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1. **Aim/Purpose of this Guideline**

1.1. All healthcare professionals have a duty to set a standard by which to practice. With a focus on clinical effectiveness and evidence based care theatre staff must be able to demonstrate the ability to audit care and theatre practice. The care that is delivered and improvements in practice must be based on evidence and best practice guidance.

1.2. The aim of this policy is to outline the standards of care that must be delivered to each individual patient to ensure a high quality of care is provided to patients entering all Trust Operating Theatres.

1.3. **Objectives**

- To ensure that a standard of care is delivered to each individual that is equitable and fair.
- To identify the standards of care to be delivered to patients through all the areas within the operating theatres i.e. anaesthetic room, Operating Theatres and the Post Anaesthetic Care Unit.
- To enable auditing of theatre practice and patient care throughout all areas.
- To ensure all staff are aware of standards of care to be delivered to patients whilst in the Operating Department.
- To provide information to all staff of the departments expectation of the standards of care to be delivered to all patients.

1.4. **Scope**

1.5. These standards of care will apply to all Operating Theatres across Royal Cornwall Hospital Trust sites.

1.6. All new members of staff will receive an electronic copy of the standards applicable to the area they will work in. All staff will be able to access the care standards via desktops in operating departments.

2. **The Guidance**

The guidance is contained in the following sections as detailed in the table of contents.

3. **Monitoring compliance and effectiveness**

3.1. Practice against the set standards will be reviewed monthly for all theatre suites and reported at the Clinical Matron meeting.

3.2. Overall performance against the standards will be included in the interdivisional Performance Assurance Framework with overview and exceptions tabled at monthly Divisional Governance Management Meeting.
<table>
<thead>
<tr>
<th>Element to be monitored</th>
<th>Practice compliance against all practice standards will be monitored</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lead</td>
<td>Theatre Manager / Deputy Managers</td>
</tr>
<tr>
<td>Tool</td>
<td>The revised theatre safety audit tool will be used to monitor compliance monthly. Each senior auditor will assess practice observed at each audit Attach the tool to the policy or no one will know what you are monitoring.</td>
</tr>
<tr>
<td>Frequency</td>
<td>Each member of the theatre senior team will audit 10 observations of practice each month The observations will be submitted to the Divisional Nurse by the 2nd of the following month for collation and reporting at Theatre Management Group Compliance with the WHO SSC standard 16 will be reported monthly to TMG and TMCG</td>
</tr>
<tr>
<td>Reporting arrangements</td>
<td>DGMM monthly, TMG monthly TMCG monthly. Responses and actions agreed will be recorded in meeting minutes</td>
</tr>
<tr>
<td>Acting on recommendations and Lead(s)</td>
<td>It will be the responsibility of the Divisional Nurse to action any recommendations from the report and report back to DGMM, TMG on outcomes</td>
</tr>
<tr>
<td>Change in practice and lessons to be shared</td>
<td>This document consolidates and defines current practice, no changes to current practice are required. The documentation implementation will be led by the theatre managers in each area. All staff will have discussions on the local practice standards at yearly IPR. Any shortfalls by individuals identified will be dealt with by the appropriate manager in line with trust policy. Lessons learned will be shared with all stakeholders at theatre safety briefings and theatre managers meeting.</td>
</tr>
</tbody>
</table>

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, Diversity & 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.

5. **Equality and Diversity**
   5.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the ‘Equality, Diversity & Human Rights Policy’ or the Equality and Diversity website.

5.2. **Equality Impact Assessment**
The Initial Equality Impact Assessment Screening Form is at Appendix 2.
Post Anaesthetic Care Theatre Standards

_PACU Standard No 1 - Transfer of patients from the operating theatre to the post anaesthetic care unit (PACU)_

**Standard Statement:** Staff will ensure the safety and dignity of the patient during the transfer from theatre to PACU post operatively, and ensure full handover takes place.

**Method:** Patient handover from theatre to the Post-Aneasthetic Care Unit/ Recovery area

- Before transfer, the anaesthetist should be satisfied that the PACU/recovery area staff are competent and able to take responsibility for the patient.

- Recovery practitioners must be competent in assessing the patient’s condition including: vital signs, intermediate life support (AAGBI 2010), intravenous medicines administration, assessment of homeostasis, patient-controlled analgesia, epidural anaesthesia, sedation and the effective management of pain.

- An appropriate qualified member of the perioperative team should escort the patient with the anaesthetist.

**Anaesthetist Handover to PACU Staff**

- Patient's name, date of birth, and theatre they are being transferred from.
- The ward the patient is scheduled to return to.
- Planned and actual procedure(s) performed, with site and side if relevant, and surgical course.
- The type of anaesthesia used, or combination of anaesthesia such as general anaesthetic, regional block, analgesia, anti-emetics.
- The duration of anaesthetic, if appropriate.
- Details of any local infiltration to the wound, including local anaesthetic agent, strength and dose administered.
- Release times for analgesic filtration devices.
- Release times for autologous blood collection devices (in particular where local anaesthetic infiltration has also occurred).
- Post-operative plan of care for rectus sheath catheter boluses.
- Site and type of local block, drug used and total amount used, time of administration and anticipated duration of action, inspection of the insertion site.
- Patency of intravenous access
- Intraoperative temperature and any warming devices used
o Postoperative oxygen requirements in percentage and litre values and mode of delivery with appropriate drug prescription (EPMA) completed.

o Patient prescription documents (EPMA).

o The Anaesthetic Chart.

o Intravenous fluid documents, if appropriate.

o Intravenous pain relief given.

o Type of dressing, wound closure and drain (including the method used to secure and position).

o Presence of stoma / urinary catheter.

o Any allergies.

o Whether there is a need for an interpreter, carer or parent to assist in patient care and the arrangements that are in place for contacting such individuals. Ideally this should be organised prior to the patient entering PACU.

o Whether the patient has any personal items such as dentures, spectacles or hearing aids that must accompany the patient on transfer.

o Any item of clothing that may have been removed, and details of whether the patient was told in advance that this would happen.

o Relevant medical history (e.g. the presence of a pacemaker).

o Any communication difficulties (e.g. hearing loss, or partially sighted).

o Skin condition and integrity or pressure areas.

o Position of diathermy plate, if relevant.

o Care plans e.g. urinary catheter, cannula, CVP etc.

o Any other information that is specific to the patient.

o Any specific security needs, such as a patient who is serving a custodial sentence.

o Release times for analgesic filtration devices.

