentration	Bolus	Lockout	Dose Duration
Morphine	iv	IVAC PCAM	1mg/Kg 50mg made up to 50 ml with NaCl 0.9%	1mg (1ml)	5 min	Stat
Fentanyl	iv	IVAC PCAM	10mcg/ml 500mcg made up to 50 ml with NaCl 0.9%	10mcg	5 min	stat

2.23.5. Background analgesia is not commonly recommended due to safety issues:

- In PCA bolus dose only an over sedated patient will stop activating the PCA:
- Background infusions will add to sedation, and are therefore not recommended unless additional monitoring in high dependency areas is available.

2.23.6. Patients who are already on opioid analgesia will require more than the standard dose range, particularly if their oral analgesia has not been taken during the post operative period. They may require a larger bolus dose, a decreased lockout or both.

2.23.7. Seek advice from the pain team.

N.B. If a patient has received per operative intrathecal opioids such as fentanyl or diamorphine then a PCA may still be used provided that adequate monitoring is commenced.
This cannot be recommended where intrathecal morphine has been used due to the late respiratory effects which can occur.

2.24. Oxygen

All patients should be prescribed oxygen as per RCHT guidelines.

2.25. **Administration**

2.25.1. Patients receiving a PCA should have adequate peripheral venous access

2.25.2. Other fluids can be used simultaneously using the correct giving set - excluding blood or specific infusions (insulin etc) with an anti-reflux valve to prevent backtracking of the opioid.

2.25.3. The delivery site should be checked regularly as per RCHT guidelines for care of Intravenous cannulae.

2.25.4. If the patient is moved to another ward then it should be ascertained prior to transfer that the ward is adequately skilled to care for the pump, changes syringes and be able to identify and treat the complications.

2.26. Monitoring

2.26.1. Pink audit forms should be completed for every patient episode for a PCA which enables daily follow up by the acute pain team.

2.26.2. Problems encountered out of hours should be directed to the anaesthetist on call via switchboard, or by contacting theatre 6 (ext 2250) or theatre 7(ext 2262).

2.26.3. Patients with pain problems who may be suitable for PCA should be stabilised by ward staff with intravenous bolus as per guidelines or the acute

pain team contacted within hours when a Pump may be set up.

2.26.4. If there are no available trained staff out of hours to set up the PCA, then the patient should be given intravenous opioids by medical or nursing staff until stable and then maintained on im opioids.

2.27. Contact Details

Acute Pain Team and on call anaesthetists:
Acute Pain Team Mon – Friday 09.00 – 17.00 Bleep 3233

On Call Anaesthetist
For advice: Senior Anaesthetic Trainee on call or maternity on call
For urgent help: Any anaesthetist via switch

2.28. Ward Rounds

RCHT: Daily nurse rounds Mon - Friday
Tues and Thurs am consultant led rounds for advice and referrals
OOH, weekends and bank holidays – on call service only

2.29. Operation of the IVAC PCAM Pump

2.29.1. All staff should have undergone appropriate training where patients are regularly using PCA's

2.29.2. If the IVAC PCAM Pump alarms the cause of the alarm should be noted and silenced appropriately. With some alarms action may be necessary as detailed on the screen.

2.29.3. Do not attempt to use the pump if a fault code appears. Make a note of the fault code number, switch off the pump and send to medical Physics – and notify the Acute Pain Team of malfunction.

2.29.4. The pump must be clearly labelled and and cleaned according to RCHT policy.

2.29.5. Always connect the PCA pump to the AC (mains) power. The batteries will be fully charged if the pump has been connected to Mains (AC) power for at least 24 hours. When fully charged, the batteries will power the pump for approximately 6 hours.

2.29.6. All programmed values are retained following power off or AC failure. If a patient is scheduled to be moved within the hospital e.g. for investigation such as MRI or CT scan etc the patient may need to be disconnected when alternative analgesia may be necessary.

2.30. Disposable PCA Pump

2.30.1. When there is a shortage of IVAC PCAM pumps , disposable PCA pumps may be used when set up by anaesthetists, Recovery staff or Acute Pain service staff.

2.30.2. Please note there are slight differences in lockout time (6 minutes) in comparison to IVAC PCAM These should be used in designated areas only familiar with the pump

2.30.3. Clinical Observations remain the same

2.30.4. Additional Cannulae will be required for fluids

2.30.5. Lockout time is 6 minutes.

2.31. Termination of PCA

2.31.1. The PCA may be discontinued by any member of staff who is competent and prepared to accept responsibility for the change. Consideration should be given to the clinical condition of the patient and the possibility of withdrawal.

