Royal Cornwall Hospitals
NHS Trust

LocSSIP Guideline for: Pain Procedures Undertaken within Pain Intervention Room (Clinical Imaging Department)

V1.0

August 2025

Summary

This guideline outlines the process to be followed for all procedures within the Pain Intervention room (clinical imaging department).

This guidance amalgamates all previous LocSSips for individual procedures within the Pain Intervention room (clinical imaging department). This includes but is not exclusive to:

- Botox; this medication is also used in other specialties, but this only relates to its use in pain.
- Cryotherapy for pain management.
- Epidural Injections and Tunnelled Catheter insertion: Lumbar, Thoracic, Cervical and Caudal.
- Facet Radiofrequency Denervation.
- Intrathecal Administration.
- Lidocaine Infusions.
- Peripheral Nerve Blocks e.g. Suprascapular or genicular nerve blocks Phenol Injections.
- Radiofrequency Lesioning.
- Spinal Injections: Facet Joint, Sacro-Iliac Joint and Nerve Root Blocks Stellate Ganglion Block.
- Sympathectomy.
- Trigger Point Injections.

The guideline has been written because of the need to for organisations to create local safety standards for invasive procedures (LocSSIP) policy in response to high level safety principles identified in the National Safety Standards for Invasive Procedures (NatSSIP).

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

The Trust has a duty under the Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 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 cannot rely on opt out, it must be opt in.

Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 is applicable to all staff; this includes those working as contractors and providers of services.

For more information about your obligations under the Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 please see the Information Use Framework Policy or contact the Information Governance Team.

Royal Cornwall Hospital Trust rch-tr.infogov@nhs.net

1. Introduction

1.1. The Royal Cornwall Hospital Trust is committed to providing high quality patient centred care and a safe environment for all patients undergoing any Pain Intervention / treatment / procedure.

1.2. Personal identifiable data (PID) must be managed in accordance with this policy and commensurate with current legislation, clinical and operational needs, this includes photography, images, voice recordings and video.

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

2. Background

2.1. This guideline is intended to build on the principles outlined in the National Safety Standards for Invasive Procedures to mitigate risk of never events, serious incidents or near misses and provide a process for analysis or learning.

2.2. The purpose of this document is to demonstrate what is required to provide safer care and conform to national standards and recommended safe practices.

2.3. It aims to enhance the existing Pain Services WHO surgical safety checklist (CHA3437).

3. Definitions

3.1. **Botulinum Toxin** is a neurotoxic protein which prevents the release of the neurotransmitter acetylcholine from axon endings at the neuromuscular junction, thus causing flaccid paralysis. This guidance applies to all patients undergoing procedures where botulinum toxin is used to treat painful muscle spasms for e.g. in the back or neck area.

3.2. **Cryotherapy** is a pain treatment that uses the method of localised freezing temperatures to deaden an irritated nerve.

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3.3. **Epidural Injections:** The epidural space is situated between the spinal cord and the vertebrae. An injection containing steroid medicine usually together with an anaesthetic can be inserted into this space to reduce inflammation around the spinal cord and providing pain relief.

3.3.1. The lumbar region is the lower part of the spine. Medical procedures such as a lumbar puncture involves inserting a needle into the spinal canal to collect cerebrospinal fluid for diagnostic testing.

3.3.2. The Thoracic spine is the longest and most complex region of the spine connecting the cervical spine above to the lumbar spine below.

3.3.3. The cervical spine, or neck, begins at the base of the skull and connects to the thoracic region of the spine.

3.3.4. The Caudal hiatus is a small opening at the base of the spine that permits easy access to the epidural space. Injecting into this space using the caudal hiatus is very safe, comfortable and effective.

3.3.5. A tunnelled epidural catheter is a very thin flexible tube that is implanted into the spine. Through it you can receive ongoing doses of medication without the need of numerous injections. This would most commonly be used for lumbar or thoracic epidural catheters.

3.4. **Facet Denervation:** This procedure may also be known as facet rhizolys radiofrequency ablation or radiofrequency neurotomy. Radiofrequency denervation is a treatment which uses radiofrequency waves to block nerves around the facet joints in the spine which are causing pain. This can be caused by arthritis or Injury.

3.5. **Intrathecal Administration:** Intrathecal administration is a route of administration for drugs via an injection into the spinal canal, or into the subarachnoid space so that it reaches the cerebrospinal fluid (CSF). It is useful in spinal anaesthesia, chemotherapy and pain management. Within Pain Services intrathecal catheters or pumps are implanted for symptom management of complex pain management patients or palliative care patients.