- Recommendations for Standards for Monitoring during Anaesthesia and Recovery 2007 AAGBI
**PACU Standard No 2 - Post-Anaesthetic Recovery Care of the Adult Patient in the Post Anaesthetic Recovery Unit.**

**Standard Statement:** Staff will ensure the safety and dignity of the patient during the post anaesthetic care phase and ensure full handover to ward area takes place

- The PACU is a specialist clinical area – therefore recovery practitioners must possess the competencies to provide safe and effective care without direct supervision. The practitioner must understand the implications of the surgery the patient has undergone and the complications which can be expected. When critically ill patients are managed in the recovery unit, the primary responsibility for the patient lies with the critical care team e.g. the anaesthetist for that patient, or ITU anaesthetist. The standard of nursing and medical care should be equal to that within the critical care unit.

- Recovery practitioners must be competent in advanced airway management and in managing a patient with a laryngeal mask airway insitu. The removal of the endotracheal tube is the responsibility of the anaesthetist. The anaesthetist can delegate removal of an endotracheal tube to a non-medical recovery practitioner who has received validated training for the task and is deemed competent to perform the duty. Training and assessment of competence must be documented.

- No fewer than two PACU trained registered staff should be present in the recovery unit when there is a patient who does not fulfill the criteria for discharge,

**Preparation of the Recovery Unit**

Everything must be checked, prepared and ready before the patient arrives in the unit. At the beginning of each shift check that:

- The adult and paediatric crash trolley, the defibrillator and line trolley has been checked
- Waters bags are working and with a mask available and a selection of face masks of various sizes available
- Check cardiac monitors are working together with leads and appropriate blood pressure cuffs and probes
- Oxygen flow meters are working.
- Suction is working and fitted with tubing and yankaur – suction catheters available with gloves
- Disposable items are available including a selection of airways, laryngeal connectors (‘T’ pieces), vomit bowls, cannula bungs, gauze, cotton wool, syringes and sticky tape
- Patient observation charts are available to include NEWS, and neurological observation chart and any appropriate care plan.
- Sharps and rubbish containers are available
- Various sizes of unsterile rubber gloves are available
- Alarm bells are working to call for help
- All drug cupboards are restocked together with IV and irrigation fluids
- Good supply of pillows, blankets and linen available together with warm touch heater and blankets, and a supply of incontinence pads

- IV drip poles, 1 per bay
- Ensure all ceiling lights are working
- Ensure recovery unit has been cleaned and damp dusted
- Check refrigerator and record temperature
- Check anaesthetic machine (if applicable)
- Ensure portable oxygen cylinders are available with adequate oxygen
- Check patient transfer box and portable suction
- Check availability of PCA, epidural and IV pumps
- Ensure controlled drugs are checked on a twice daily basis
- BM boxes checked daily
- Haemacue checked daily
- Each bay checked for hand gel, tissues, plastic aprons, gloves and any other general items required.

(Hartfield, A et al 1996)

- Patients must be kept under clinical observations at all times and vital signs recorded. The frequency of observations will depend on the stage of recovery, nature of surgery and clinical condition of the patient. The Association of Anaesthetists of Great Britain and Ireland (AAGBI, 2002) recommend the recording of:
  - Level of consciousness
  - Haemoglobin oxygen saturation and oxygen administration
  - Blood pressure
  - Respiratory rate
  - Heart rate and rhythm
  - Pain intensity at rest and on movement
  - Fluid balance
  - Medicines administered
  - Temperature, urinary output, central venous pressure, end tidal CO2, surgical drainage – depending on circumstance

- Each patient must be assessed on admission and re-assessed as necessary following ABC protocol (See Appendix 5); assessment must include using pressure sore risk calculator and National Early Warning System (NEWS) score. Patients with lower limb fractures to follow specific pressure ulcer prevention policy (RCHT 2012).
- Naloxone injection to reverse over sedation and opioid-induced respiratory depression should be available in all locations where diamorphine and morphine are stored.
- Patients must not be returned to the ward until emesis and post-operative pain is optimally managed and the patient is comfortable. There should be a simple pain assessment tool incorporating a numerical (eg: 0-10) or descriptive (mild, moderate, severe) scale.
Appendix 5 ABC Assessment Protocol

On admission to the recovery unit immediately check the following in order:

A = Airway
- Ensure a clear airway, and the patient is breathing – air passage is quiet and the air moves freely in and out
- Use suction if required and if necessary ensure airway is in situ
- Administer oxygen via a face mask or laryngeal airway.
- Begin with 10 litres and titrate with pulse oximetry

B = Breathing
- Check that the chest is moving, equally and bilaterally and air is moving in and out of the patients’ mouth. Measure and record respiration’s 5, 10 and 15 minutely – titrate as appropriate
- Look for any signs of cyanosis and ensure pulse oximetry is above 95%

C = Circulation
- Commence cardiac monitoring
- Measure and record blood pressure, pulse rate, 5, 10 and 15 minutely – titrate as appropriate
- Ensure adequate perfusion and peripheral return from limbs, monitor temperature

D = Drugs, drips and drains
- Note drugs given in theatre, especially analgesics which may affect the patients breathing
- Check for patient allergies and what drugs will be required in recovery especially antibiotics and analgesics
- Note IV fluids in progress and check fluids given in theatre including crystalloid, colloids and blood. Check cannula, central and arterial line sites are all running freely
- Note drain tubes; with what and how fast they are draining – mark drain level with date and time
- Ensure urinary catheter is draining and if necessary measure

E = Extras
- If necessary monitor blood glucose levels
- Plaster checks
- Check pulses following arterial surgery
- Check circulation to graft sites
- Monitor analgesia

(Hartfield et al 1996)

- Theatre staff will assist in the application of the oxygen delivery system and full monitoring as required
- The anaesthetic assistant will handover any relevant information concerning the patient to the Designated PACU staff member
• The scrub practitioner should handover any relevant information regarding the surgical procedure etc to the PACU practitioner, any property to the patient should also be transferred to PACU

• All relevant documentation should accompany the patient and should be completed

• Other relevant patient care details such as pressure are problems, known skin breaches or adverse reactions must be recorded in the peri-operative document and handed over to PACU for communication to the ward staff

• The theatre staff will sign the perioperative document on completion of handover

**Post-anaesthetic care of the paediatric patient**

• Children will be recovered in a segregated PACU/recovery area with provision for parents to join them in the unit when appropriate.