2.31.2. Criteria for stopping the PCA include:

2.31.3. The patient is able to take analgesia via an alternative route and this is prescribed

2.31.4. The previous 24 hour PCA opioid usage in mg should be used as the basis for the oral regime. The dose should be doubled and divided into suitable dosing intervals (morphine only).

2.31.5. Patients receiving < 20mg of morphine may be converted directly to either Tramadol or Codeine.

2.31.6. Morphine analgesia (oromorph) should be prescribed on a prn basis and a multi modal approach using paracetamol and NSAID prescribed regularly unless contraindicated.

2.31.7. Alternative analgesia regimes can be used if a patient requires ongoing opioid analgesia with other opioids such as fentanyl patches but advice should be sought from the Acute Pain Team as to the best long term approach.

3. Monitoring compliance and effectiveness

Element to be monitored	Adherence to RCHT guidelines
Lead	Pain service
Tool	Regular audit of the pain service is undertaken along with daily review of complicated cases.
Frequency	See above
Reporting arrangements	The committee reviewing the cases will be the anaesthesia directorate. Cases will be discussed at audit meetings and the details will be recorded in the minutes.
Acting on	See above

recommendations and Lead(s)	
Change in practice and lessons to be shared	Required changes to practice will be identified and actioned within a month. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders

4. Equality and Diversity

4.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the 'Equality, Inclusion & Human Rights Policy' or the Equality and Diversity website.

4.2. Equality Impact Assessment

The Initial Equality Impact Assessment Screening Form is at Appendix 2.

Appendix 1. Governance Information

Document Title	Acute Post-Operative Patient Controlled Analgesia Clinical Guideline V2.0		
Date Issued/Approved:	July 2019		
Date Valid From:	August 2019		
Date Valid To:	August 2022		
Directorate / Department responsible (author/owner):	Anaesthesia and Theatre Directorate Acute Pain Team Lead Clinician Dr Nick Marshall		
Contact details:	Pain Clinic 01872 252792		
Brief summary of contents	Summary of the use of patient administered opioid medication for the treatment of post operative pain and the requirements to deliver this service safely in the ward environment.		
Suggested Keywords:	Post operative pain control Patient controlled administration Intravenous Opioid Therapy.		
Target Audience	RCHT	CFT	KCCG
	✓		
Executive Director responsible for Policy:	Dr Rob Parry, Medical Director		
Date revised:	July 2019		
This document replaces (exact title of previous version):	New document summarizing all aspects of patient administered opioid analgesia necessary for ward delivery incorporating Medical and nursing guidelines		
Approval route (names of committees)/consultation:	Anaesthetic Department		
Care Group General Manager confirming approval processes	Clinical Director: Dr Russell Evans Divisional Manager: Miss Roberta Fuller		
Name and Post Title of additional signatories	*Not Required*		
Name and Signature of Care Group/Directorate Governance Lead confirming approval by specialty and care group management meetings	{Original Copy Signed}		
	Name: Matthew Body		
Signature of Executive Director giving approval	{Original Copy Signed}		

Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet & Intranet	✓	Intranet Only	
Document Library Folder/Sub Folder	Clinical / Anaesthesia			
Links to key external standards	NPSA Royal College of Anaesthesia Guidelines Pain Society of GB and Ireland Guidelines			
Related Documents:	▪ Management of PCA infusions ▪ Intravenous Cannulation ▪ Opioid Prescribing ▪ Control of Infection ▪ Acute Pain Management Scientific Evidence, 2nd/3rd edition 2005,2010 Australian and New Zealand College of Anaesthetists ▪ Brampton W.J. (2006). Postoperative nausea and vomiting (PONV). Chapter 3.5 in Raising the Standard: A compendium of audit recipes for continuous quality improvement in anaesthesia. 2nd edition. Royal College of Anaesthetists, London [online]: Available from: the The Royal College of Anaesthetists website. Accessed on 29 August 2008. ▪ Counsell D. (2006). Efficacy of acute pain management in the postoperative period. Chapter 11.5 in Raising the Standard: A compendium of audit recipes for continuous quality improvement in anaesthesia. 2nd edition. Royal College of Anaesthetists, London [online]: Available from: the The Royal College of Anaesthetists website. Accessed on 29 August 2008. ▪ Lloyd-Thomas, AR, Management of post-operative analgesia; Current opinion in Anaesthesiology 1994; 7:262-6 ▪ Macintyre P.E., Safety and efficacy of patient-controlled analgesia; British Journal of Anaesthesia 2001; 87(1):36-46 ▪ Marshall J and Duncan F (2006) Pain management in the recovery room. Chapter 11.3 in Raising the Standard: a compendium of audit recipes for continuous quality improvement in anaesthesia. 2nd edition. Royal College of Anaesthetists. London. NPSA (2008) Rapid Response Report 05 – Reducing Dosing errors with Opioid			

