

LocSSIP Guideline for Musculoskeletal X-ray Guided Injections in the Treatment Room at St Michael's Hospital

V1.0

June 2025

Summary

This guideline outlines the requirements that must be met to ensure the safety of staff and patients during musculoskeletal x-ray guided injections in the treatment room at St Michael's hospital. The protocol is designed to meet LocSSIP's (Local Safety Standards for Invasive Procedure) requirements for the following procedures:

- X-ray guided injections to hands.
- X-ray guided injections feet.
- X-ray guided injections hips.

The guideline has been written as a result of the LocSIPPs requirement (Local Safety Standards for Invasive Procedures).

Table of Contents

Summary	2
1. Introduction.....	5
2. Background.....	5
3. Definitions	5
4. Governance and Audit	6
5. Documentation of Musculoskeletal X-ray Guided Injections.....	6
6. Workforce.....	6
7. Scheduling and List Management.....	7
8. Handovers and Information Transfer.....	7
9. Procedural Verification and Site Marking.....	7
10. Safety Briefing	8
11. Sign In.....	8
12. Prosthesis Verification.....	8
13. Prevention of Retained Foreign Objects	8
14. Sign Out.....	9
15. Debriefing.....	9
16. Dissemination and Implementation	9
17. Monitoring compliance and effectiveness	10
18. Updating and Review	10
19. Equality and Diversity	10
Appendix 1. Governance Information	11
Appendix 2. Equality Impact Assessment.....	13

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.

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1. Introduction

- 1.1. The Royal Cornwall Hospitals Trust (RCHT), including St Michaels Hospital (SMH), is committed to providing high quality patient centered care and a safe environment for all patients undergoing any invasive procedure.
- 1.2. This guideline has been produced in line with [National Safety Standards for Invasive Procedures](#) (NatSSIPs), version 2.
- 1.3. The document will provide the standards expected for the safe administration of musculoskeletal x-ray guided injections by both medical, nursing and Allied Health staff in the Treatment Room at St Michael's Hospital / any of the sites within the Royal Cornwall Hospital Trust.
- 1.4. The aim of this document is to outline the recommended practice for managing patients from the time they enter the procedure room until they leave.
- 1.5. This guideline should be read in conjunction with the following documents:
 - [RCHT Safety Standards in Surgery and Invasive Procedures Policy](#)
 - [National Safety Standards for Invasive Procedures](#)
 - [RCHT Consent to Examination or Treatment policy](#)
 - [Ionising Radiation Safety Policy](#)
 - [NHS England » National infection prevention and control](#)
- 1.6. Personal identifiable data (PID) must be managed in accordance with this policy and comply with current legislation, clinical and operational needs, this included photography, images, voice recordings and video.

2. Background

- 2.1. This guideline is intended to build on the principles outlined in the RCHT Safety Standards in Surgery and Invasive Procedures Policy and to reflect the standards expected when carrying out an invasive procedure within the SMH treatment room setting.
- 2.2. The image guided invasive procedures which this protocol covers are performed by injecting local anesthesia and steroids in and around the hip, foot and ankle to help relieve pain caused by MSK conditions and / or to provide diagnostic information.
- 2.3. Patients are admitted and this is done as a day case currently.

3. Definitions

- 3.1. Definition of abbreviations used in this document:

RCHT – Royal Cornwall Hospital Trusts.

SMH – St Michael's Hospital.

LocSSIP's – Local Safety Standards for Invasive Procedure.

NatSSIPs – National Safety Standards for Invasive Procedures.

IR(ME)R – Ionising Radiation (Medical Exposure) Regulations.

WHO – World Health Organisation.

Invasive procedure.

Image guided.

Local anesthetic.

PID - Personal identifiable data.

4. Governance and Audit

- 4.1. The standards and assurance of care is overseen by the Peripheral Site, Trauma and Orthopedic Care Group.
- 4.2. The Peripheral Sites Care Group will monitor the implementation of this guideline and will commission a bi-annual audit of adherence.
- 4.3. Patients must be assessed prior to the procedure and informed consent gained. This is necessary even if a repeat procedure on a different occasion. Procedure Specific patient agreements forms are used.