• There should be available a full range of face masks, breathing systems, airways, nasal sponges and tracheal tubes. Monitoring equipment should include a full range of non-invasive blood pressure cuffs and small pulse oximeters.

• There should be access to the advice of a paediatric nurse.

• Paediatric postoperative pain should be managed effectively using pain assessment tools.

**Additional care of the “unwell” patient in PACU**

• When patients are unwell in recovery and the original operating list remains ongoing, the operating surgeon and anaesthetist must be informed. Where they are unable to send a deputy, the on call registrar should be called.

• The theatre coordinator should be informed at the earliest opportunity and should assess the current status of all lists to facilitate rapid return to theatre and appropriate deployment of staff and equipment if required.

• Where patients are unwell in recovery and the list has finished (inside or outside normal operating hours) the on call registrar should be contacted. They should prioritise the patients needs alongside other emergencies and will be responsible for informing the consultant if required.

• The responsible consultant / operating surgeon should be informed but may not be able to attend.

• Out of hours the on call registrar for general surgery is the first point of contact for unwell vascular, GI and breast patients.

• There may be an on call urology registrar (some days only) who would be the first point of contact when on duty. Out of hours emergencies for urology patients should be managed by contacting both the on call general surgery SHO and the on call urology consultant. The on call general surgery registrar is expected to behave in a professional manner and assist absolute emergencies if required for urology patients.

Compliance – 100%

Exceptions – None
PACU Standard No 3 - Maintenance of airway in the unconscious / semiconscious / conscious patient.

Standards Statement: On admission each patient in PACU will have their airway, respiratory rate and oxygen saturation level monitored until the patient is able to safely maintain their own airway without intervention.

Method

- Head tilt, chin lift and jaw thrust
- Oropharyngeal airway (Guedal airway).
- Laryngeal mask airway. (LMA)
- Nasopharyngeal airway.

Compliance 100%

Exceptions None

Interventions

- Look for chest and abdominal movement. Listen and feel for air flow at the mouth and nose.
- Monitor saturation’s. Monitor respiratory rate and rhythm.
- Administer oxygen.
- Recognise airway obstruction. Noisy breathing is obstructed breathing.
- If required suck out mouth and pharynx. Yanker sucker.
- Take care not to pull the LMA past the teeth, this may cause damage.
- Check to see no residual secretion remains in the oral cavity.
- Place the oxygen mask onto the patients face.

Reference


Oxford University Press
**PACU Standard No 4 - Monitor the breathing of the postoperative patient.**

**Standard statement:** On admission into PACU all patients will be monitored with a pulse oximeter and will have an O2 saturation reading of > 96% with or without oxygen, with a normal respiratory rate and pattern.

**Method**

- Place oximeter on patients finger on admission into PACU.
- Count respiratory rate on admission into PACU.
- Note the rhythm of patients respiration's on admission into PACU.
- Listen to the patient's breath sounds as soon as a problem is identified.

Compliance 100%

Exceptions: Known underlying disease process.

**Interventions**

- Administer oxygen as required by the patient’s condition.
- Use suction catheter if required to remove excess secretions.
- Watch airway and chest movement.
- Look for signs of cyanosis and hypoxia.
- Listen to the patient’s chest.
- Record respiratory rate and rhythm.
- Encourage your patient to cough and expectorate.
- Position your patient in an upright position to help their breathing.
- Administer medications as per prescription (EPMA) chart.

**Reference**

**PACU Standard No 5 - Cardiovascular System.**

**Standard statement:** All patients will be monitored according to their individual requirement. They will have their cardiovascular status maintained by appropriate measures.

Patients should have an adequate stock of cross matched blood and blood products according to their individual needs prior to being admitted for surgery.

Patients will be cardiovascularly stable when discharged to the ward.

**Method**

- All staff will have training in the equipment currently used.
- Staff will have an increasing understanding of the patients post-operative conditions.
- Staff able to recognise any abnormality in patient’s condition.
- Depending on procedure performed check that there are cross matched units of blood for the patient available if required.

**Compliance 100%**

**Exceptions None**

**Interventions**

- Vital signs are measured according to the patients individual need and as their condition dictates.
- Ensure the correct blood pressure cuff size is used. The bladder size should be 40 – 50% of the upper arm circumference. The bladder length should encircle 80% of the arm.
- If arrhythmias are detected the doctor should be informed and the patient treated accordingly.
- 12 lead electrocardiograph should be taken in the event of chest pain or arrhythmias to detect serious ECG changes.
- Aseptic technique used at all times when changing or removing intravenous lines.
- Monitor fluid balance closely.
- Use Doppler to detect a pulse which is difficult to palpate following vascular surgery.
- Note the colour and heat of the limbs following distal vascular surgery.

**Reference**

Adam. SK and Osborne. S. (1999) Critical Care Nursing

Oxford Medical Publications
**PACU Standard No 6 - Haemodynamic Monitoring**

**Standard statement** Those patients who require continuous monitoring will have their vital signs invasively monitored until they are discharged to the Intensive Therapy Unit to continue their High Dependency Care or until they are fully recovered and able to return to a ward.

Staff monitoring HDU patients will work within an agreed criteria set out by the anaesthetist.

The patient will suffer no ill effects from being invasively monitored.

**Method**

- All staff will have training and competency assessment in the use of invasive monitoring.

- An awareness of the possible complications of being invasively monitored will be understood by all staff.

- Equipment is regularly checked and maintained.

- Compliance 100%

- Exceptions None

**Interventions**

- Prepare the patient for the insertion or removal of the monitoring equipment.