	Medicines
Training Need Identified?	Yes - competency documents already developed and disseminated and monitored by the acute pain team. The learning and development department have been informed.

Version Control Table

Date	Version No	Summary of Changes	Changes Made by *(Name and Job Title)*
1 Aug 2011	V1.0	Initial version	Dr Nick Marshall
24 June 2019	V2.0	Reformatted into new trust template. Update policy referred to in 2.35	Dr Nick Marshall

Appendix 2. Initial Equality Impact Assessment Form

<table>
<tr><td colspan="6">Name of the strategy / policy /proposal / service function to be assessed

Acute Post-Operative Patient Controlled Analgesia Clinical Guideline V2.0</td></tr>
<tr><td colspan="3">Directorate and service area:
Anaesthesia</td><td colspan="3">New or existing document:
Existing</td></tr>
<tr><td colspan="3">Name of individual completing assessment:</td><td colspan="3">Telephone:
01872 252792</td></tr>
<tr><td>1. Policy Aim*

Who is the strategy / policy / proposal / service function aimed at?</td><td colspan="5">The purpose of this guideline is to provide information for he safe use of patient controlled analgesia</td></tr>
<tr><td>2. Policy Objectives*</td><td colspan="5">To provide information for he safe use of patient controlled analgesia</td></tr>
<tr><td>3. Policy – intended Outcomes*</td><td colspan="5">Appropriate and safe prescription of PCA</td></tr>
<tr><td>4. *How will you measure the outcome?</td><td colspan="5">Monitoring through audit and case discussion at governance meetings.</td></tr>
<tr><td>5. Who is intended to benefit from the policy?</td><td colspan="5">Patients and staff</td></tr>
<tr><td rowspan="3">6a Who did you consult with

b). Please identify the groups who have been consulted about this procedure.</td><td>Workforce</td><td>Patients</td><td>Local groups</td><td>External organisations</td><td>Other</td></tr>
<tr><td>X</td><td></td><td></td><td></td><td></td></tr>
<tr><td colspan="5">Anaesthetic Department</td></tr>
<tr><td>What was the outcome of the consultation?</td><td colspan="5">Acceptance</td></tr>
</table>

7. The Impact
Please complete the following table. **If you are unsure/don't know if there is a negative impact you need to repeat the consultation step**.

Are there concerns that the policy **could** have differential impact on:

Equality Strands:	Yes	No	Unsure	Rationale for Assessment / Existing Evidence
Age		**X**		
Sex (male, female, trans-gender / gender reassignment)		**X**		
Race / Ethnic communities /groups		**X**		
Disability - Learning disability, physical impairment, sensory impairment, mental health conditions and some long term health conditions.		**X**		
Religion / other beliefs		**X**		
Marriage and Civil partnership		**X**		
Pregnancy and maternity		**X**		
Sexual Orientation, Bisexual, Gay, heterosexual, Lesbian		**X**		

You will need to continue to a full Equality Impact Assessment if the following have been highlighted:

- You have ticked "Yes" in any column above and
- No consultation or evidence of there being consultation- this excludes any *policies* which have been identified as not requiring consultation**. or**
- Major this relates to service redesign or development

8. Please indicate if a full equality analysis is recommended.	**Yes**		**No**	**x**

9. If you are **not** recommending a Full Impact assessment please explain why.

Not indicated

Date of completion and submission	24 June 2019	Members approving screening assessment	Policy Review Group (PRG) **APPROVED**

This EIA will not be uploaded to the Trust website without the approval of the Policy Review Group.

A summary of the results will be published on the Trust's web site.