5. Documentation of Musculoskeletal X-ray Guided Injections

- 5.1. Personal identifiable data (PID) must be managed in accordance with this policy and comply with current legislation, clinical and operational needs, this included photography, images, voice recordings and video.
- 5.2. Documentation of all musculoskeletal x-ray guided injections will be held within the patient's health record and the trust's electronic record.
- 5.3. Appropriate consent will be gained by the responsible person for the procedure prior to all procedures.
- 5.4. This document incorporates the process undertaken as part of the WHO safer surgery checklist which is stored in the patient's medical notes.

6. Workforce

- 6.1. Minimum workforce requirements for these invasive procedures are as follows:
 - One Orthopaedic Practitioner competent to undertake MSK injections and may act as IR(ME)R practitioner and operator and is entitled to do so.
 - One Radiographer will be required to provide images to guide the injection for

the hip and foot injection.

- One assistant to support the maintenance of a sterile field and supporting patient care.
- For single operator procedures only, the Orthopaedic Practitioner is competent to undertake MSK injections as required, and practice is adapted appropriately for invasive procedure safety.

6.2. Training - Clinicians performing the intervention should have sound knowledge and experience relevant to the procedure, including safe use of radiation as per Ionising Radiation Medical Exposure Regulations (IR(ME)R) Employers Procedures.

6.3. The Healthcare professional's assistant - It is the responsibility of each member of staff i.e. nurses or ODP involved in the procedures outlined to work within their scope of competence under the terms of their professional body i.e. the General Medical Council (GMC), Nursing and Midwifery Council (NMC) or Health and Care Professions Council (HCPC) standards or codes for conduct, performance and ethics.

6.4. All staff must undertake RCHT WHO checklist training and Human Factors training to ensure the standards of safety regarding invasive procedures are understood.

6.5. All staff without appropriate competency will be supervised.

7. Scheduling and List Management

These procedures will be performed as necessary when safe to do so in an appropriate environment.

8. Handovers and Information Transfer

The team will undertake a briefing at the start of the procedure list which will include:

- Introductions.
- Patients on the list.
- Safety concerns including allergies etc.
- Confirmation of consent and any marking will be confirmed as completed, or the team made aware that these actions are yet to be completed.

9. Procedural Verification and Site Marking

9.1. Procedure verification will occur at team briefing and during the WHO checklist where triangulation against the list, consent form, patient expectations are triangulated and confirmed.

9.2. The intended site and side must always be marked as per RCHT invasive

procedure standards.

10. Safety Briefing

If any issues have arisen or problems such as equipment difficulties, a debriefing is to be undertaken and recorded by the responsible practitioner in the patient note, and a Datix completed if appropriate.

11. Sign In

11.1. All patients undergoing these procedures must undergo safety checks on arrival in the treatment room: the sign in, before commencing these procedures.

11.2. At least 2 people should complete the sign in process, alongside the patient. All members of the team must introduce themselves and observe “silent cockpit,” whilst a designated member of the team performs the WHO “sign in.” out loud and records on the WHO safety checklist. This includes:

- All team members should be present to introduce themselves by name and role.
- Patient to confirm his/her identity, procedure and site, using name, date of birth and the staff should check the hospital number/NHS number is correct.
- Written consent form checked.
- Essential imaging has been reviewed.
- All IRMER requirements met.
- The procedural site is marked.
- Patient allergies confirmed.
- That the required equipment is available and in date.
- Anticoagulation status.
- Diabetic status.
- Imaging reviewed and displayed.
- Any additional risk factors for the procedure identified.

12. Prosthesis Verification

There are no prosthetics used in this procedure; these are external injections.

13. Prevention of Retained Foreign Objects

There are no items inserted into cavities; this is an external injection.

14. Sign Out

The WHO checklist should be completed before the patient leaves the procedure room. The patient is recovered to the ward where they receive all relevant post-procedural care advice.

15. Debriefing

15.1. All members of the team must feel comfortable to contribute to the discussion and raise any queries or concerns. This can be carried out at the end of a list or case -by-case and should involve the entire team who participated in the procedure.

15.2. Key points of the debrief include:

- Things that went well.
- Things that went poorly / wrong.
- Areas for improvement.
- How the team can change / adapt processes if required.

15.3. If any issues have arisen or problems such as equipment difficulties, a debriefing is to be undertaken and recorded by the responsible practitioner in the patient's health record, and a Datix completed if appropriate.