- Ensure that the arterial line is secure and correctly zeroed.

- If requested or clinically indicated the Central Venous Catheter is x-rayed if new and that the x-ray is checked prior to use.

- Keep arm with arterial line visible to ensure continuous observation.

- Oxygen saturation monitored continuously.

- 3 lead ECG monitoring.

- Respiratory rate and rhythm monitored.

- Hourly urine measurements.

- Regular inspection of wound sites and drains.

**Reference**

Adam. SK and Osborne. S. (1999) Critical Care Nursing

Oxford Medical Publications
**PACU Standard No 7 - Fluid Balance**

**Standard statement:** The patient in PACU will have an accurate record of their fluid balance and adequate fluids prescribed for their discharge to the ward. The patient should be neither dehydrated nor overloaded with fluid. Urine output should in the average adult be a minimum of 0.5 ml/kg/h. The patient will not experience any deterioration of their kidney function.

**Method**

- All IV fluids will be recorded when set up on the fluid balance sheet.
- Oral intake will be monitored and recorded.
- NG output will be monitored and recorded.
- Urine output will be measured either hourly or four hourly as the patient’s condition dictates.
- Staff will have training to ensure they understand the signs and symptoms of fluid overload and dehydration.
- All output from indwelling drains will be measured and monitored.
- The fluid balance sheet must be maintained to show a running total of fluid balance for the patient.

**Compliance 100%**

**Exceptions None**

**Interventions**

- Check urinary catheter is draining and not blocked.
- Label any drains for ease of reference. Ensure they are not clamped.
- Follow procedure for trans cell drain and document appropriately.
- Check patency of all IV cannula on a regular basis.
- Remove IV cannula if it is not patent or looks infected.
- Check all IV infusion lines are patent and intact.
- Label all IV infusion lines. Fluid being infused and date.
- Label IV infusion with completion time.
- Follow hospital policy for the infusion of blood and blood products.
- Adhere to an aseptic technique at all times.

**Reference**

Adam. SK and Osborne. S. (1999) Critical Care Nursing

Oxford Medical Publications
**PACU Standard No 8 - Pain Control**

**Standard statement:** The patient will have effective pain relief which will be continuously monitored and evaluated in the recovery area.

A patient should experience no more than moderate pain and no ill effects of analgesia can be observed.

**Method**

- Pain assessment and documentation should be regarded as the fifth vital sign.
- The RCHT pain assessment tools and guidance should be used:
  - Guidelines for the assessment and documentation of pain (adults)
  - Guidance on the assessment and documentation of pain in children
  - Guidance for the assessment and management of pain in dementia
- Pain intensity must be assessed and recorded on the patient’s care plan on admission, and on discharge from recovery. Pain intensity on discharge must be at a level acceptable to the patient
- Patients should participate in the assessment process wherever possible.
- Non-verbal clues (facial expression, upper limb movements, and tolerance of intubation); physiological signs (blood pressure, heart rate) should also form part of the assessment.
- The recovery practitioner must be aware of the cultural differences in pain behaviours while remaining sensitive to the individual needs of the patient and their family.
- The recovery practitioner must act as the patients advocate if they feel the patient needs that support.
- Staff must be competent in undertaking therapeutic analgesic interventions by a number of routes including intravenous, rectal and subcutaneous. All PACU staff should be specifically trained in the management of patients with PCA’s epidurals, spinal, peripheral nerve blockade and rectus sheath catheter top up administration.
- Diversional therapy should be employed to assist in pain management where the recovery practitioner thinks necessary (i.e. change of position or tactile reassurance). Guided imagery and music can be useful to reduce pain intensity.
- Patients experiencing pain must be afforded some privacy and dignity when receiving treatment.
- There must be a referral process to the pain team for follow-up if appropriate.
- At hand-over of care, pain assessment and the effectiveness of interventions must be a principal point in the process.
• All documentation must be complete in accordance with the perioperative documentation policy, with a signed hand-over to the receiving nurse indicating a complete transfer of care. This includes the ‘Pain Team’ documentation if appropriate.

• Infusion devices for pain management must be easily distinguishable from those used for intravenous therapy.

• Infusion devices for epidural infusion must be easily distinguishable from those used for intravenous (PCA use) and other therapies.

• Pharmacy prepared infusions should be used to minimise variations in prescribing practice and reduce the risk of confusion.

• Pain management related infusion-giving sets and epidural catheters should be clearly identified. Epidural lines should be yellow to differentiate epidural/spinal lines from arterial (red), enteral (purple) and regional (grey).

• Guidelines for Peri and post-operative Pain Control for Complex Patients

• Clinical Guidelines for use of Ketamine as an adjunct analgesic for use by anaesthetist only

• Intravenous Opioids for adults in Recovery Areas – “The Recovery Protocol”

• Clinical Guidelines For Drug Doses In Obesity

• Analgesic Advice for Ward Doctors

Patient Controlled Analgesia (PCA)

• Acute Post operative analgesia guidelines Patient Controlled analgesia

• Nursing Guideline for the use of Patient Controlled Analgesia.[PCA] Adult

• Clinical Guideline for Remifentanil PCA on Labour Ward

• Nursing Guidelines for nursing children with a Patient Controlled Analgesia (PCA) or intravenous opioid infusion

• The checking and administration procedure for Patient Controlled Analgesia must be undertaken by a registered and competent recovery practitioner. The second recovery practitioner provides an independent check to confirm the identity of the drug(s), strength, dose to be administered, the expiry dates and the patient identity and allergies / sensitivities.

• A record must be kept of the identity of the infusion device and patient details. The infusion devices must be checked before each use. Faulty devices must be reported to the medical physics department. The identity number of the faulty device must be recorded and the device decontaminated, labelled as faulty and taken out of use.

• The infusion devices must be cleaned after each use.

• The infusion site must be checked for patency and assessed using a visual phlebitis score (VIP). Any reaction must be reported and acted upon.
• Naloxone injection to reverse over sedation and opioid induced respiratory depression must be available in all locations where and diamorphine and morphine are stored.