3.6. **Lidocaine Infusions:** A Lidocaine Infusion is when local anaesthetic is given by a pump over a period of time into a vein. It is prescribed to patients who have chronic widespread pain.

3.7. **Peripheral Nerve Blocks:** Peripheral nerve blocks are injections of local anaesthetic +/- steroid, to numb the nerves supplying a certain part of the body such as shoulder/knee etc. The aim is to provide temporary or long-lasting relief.

3.8. **Phenol Injections:** Phenol is used to treat pain in a small number of painful conditions when all other avenues have proven unsuccessful. Phenol injections are used to deliberately destroy the nerves known to send pain signals. These nerves are usually restricted to those that are involved in sensation. This can result in long-term pain relief.

3.9. **Radiofrequency Lesioning:** This is a minimally invasive procedure which uses electrical impulses to destroy damaged nerves or tissues that send pain signals to the brain.

3.10. **Spinal Injections:**

3.10.1. The facet Joints are the connections between the bones of the spine. The Sacro-iliac Joint connects the hip bones to the sacrum. Nerve roots are the short branches of the spinal nerve which exit the spinal cord.

3.10.2. Local anaesthesia and steroids are injected into these areas to help relieve pain caused by compressed and inflamed nerves. For diagnostic procedures local anaesthetic alone may be used.

3.11. **Stellate Ganglion block:** The stellate ganglion is a collection of nerves found at the level of the sixth and seventh cervical vertebrae.

A Stellate ganglion block is an injection of local anaesthetic into these nerves that can help relieve pain in the head, neck, upper arm and upper chest. It can also help increase circulation and blood supply to the arm.

3.12. **Sympathectomy Injections** contain a local anaesthetic and an anti-inflammatory steroid. They are injected at the junction of sympathetic nerves which control the affected area. The solution blocks pain signals being sent to the brain

3.13. **Trigger Point Injections:** A trigger point is an area of soft tissue on the body which when pressed causes pain. This is often muscle which does not relax after contracting therefore a knot or tight band of muscle is formed. A series of injections may be required containing a steroid and local anaesthetic or combination of the two to treat the pain.

4. Governance and Audit

4.1. The Anaesthetics, Theatres and Critical Care (ACCT) governance group will monitor the implementation of this guideline and commission a bi-annual audit of adherence.

4.2. Patients must be assessed prior to the procedure and informed consent given. This is necessary even if a repeat procedure on a different occasion.

4.3. The WHO checklist will have an ad hoc audit undertaken by the Trust's Safer Surgery team.

5. Documentation of Pain Intervention procedures within clinical imaging department

5.1. The procedure will be documented within the patient's medical record and Pain Relief Procedures form (CHA 3379). This document incorporates the process undertaken as part of the WHO safer surgery checklist.

5.2. Procedure Specific patient agreement forms and electronic versions are available in addition to standard adult consent form 1 (CHA 2333). A copy of the consent must be given to the patient.

6. Workforce

6.1. Minimum workforce requirements for these invasive procedures are as follows:

6.1.1. A suitably trained professional to undertake the procedure, i.e. Pain/Anaesthetic Consultant.

6.1.2. A radiographer is required.

6.1.3. Assistant to the operator: A skilled registered practitioner should be available to check and draw up drugs in a safe and sterile manner. The use of Health Care Assistants is not considered adequate as assistance for the operator. If sedation is required, the operator assistant should be a trained theatre ODP.

6.1.4. A theatre assistant or HCSW within the procedure room to monitor the patient. They should not have any other responsibilities.

6.1.5. The post procedure area (recovery area) should be fully equipped and appropriately staffed. Resuscitation equipment, trained staff and facilities must be immediately available should this be required. There should be adequate number of staff available to admit, care for and discharge a full list of patients.

6.2. All staff without appropriate competency will be supervised. The Pain Consultant/clinician will be the primary point of contact for the patient for medical opinion.

6.3. It is the responsibility of each member of staff i.e. registered practitioners/registered nurses/ODP involved in the procedures outlined to work within their scope of competence under the terms of their professional body i.e. the Nursing and Midwifery Council (NMC) 'Code of Professional Standards for Conduct'. Health and care Professions Council (HCPC) i.e. Standards of Conduct, Performance and Ethics.

6.4. It is the responsibility of each member of staff to comply with these set of standards and escalate any concerns regarding competence. Incidents, near miss must be reported in the Datix system. All staff will communicate and work as a team and speak out if they have any concerns underpinned by undertaking annual training i.e. WHO, Patient Safety (human factors) Freedom to Speak up on ESR.