16. Dissemination and Implementation

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

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

17. Monitoring compliance and effectiveness

Information Category	Detail of process and methodology for monitoring compliance
Element to be monitored	Quantitative and qualitative compliance with WHO checklists and documentation requirements.
Lead	Peripheral Sites Care Group Safer Surgery Lead, Governance Manager and Clinical Governance Manager.
Tool	WHO auditing feeds into the Safer Surgery and Invasive Procedures Committee.
Frequency	WHO checklist to be used for procedures and monitored for each patient.
Reporting arrangements	Any compliance issues alongside areas of failure within this procedure will be escalated to the Safer Surgery and Invasive Procedures Committee and shared within the Trauma and Orthopaedics Clinical Governance Meetings.
Acting on recommendations and Lead(s)	Any compliance issues will be highlighted at the Trauma and Orthopaedics Clinical Governance Meetings and acted upon by the Trauma and Orthopaedics clinical team.
Change in practice and lessons to be shared	Required changes to practice will be identified and actioned within this process. 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 through the Trauma and Orthopaedics Clinical Governance Meetings.

18. Updating and Review

18.1. 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.

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

19. Equality and Diversity

19.1. 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](#).

19.2. 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 Musculoskeletal X-ray Guided Injections in the Treatment Room at St Michael's Hospital V1.0
This document replaces (exact title of previous version):	New Document.
Date Issued/Approved:	June 2025.
Date Valid From:	June 2025.
Date Valid To:	June 2028.
Directorate/Department responsible (author/owner):	Trauma and Orthopaedic Governance Leads.
Contact details:	01736 874030.
Brief summary of contents:	LocSSIP Guideline for Musculoskeletal X-ray Guided Injections.
Suggested Keywords:	LocSSIP, Musculoskeletal, X-ray Guided, Injections, Treatment Room, St Michael's Hospital, SMH.
Target Audience:	RCHT: Yes CFT: No CIOB ICB: No
Executive Director responsible for Policy:	Chief Medical Officer.
Approval route for consultation and ratification:	Peripheral Sites Care Group Board Meeting. Trauma and Orthopaedic Clinical Governance Meeting. Clinical Imaging Governance Meeting. Clinical Support Care Group. Safer Surgery and Invasive Procedure Meeting.
General Manager confirming approval processes:	Paul Sylvester, Peripheral Sites Care Group General Manager.
Name of Governance Lead confirming approval by specialty and care group	Natasha Andrews, Peripheral Sites Care Group Governance Manager.

Information Category	Detailed Information
management meetings:	
Links to key external standards:	Ionising Radiation Regulations (2017). Ionising Radiation Medical Exposure Regulations (IRMER) 2024.
Related Documents:	Safety Standards in Surgery and Invasive Procedures Policy.
Training Need Identified?	No.
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet and Intranet
Document Library Folder/Sub Folder:	Trauma and Orthopaedics / Elective.

Version Control Table

Date	Version Number	Summary of Changes	Changes Made by
April 2025.	V1.0.	Initial issue.	Natasha Andrews, Peripheral Sites Governance Manager.

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
richt.inclusion@nhs.net

Information Category	Detailed Information
Name of the strategy/policy/proposal/service function to be assessed:	LocSSIP Guideline for Musculoskeletal X-ray Guided Injections in the Treatment Room at St Michael's Hospital V1.0.
Directorate and service area:	Orthopaedics, Peripheral Sites Care Group Department.
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):	Natasha Andrews, Peripheral Sites Care Group Governance Manager.
Contact details:	01736 874030.

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)	Staff performing musculoskeletal x-ray guided injections.
2. Policy Objectives	To meet LocSIPPs Requirement (Local Safety Standards for Invasive Procedures).
3. Policy Intended Outcomes	To ensure all staff are following an accepted safe method of musculoskeletal x-ray guided injections.
4. How will you measure each outcome?	Audit and debrief.
5. Who is intended to benefit from the policy?	Service users and clinician group.

Information Category	Detailed Information
6a. Who did you consult with? (Please select Yes or No for each category)	<ul style="list-style-type: none"> Workforce: Yes Patients/visitors: No Local groups/system partners: No External organisations: No Other: Yes
6b. Please list the individuals/groups who have been consulted about this policy.	Please record specific names of individuals/groups: Trauma and Orthopedic Clinical Governance. Clinical Imaging. Safer Surgery and Invasive Procedures Committee.
6c. What was the outcome of the consultation?	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	
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: Natasha Andrews.

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](#)