• All records must be contemporaneous and complete (PCA chart, vital signs chart, prescription sheet, fluid balance, pain team sheet and care documentation).

**Epidural Administration: management of equipment and assessment of patients**

• **Epidural Insertion Guidelines**

• **Clinical Guideline for Nursing Protocol for the care of epidural infusions (adult)**

• **Acute post operative analgesia guidelines; Neuroaxial blockade: Epidural Guidelines**

• **Clinical Guideline for Management of Leg Weakness with Epidural Analgesia**

• Staff caring for patients receiving epidural analgesia must have received specific education and training and be deemed competent. Staff must attend update sessions at least once every three years.

• A record must be kept of the identity of the infusion device and patient details. This must be placed on the PACU documentation and electronically e.g. EPMA

• The infusion devices must be checked before each use. Faulty devices must be reported to the medical physics department. The identity number of the faulty device must be recorded and the device decontaminated, labeled as faulty and taken out of use.

• The infusion devices must be cleaned after each use and a green “I am clean” label applied.

• Preparation of the pump and the prescribed analgesia regime must be undertaken by a registered and competent practitioner.

• All observations must be performed regularly and recorded on the observation chart, according to local policy. Pressure areas, especially heels, must be observed in all patients receiving epidural analgesia.

• Patients with fractures below the waist must follow the appropriate care pathway. Monitoring of the level of sensory and motor block is essential.

• An increasing degree of motor weakness requires immediate review by an anaesthetist. Observations must be continued and recorded for at least 24 hours after attempted epidural insertion or epidural catheter removal to aid early detection of epidural haematoma formation.

• The infusion rate, volume delivered and route of administration must be checked regularly and recorded, as well as being checked against the prescription.

• Emergency drugs must be readily available including Naloxone and Ephedrine.

• Trouble shooting guidelines are available in the local epidural policy.
• Any change in the patient’s condition must be recorded contemporaneously and reported where necessary.
• The Pain Team audit form must be filled in as this acts as a referral for next day review by the Pain team.

**Continuous peripheral nerve blockade: Management of equipment and assessment of patients**

• Staff caring for patients receiving peripheral regional analgesia must have received education and training and be deemed competent.
• The overall management and guidelines can be found here: *Continuous Local Anaesthetic Infusions for Post Operative Pain Relief*

Compliance 100%
Exceptions None

**Interventions**

• Ensure staff order and maintain sufficient supplies of analgesic drugs, and also keep accurate records of administration.
• Staff aware of the details on protocols sheet.
• Pain and sedation scoring of patients having sophisticated pain control techniques.
• Systems for regular maintenance and repair of syringe driver pumps.
• Training for new staff in the use of epidural and intra-venous opiates infusions.
• Staff trained to assess, monitor and evaluate the effects of pain relief.
• Regular updating of staff and encouragement to participate in pain relief research.
• Staff trained to recognise side effects when administering specialised pain control and able to take appropriate action.

Acute Pain Service – ****

Reference:
PACU Standard No 9 - Administration of medications to patients in PACU.

Standard statement: On admission into PACU all patients will have a current medication chart, (EPMA) with appropriate medications to better control their post-operative symptoms.

This must have the correct patient information, be prescribed, signed and dated by the doctor in charge of their care.

The correct administration of medications will be carried out by the practitioner in charge of their care, a designated nurse/ODP or a nurse/ODP in further training under direct supervision of the practitioner in charge of that patients care.

The administration of symptom controlling medication will take place within 10 minutes of the symptom being identified.

Method

- Give medication according to the symptom and medication chart (EPMA).
- I.e. :- PO, PR, IV, IM or S/C.
- Check name bands, medication chart, anaesthetic chart, prescription, route and drug dose.

Compliance 100%

Exceptions Drug incompatibilities, known patient allergies and if the drug was previously administered to the patient.

Interventions

- Assess the patients pain score, and if the patient is suffering from nausea.
- Choose from the medication chart (EPMA) an appropriate drug and route to control the patients symptom/s.
- Look at the anaesthetic chart for any premedication already given.
- Check for patient allergies and always monitor for drug related reactions.
- Note drug incompatibilities, whenever possible, administer drugs separately.
- When administering drugs keep patient safety in mind. Check patient identity bands against patient s own medication chart. Sign the chart when the drug has been given, not before.
- Explain to the patient what you intend to give and why.
- Assess patients respiration rate and blood pressure, before, during and after the administration of the drug.
- Follow the RCH policy for the administration of medications.
- If you are unsure during any stage of the procedure, seek advice.
- Refer to the RCH administration of drugs policy. BNF. IV work book.

References

RCH Drug Administration Policy.
British National Formulary.
PACU Standard No 10 - Communication

**Standard statement:** Patients and their relatives / carers will receive clear, accurate and relevant information whilst in PACU. They should feel free to seek advice and express their needs and feelings.

**Method**
- All staff will be proficient in communication skills and receive training as appropriate.
- All staff will ensure they are friendly and approachable at all times.
- Communication with all patients will commence on admission into PACU, regardless of conscious level.
- PACU staff will gather information from theatre handover and patient documentation to ascertain the patients preferred name, communication abilities and needs (e.g. Sight, hearing, comprehension, verbal abilities, special needs etc.)
- All bed areas will have an accessible, working emergency call bell.
- Lights will be dimmed at night and noise kept to a minimum at night.
- Ensure main carer is known to all staff and where appropriate, involved with decisions affecting patients’ care.
- Patients understanding of new information will be verified
- All staff to be aware of patient’s need for privacy for communication where possible.
- All documentation should be clear, accurate and complete, whether hand – written (in black pen) or computerised and signed by the appropriate staff.

**Compliance 100%**

**Exceptions None**

**Interventions**
- Ensure up – to – date liaison between all health care staff.
- All relatives and carer’s will be prepared for entering the recovery environment, both psychologically and with regard to their and others safety.
- Patient will have anxieties dealt with by reassurance, information, with access to relatives or specialist staff as needed.
- Nurses may give specific counselling as they feel able or ensure patients are referred to the appropriate services.
- Specific communication needs will be addressed quickly by appropriate means (e.g. Hearing aid, spectacles, carer’s involvement etc.)