7. Training

7.1. Clinicians performing the intervention should have sound knowledge and experience relevant to the interventional pain procedure. They should also be able to demonstrate their knowledge on the applied anatomy relevant to the interventional procedures and should be able to recognise radiographic anatomy. They should understand the principles of radiation safety if using fluoroscopy.

7.2. Regular simulation training should be provided for all staff to ensure appropriate competency to deal with emergency procedures within the pain procedures theatre.

7.3. The assistant to the operator should be skilled in Immediate Life Support (ILS). All assistants should be appropriately trained nursing or theatre staff (FPM 2020).

8. Scheduling and List Management

8.1. These procedures will be performed as necessary when safe to do so in an appropriate environment, with adequately trained staff available. This should comply with occupational and safety standards.

8.2. The procedure room must conform to DHSC building standards,17–19 including standards on airflow, filtration, surface finishes and ceiling height.

9. Handovers and Information Transfer

9.1. **On Admission**: The admissions nurse will complete the necessary admission paperwork with the patient. The Pain Relief Procedures document (CHA 3379) should be commenced, this will note any medications, allergies, special considerations and also includes a pre-operative checklist. Any anomalies at this time will be highlighted by the admitting nurse to the Pain Consultant/Clinician. The patient will be provided with a wrist band (identity band) with accurate details to identify them and match them to their care.

9.2. **Prior to commencing the list**, all staff should take part in a Team Brief: any safety issues should be shared by the operator. Each patient should be discussed in list order from the perspective of the operator, operator's assistant, and other key personnel.

9.3. **Before each procedure** all team members will verbally confirm that the patient's identity is correct.

The patient will confirm that they understand the nature of the procedure to be performed, the laterality (site of procedure, often marked), are fasted if applicable, allergies are noted and will verbally confirm that they have given written consent or eConsent which is correct. This includes completion of the WHO pain intervention safety checklist CHA 3437 and forms part of the Sign In and Time out if completed at the same time.

9.4. Ionising Radiation Medical Exposure Regulations (IRMER) 2000 requirements must be met prior to the procedure; clinical evaluation, checking pregnancy status of patient when applicable.

9.5. **Post procedure**: on completion of the procedure the Pain Consultant/clinician verbally confirms with the whole team the name and side of the procedure performed and disposes of any sharps safely. This is documented and signed on the WHO pain intervention safety checklist CHA 3437 (Sign out).

9.6. **Before discharge**: Patients' limbs should be assessed for numbness and/or weakness if appropriate. Unexpected significant limb weakness, sensory loss or headache may require an overnight stay.

9.7. **On discharge**: A telephone contact number must be provided to the patient to enable them to report any acute complication such as headache, fever, prolonged numbness/weakness or urinary retention.

10. Procedural Verification and Site Marking

10.1. The team involved in the procedure will participate in the combined safety check. The following information should be confirmed and agreed by the team with the involvement of the patient where possible.

10.2. A STOP-CHECK (Time out) will be agreed if applicable at the sign in stage of the WHO safety checklist.

11. Safety Briefing

11.1. A debriefing should be undertaken at the end of the list and recorded by the responsible practitioner in the patients notes: The debriefing should contain any issues which have arisen, or problems such as equipment difficulties, or lessons learned and a Datix should be completed if appropriate.

11.2. If a patient has a cannula: this must be noted on the day case cannula care plan procedure form and verbally handed over to the recovery team.

12. Sign In

See section 9.3.

13. Time Out

See section 9.3.

14. Prevention of Retained Foreign Objects

Needles used in the procedure are safely disposed of by Pain Consultant/Anaesthetist ensuring all used are accounted for- see section 9.5.

15. Sign Out

15.1. The patient must be assessed before and after the procedure to determine the diagnostic/therapeutic value of the procedure.

15.2. Post procedural care should be agreed with the patient and documented on the Pain Relief Procedures form with the patient (CHA 3379). Written post op instruction will be given to the patient as appropriate, other information links will be sent to GP and copied to patient in post procedure correspondence. Follow up care will be agreed with the patient.

16. Debriefing

16.1. See section 11.1.

16.2. All members of the team must feel comfortable to contribute to the discussion and raise any queries or concerns

16.3. The Pain Service NatSSIPS audit must be completed and results collated.

17. Dissemination and Implementation

17.1. The document is available on the document library. Significant updates will be communicated via Trust wide email.

17.2. Implementation of the policy will be via Trust wide communication and supported by appropriate training for the relevant members of staff.