**Reference**

Churchill Livingstone
Theatre Practice Standards - Post Anaesthetic Care
**PACU Standard No 11 - Privacy and Dignity.**

**Standard statement:** All patients when admitted into PACU will have their privacy maintained, they will be treated with dignity by all staff members at all times regardless of their race, gender or medical condition.

The patient will know who their nurse is as soon as they are conscious and able to understand where they are.

**Method**

- Introduce yourself to the patient when the appropriate time arises.
- Orientate the patient to time and place.
- Ensure that all medical notes are kept with the patient in a folder.
- Receive patient handover from other members of the MDT.
- Always consider the patients feelings when interventions of a personal nature are required.
- Try to announce your arrival to a private bed space. (Curtains or screens pulled around)

Compliance 100%

Exceptions None

**Interventions**

- Introduce yourself, tell the patient where they are and reassure them.
- Speak to the patient in a clear voice with respect and understanding.
- Be sympathetic of the patients medical condition and how it affects them.
- Always explain any procedure to the patient before you act.
- Never expose the patient unnecessarily.
- Always answer any questions honestly.
- Keep the patient informed of your intentions.

**Reference**


Churchill Livingstone
PACU Standard No 12 - Elimination

Standard statement: All patients in PACU will have their toilet needs met with prompt and appropriate methods of elimination. They will be treated with dignity and be given privacy to conduct their toilet needs. They will be offered the appropriate assistance in order to achieve a satisfactory outcome without deterioration or complications post operatively.

Method

- Ask the patient if they need to use the toilet.
- Adequate toileting devices are available.

Compliance 100%

Exceptions None

Interventions

- Observation of bladder, bowel / stoma function.
- Ensure privacy and dignity for the patient at all times.
- Ensure toilet devices are available.
- Ensure the infection control policy is adhered to when dealing with waste products.
- Note any abnormalities in appearance of urine or stool, report to doctor if concerned.
- Note volume and quantity. Record appropriately on fluid chart.
- Ensure an aseptic technique is used when catheterising or dealing with an indwelling catheter.
- Hourly urine measurements if appropriate.

Reference

PACU Standard No 13 - Post operative nausea and vomiting.

Standard statement: To prevent or reduce post-operative nausea and vomiting. For patients in PACU to remain comfortable and free from post-operative nausea and vomiting. For patients to remain safe from the effects of nausea and vomiting.

Method

- Patients should be managed by the pre-op fasting policy
- There should not be excessive starvation time.
  - Pre-operative fasting guidelines for elective surgery  Valid From: 01/11/2010 - To: 01/12/2013
  - A Policy for Fasting Patients Who Require Anaesthesia or Intravenous Sedation Valid From: 11/01/2013 - To: 31/12/2013
- Post Operative Nausea and Vomiting Algorithm
  - Patients at risk of PONV should be identified in the preoperative period
  - Patients at high risk of PONV should receive anti-emetic prophylaxis.
  - Patients suffering nausea and vomiting should be afforded privacy and dignity.
  - Tissues, and face wash should be provided for the patients suffering PONV.
  - Drug therapy should be administered for persistent or symptomatic PONV).
  - A fan can be provided to agitate air for a cooling breeze.
  - Mouthwash can be provided for hygiene and comfort (AfPP 2011).
  - Any vomiting must be recorded on the fluid balance chart.
  - If a nasogastric tube is in situ, any aspirate from this must be recorded. Aspiration via suction can be performed where necessary.
  - Reassurance should be given to the patient.
  - Patients must not be returned to the ward until emesis and post-operative pain is optimally managed and the patient is comfortable.

Compliance 100%

Exceptions None

Interventions

- Continued education for all staff in the management of post-operative nausea and vomiting.
- Staff will use gloves and aprons when dealing with body fluids.
- All staff will be able to pass a NG tube safely and demonstrate its patency.
- Antiemetic drugs will be administered according to hospital policy.
- The patient will if allowed sit up to avoid aspiration and to promote orientation.
- Strict fluid balance will be adhered to, ensuring dehydration does not occur.

Reference

**PACU Standard No 14 - Hygiene**

**Standard statement:** Patients in PACU will have their hygiene needs met promptly when identified, or at a time which is clinically convenient. For patients to feel clean and comfortable.

**Method**

- Wash patients skin with soap and water.
- Provide clean linen and gown if necessary.
- Offer mouth care to patients.
- Give eye care wherever appropriate.
- Perform catheter care when needed.

Compliance 100%

Exceptions None

**Interventions**

- Be aware of the patients medical condition.
- Be aware of the patients temperature.
- Ensure that the patient understands the intervention.
- Always provide privacy.
- Always treat the patient with dignity.
- Allow the patient to help if possible.
- Ensure the safe disposal of soiled laundry.
- During intervention assess your patients skin.

**Reference**


**PACU Standard No 15 - Infection Control**

**Standard statement:** All patients who are admitted into PACU will be protected from hospital acquired infection.

**Method**

All PACU staff will keep their statutory infection control updated by attending the appropriate course.

All PACU staff will have yearly assessment of ANTT

PACU nurses will put into practice the RCH infection control policy guidelines.

Compliance 100%

Exceptions None

**Interventions**

- Good hand hygiene.
- Standard blood and body fluid precautions.
- Cleaning, disinfection or sterilisation of equipment, instruments and surfaces.
- Correct use of disinfectants.
- Correct aseptic technique.
- Safe disposal of waste, sharps and linen.
- Isolation precautions when patients have a known or suspected infection.
- Appropriate use of PPE when necessary

**Reference**

Royal United Hospital Infection Control Policy

**PACU Standard No 16 - Prevention of Pressure Sores**

**Standard statement:** Patients will have their pressure area needs assessed on admission into PACU. Patients will have their pressure areas inspected and assessed by a PACU practitioner within 15 minutes of becoming conscious or as soon as they are able to tolerate being moved.

To promote healthy intact skin.

**Method**

- Assess pressure area risk by using the Waterlow score.
- Continued and further training for all staff in the safe moving of patients.
- Equipment available for moving patients and training in its use.
- Appropriate mattress for patient needs.
- Updated knowledge of staff with RCHT pressure area prevention policy.
- Plan care and implement plan.

Compliance 100%

Exceptions None

**Interventions**

- Roll patient on admission and assess skin condition.
- Plan pressure area care whilst in PACU.
- Document skin condition.
- If incontinent wash and dry to prevent skin breakdown.
- Position patient for optimum pressure area care.
- Support vulnerable areas adequately.
- Avoid shearing and friction by using slide sheets when moving patients.
- Treat any existing pressure sores, using research based practice.

**Reference**

RCHT Pressure Ulcer Prevention And Management

**PACU Standard No 17 - Wound Management**

**Standard statement:** Wounds will be inspected promptly following patient transfer to the PACU. The wound will be assessed for signs of infection and blood loss.

Measurements from drains will be recorded at this time and further assessment of wound and drains will follow at regular intervals.

**Method**
- Aseptic technique will be adhered to at all times by all staff.
- Stoma will be assessed for perfusion.
- PACU staff will be trained to recognise any complications.

Compliance 100%

Exceptions None

**Interventions**
- Demonstration by staff of ANTT.
- Infection control protocol adhered to.
- Assessment of wounds and drains alongside observations.
- Demonstrate ability to manage drains.
- Ability to change a stoma bag.

**Reference**

PACU Standard No 18 - Patient Discharge from the Post-anaesthetic care unit/recovery

Standard statement: Patients will be safely discharged from the PACU area

Criteria for discharge

- The patient is conscious and able to maintain their own airway. Their protective reflexes should be present.

- The patient’s rate and depth of respiration and their oxygen saturation must be within the parameters set by the anaesthetist for each individual patient

- The patient’s cardiovascular system must be stable with no unexplained irregularity or persistent bleeding. Consecutive readings of pulse and blood pressure should approximate to normal preoperative values or be at an acceptable level commensurate with the planned postoperative care. Peripheral perfusion should be adequate.

- Pain and nausea should be adequately treated and continuing treatment must be prescribed.

- Temperature should be within acceptable limits and there should be no evidence that hypothermia or malignant hyperthermia are developing.

- All of the prophylactic medicine prescribed for the peri-operative period must have been given.

- Oxygen and intravenous fluids should be prescribed.

- If catheterised, the urinary output must be within the parameters set by the anaesthetist for each individual patient

- A bed must be available and sufficient staffing on the unit in which the patient is to be received.

- NEWS Score and all documentation/care plans e.g. IV completed and acceptable.
### Guidance for duration of stay in the Recovery Unit (Adult Patients)

**All patients must fulfil criteria for discharge**

| Procedure Description | Minimum Stay
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Local Anaesthetic (May return to the ward from theatre)</td>
<td>1 set of observations and return to ward.</td>
</tr>
<tr>
<td>Simple short operations under sedation.</td>
<td>Once the patient is fully conscious; a minimum stay of 15 minutes.</td>
</tr>
<tr>
<td>Simple short operations under general anaesthesia (20 minutes or less)</td>
<td>Once the patient is fully conscious and maintaining their own airway; a minimum stay of 15 minutes.</td>
</tr>
<tr>
<td>Medium duration operations (20 minutes to 2 hours)</td>
<td>Once the patient is fully conscious and maintaining their own airway; a minimum stay of 30 minutes.</td>
</tr>
<tr>
<td>Operations exceeding 2 hours</td>
<td>Once the patient is fully conscious and maintaining their own airway; a minimum stay of 60 minutes</td>
</tr>
<tr>
<td>Should the patient:</td>
<td>Discharge should be delayed for at least 15 minutes</td>
</tr>
<tr>
<td>Receive a first dose of antibiotics</td>
<td></td>
</tr>
<tr>
<td>Commence a transfusion of a blood product</td>
<td></td>
</tr>
<tr>
<td>Should the patient:</td>
<td>Discharge should be delayed for at least 30 minutes</td>
</tr>
<tr>
<td>Receive a dose of IV pain relief, other than a self administered PCA</td>
<td></td>
</tr>
<tr>
<td>Receive a bolus dose via an epidural catheter</td>
<td></td>
</tr>
</tbody>
</table>
Handover information

Handovers should be both verbal and written and should be documented.

Surgeons/operators must participate in handovers in which the patient’s pathway has deviated from that planned and when patients are handed over to critical care teams after procedures.

Participation of the patient and / or representative (parent, guardian, carer or birth partner) should be encouraged when feasible.

During handovers only one person should speak at a time, and the conversation during the handover should relate only to the patient. Non-handover activities should cease during the handover. Each team member should be given the opportunity to ask questions and clarify information.

The following information must be included in the handover from recovery:

- Patient’s name and date of birth checked against identity band.
- Planned and actual procedure(s) that was carried out with site and side if relevant, and surgical course including surgical complications and interventions to correct these.
- The type of anaesthesia used, or combination of anaesthesia such as general anaesthetic and regional block (including attempted epidural insertion and the need to continue observation of sensation and movement for a minimum of 24 hours).
- The duration of anaesthetic and any complications, if appropriate and interventions to correct these.
- Details of any local infiltration to the wound, including local anaesthetic agent, strength and dose administered. Also the patient’s pain score.
- Patient prescription documents.
- Intravenous fluid documents, including blood products given with estimated losses, if appropriate.
- Type of dressing, drain and wound closure used including any further information or instructions in relation to drains e.g. suction or not.
- Amount of exudates in the drain and, if this is excessive, what action has been taken such as informing the surgeon.
- Reinfusion times for autologous blood products
- Commencement times for local infiltration devices (pain busters)
- ‘Top-up’ intervals for rectus sheath devices and personnel charged with this task
- Oxygen therapy requirement for patient and completed drug prescription
- VTE therapy documented
- Invasive device care plans supplied
- Additional to: Skin condition and integrity – Lower Limb pathway followed where appropriate. Waterlow score completed and documented.
- Presence of stoma / urinary catheter and state of fluid balance/output.
• Any intentionally retained objects and plans for removal, if relevant.
• Confirmation that any throat pack has been removed.
• Oxygen requirements, percentage and duration.
• NEWS score
• Any allergies or sensitivities.
• Whether there is a need for an interpreter, carer or parent to assist in patient care and
  the arrangements that are in place for contacting such individuals if they are not
  accompanying the patient back to the ward.
• Whether the patient has any personal items such as dentures, spectacles or hearing
  aids that must accompany the patient on transfer, or if these items have been returned
  to the patient.
• Relevant medical history (e.g. the presence of a pacemaker).
• Skin condition, integrity and Waterlow score.
• Any changes at the site of the diathermy plate, if appropriate.
• Any other information that is specific to the patient, post-operative surgical and
  anaesthetic instructions. Including any patient safety incidents.