18. Monitoring compliance and effectiveness

Information Category	Detail of process and methodology for monitoring compliance
Element to be monitored	The effectiveness and safety of procedures undertaken by the Pain Services within the clinical imaging department.
Lead	Dr Alex Doyle – Consultant in Pain Management and Anaesthesia.
Tool	NatSIPP form debrief which acts to review the safety of the procedure list. Any emerging trends, areas of failure within the Pain Services list will be discussed and rectified.
Frequency	This is monitored for each procedure list, a report completed monthly and shared quarterly.
Reporting arrangements	The report will be shared with the ACCT Governance Huddle.
Acting on recommendations and Lead(s)	Pain Services Governance lead, in conjunction with ACCT Governance lead and theatre matron/service lead appropriate to the findings.
Change in practice and lessons to be shared	Change in Practice will be shared through the pain team and wider Trust if appropriate via Team Brief, Governance Days and email.

19. Updating and Review

19.1. The document review process is managed via the document library. Document review will be every three years unless best practice dictates otherwise. The author remains responsible for the policy document review. Should they no longer work in the organisation or in the relevant practice area then an appropriate practitioner will be nominated to undertake the document review by the designed director.

19.2. Revision activity will be recorded in the versions control table to ensure robust document control measures are maintained.

20. Equality and Diversity

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

20.2. Equality Impact Assessment

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

Appendix 1. Governance Information

Information Category	Detailed Information
Document Title:	LocSSIP Guideline for: Pain Procedures Undertaken within Pain Intervention Room (Clinical Imaging Department) V1.0
This document replaces (exact title of previous version):	LocSSIP Guideline for: Botulinum Toxin Injection - Undertaken within Pain Intervention Room (Clinical Imaging Department) V1.0. LocSSIP Guideline for: Cryotherapy V1.0. LocSSIP Guideline for: Epidural Injections and Tunnelled Catheters: Lumbar, Thoracic, Cervical and Caudal V1.0. LocSSIP Guideline for: Facet Denervation V1.0. LocSSIP Guideline for: Intrathecal Administration V1.0. LocSSIP Guideline for: Lidocaine Infusions V1.0. LocSSIP Guideline for: Radiofrequency Lesioning V1.0. LocSSIP Guideline for: Spinal Injections: Facet Joint, Sacro-iliac Joint and Nerve Root Block V1.0. LocSSIP Guideline for: Stellate Ganglion Block. LocSSIP Guideline for: Sympathectomy V1.0. LocSSIP Guideline for: “Trigger point injections” V1.0.
Date Issued/Approved:	August 2025
Date Valid From:	August 2025
Date Valid To:	August 2028
Directorate/Department responsible (author/owner):	Sarah Medlicott, Lead Pain Nurse
Contact details:	01872 254503
Brief summary of contents:	Process to be followed for all interventional pain procedures undertaken in the Pain Intervention room (clinical imaging department).
Suggested Keywords:	Pain, LocSSIP, botulinum toxin injection, botox, cryotherapy, epidural, intrathecal, facet denervation, lidocaine infusion, radiofrequency lesioning, spinal

Information Category	Detailed Information
	injections, sacro-iliac joint injections, stellate ganglion block, sympathectomy, trigger point injection, nerve root block.
Target Audience:	**RCHT:** Yes **CFT:** No **CIOS ICB:** No
Executive Director responsible for Policy:	Chief Medical Officer
Approval route for consultation and ratification:	Pain Services MDT. ACCT Care Group Governance Meeting. ACCT Care Group Board. Patient Safety Team to approve amalgamation of all LocSSIPs.
General Manager confirming approval processes:	Doug Riley
Name of Governance Lead confirming approval by specialty and care group management meetings:	Suzanne Barber, ACCT Governance Lead
Links to key external standards:	British Pain Society and Faculty of Pain Medicine of the Royal College of Anaesthetists (2020) *Standards of Good Practice for Spinal Interventional Procedures in Pain Medicine*. Available from: BPS_and_FPM_Spinal_Intervention_Guidelines_PDF_Final_May_2020_2_new_ISBN.pdf [Accessed 15/7/25] Faculty of Pain Medicine (2021) Core Standards for Pain Management Services in the UK 2nd Edition. Section 7.3 Interventional Techniques in Pain Management. Available from: FPM-Core-Standards-2021.pdf [Accessed 15/7/25] Safety Practices for Interventional Pain Procedures (2025) International Pain and Spine Intervention Society (IPSIS). Available from: Safety Practices for Interventional Pain Procedures [Accessed 15/7/25] Revised National Safety Standards for Invasive Procedures (NatSSIPs2)(2023). Available from The National Safety Standards for Invasive Procedures (NatSSIPs) | Centre for Perioperative Care.