Transfer to the ward

• During the transfer from recovery to the ward, the patient should be escorted by a
  competent registered practitioner who has achieved validated training to perform the
  escort role.
• Suitable equipment such as oxygen and suction must also be available.

When transferring a patient to ITU/HDU:

• Check and ensure all transfer equipment (e.g. portable sucker, portable O2, monitor)
  is available.
• If the patient is ventilated, an anaesthetist will escort and the PACU staff must make
  sure that they are available.
• A minimum of three personnel must accompany the patient.
• The receiving area must be warned in advance and agreement must be obtained
  before transfer.
• A crash box must accompany the ventilated patient.
• The anaesthetist will decide if there are any other drugs that should accompany
  patient.
• If transfer requires the use of lifts, then the portering staff must be informed and
  arrange for the lifts to be held on the appropriate floors.

Palliative / End of life care

• Occasionally, a patient who is expected to die imminently will be taken to PACU. The
  patient should be managed according to an end of life care pathway in isolation from
  others who should not ideally be aware of the situation. Relatives must be able to be
  present and a dedicated nurse should be available.
## Appendix 1. Governance Information

<table>
<thead>
<tr>
<th>Document Title</th>
<th>Theatre Practice Standards - Post Anaesthetic Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date Issued/Approved:</td>
<td>24 Feb 14</td>
</tr>
<tr>
<td>Date Valid From:</td>
<td>01 May 2017</td>
</tr>
<tr>
<td>Date Valid To:</td>
<td>01 May 2020</td>
</tr>
<tr>
<td>Directorate / Department responsible (author/owner):</td>
<td>Sue Preston, Senior Matron, Theatres</td>
</tr>
<tr>
<td>Contact details:</td>
<td>01872 258188</td>
</tr>
<tr>
<td>Brief summary of contents</td>
<td>Defined clinical practice standards relevant to post anaesthetic care</td>
</tr>
</tbody>
</table>
| Suggested Keywords: | *Post anaesthetic care*  
*Recovery*  
*Practice standards.* |
| Target Audience | RCHT | PCH | CFT | KCCG |
| Executive Director responsible for Policy: | Medical Director |
| Date revised: | May 2017 |
| This document replaces (exact title of previous version): | |
| Approval route (names of committees)/consultation: | *Divisional Governance*  
*Theatre Management Group* |
| Divisional Manager confirming approval processes | Duncan Bliss |
| Name and Post Title of additional signatories | Sue Preston |
| 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 / Theatres |
| Links to key external standards | |
| Related Documents: | |
| Training Need Identified? | No – this document supersedes current theatre practice policy documents and does not implement new practice. |
Version Control Table

<table>
<thead>
<tr>
<th>Date</th>
<th>Version No</th>
<th>Summary of Changes</th>
<th>Changes Made by (Name and Job Title)</th>
</tr>
</thead>
<tbody>
<tr>
<td>24 Feb 14</td>
<td>V1.0</td>
<td>Initial Issue</td>
<td>Sue Preston, Senior Matron, Theatres</td>
</tr>
<tr>
<td>May 2017</td>
<td>V2</td>
<td>Compliance with Natsips</td>
<td>Cathy Edwards</td>
</tr>
</tbody>
</table>

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

This document is to be retained for 10 years from the date of expiry.

This document is only valid on the day of printing

Controlled Document
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Appendix 2. Initial Equality Impact Assessment Form

<table>
<thead>
<tr>
<th>Name of Name of the strategy / policy / proposal / service function to be assessed (hereafter referred to as policy) (Provide brief description): Theatre Practice Standards - Post Anaesthetic Care</th>
<th>Is this a new or existing Policy?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Directorate and service area: Clinical / Theatres</td>
<td></td>
</tr>
<tr>
<td>Name of individual completing assessment: Sue Preston, Senior Matron, Theatres</td>
<td>Telephone: 01872 258188</td>
</tr>
</tbody>
</table>

1. Policy Aim*
   Who is the strategy / policy / proposal / service function aimed at?
   See para 1.

2. Policy Objectives*
   See para 1.4

3. Policy – intended Outcomes*
   Improved standards of care to all theatre patients.

4. *How will you measure the outcome?
   As per para 3 of this guideline.

5. Who is intended to benefit from the policy?
   All patients admitted to theatre.

6a) Is consultation required with the workforce, equality groups, local interest groups etc. around this policy? No

b) If yes, have these *groups been consulted?

C). Please list any groups who have been consulted about this procedure.

7. The Impact
   Please complete the following table.

<table>
<thead>
<tr>
<th>Equality Strands:</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>✓</td>
<td></td>
</tr>
</tbody>
</table>

Rationale for Assessment / Existing Evidence
| Sex (male, female, transgender / gender reassignment) | ✓ |
| Race / Ethnic communities /groups | ✓ |
| Disability - learning disability, physical disability, sensory impairment and mental health problems | ✓ |
| Religion / other beliefs | ✓ |
| Marriage and civil partnership | ✓ |
| Pregnancy and maternity | ✓ |
| Sexual Orientation, Bisexual, Gay, heterosexual, Lesbian | ✓ |

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 service redesign or development

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

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

Signature of policy developer / lead manager / director  Date of completion and submission

Names and signatures of members carrying out the Screening Assessment
1. Sue Preston
2.

Keep one copy and send a copy to the Human Rights, Equality and Inclusion Lead, c/o Royal Cornwall Hospitals NHS Trust, Human Resources Department, Knowledge Spa, Truro, Cornwall, TR1 3HD

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

Signed _______________
Date _______________