Information Category	Detailed Information
	[Accessed 15/7/25]
Related Documents:	WHO Surgical safety checklist CHA 3437. Pain Relief Procedure CHA 3379. Consent Form/eConsent.
Training Need Identified?	No
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet and Intranet
Document Library Folder/Sub Folder:	Clinical/Pain

Version Control Table

Date	Version Number	Summary of Changes	Changes Made by
Jan 2025	V1.0	Initial issue Amalgamation of all previous specific LocSSIP documents: Pain Procedures Undertaken within Pain Intervention Room (Clinical Imaging Department). These procedures are specified in the summary. Links to relevant external standards added and appropriate standards amended to ensure we can evidence meeting them particularly workforce and training requirements.	Sarah Medlicott, Lead Pain Specialist Nurse

All or part of this document can be released under the Freedom of Information Act 2000.

All Policies, Strategies and Operating Procedures, including Business Plans, are to be kept for the lifetime of the organisation plus 6 years.

This document is only valid on the day of printing.

Controlled Document.

This document has been created following the Royal Cornwall Hospitals NHS Trust The Policy on Policies (Development and Management of Knowledge Procedural and Web Documents Policy). It should not be altered in any way without the express permission of the author or their Line Manager.

Appendix 2. Equality Impact Assessment

Section 1: Equality Impact Assessment (EIA) Form

The EIA process allows the Trust to identify where a policy or service may have a negative impact on an individual or particular group of people.

For guidance please refer to the Equality Impact Assessment Policy (available from the document library) or contact the Equality, Diversity, and Inclusion Team rcht.inclusion@nhs.net

Information Category	Detailed Information
Name of the strategy/policy/proposal/service function to be assessed:	LocSSIP Guideline for: Pain Procedures Undertaken within Pain Intervention Room (Clinical Imaging Department) V1.0
Directorate and service area:	Pain Services, ACCT
Is this a new or existing Policy?	New
Name of individual completing EIA (Should be completed by an individual with a good understanding of the Service/Policy):	Sarah Medlicott, Lead Pain Specialist Nurse
Contact details:	01872 254503

Information Category	Detailed Information
1. Policy Aim - Who is the Policy aimed at? (The Policy is the Strategy, Policy, Proposal or Service Change to be assessed)	To ensure safe and appropriate guidance for staff involved in pain procedures undertaken within the pain intervention room in the clinical imaging department.
2. Policy Objectives	Process to be followed for procedures within the Pain Intervention room (clinical imaging department) ensuring safe and effective use
3. Policy Intended Outcomes	To ensure all staff are following an accepted safe method of injection
4. How will you measure each outcome?	NatSIPP form debrief which acts to review the safety of the procedure list
5. Who is intended to benefit from the policy?	Staff, patients, RCHT

Information Category	Detailed Information
6a. Who did you consult with? (Please select Yes or No for each category)	• Workforce: Yes • Patients/visitors: No • Local groups/system partners: No • External organisations: No • Other: No
6b. Please list the individuals/groups who have been consulted about this policy.	**Please record specific names of individuals/groups:** Pain Services. ACCT Governance Huddle. Patient safety team for agreement to amalgamate all previous LocSSIPS.
6c. What was the outcome of the consultation?	Document approved.
6d. Have you used any of the following to assist your assessment?	**National or local statistics, audits, activity reports, process maps, complaints, staff, or patient surveys:** No.

7. The Impact

Following consultation with key groups, has a negative impact been identified for any protected characteristic? Please note that a rationale is required for each one.

Where a negative impact is identified without rationale, the key groups will need to be consulted again.

Protected Characteristic	(Yes or No)	Rationale
Age	No	No impact
Sex (male or female)	No	
Gender reassignment (Transgender, non-binary, gender fluid etc.)	No	
Race	No	
Disability (e.g. physical or cognitive impairment, mental health, long term conditions etc.)	No	
Religion or belief	No	

Protected Characteristic	(Yes or No)	Rationale
Marriage and civil partnership	No	
Pregnancy and maternity	No	
Sexual orientation (e.g. gay, straight, bisexual, lesbian etc.)	No	

A robust rationale must be in place for all protected characteristics. If a negative impact has been identified, please complete section 2. If no negative impact has been identified and if this is not a major service change, you can end the assessment here.

I am confident that section 2 of this EIA does not need completing as there are no highlighted risks of negative impact occurring because of this policy.

Name of person confirming result of initial impact assessment: Sarah Medlicott, Lead Pain Specialist Nurse

If a negative impact has been identified above OR this is a major service change, you will need to complete section 2 of the EIA form available here:
Section 2. Full Equality Analysis