Royal Cornwall Hospitals
NHS Trust

LocSSIPs for Joint Injection and Aspiration in the Rheumatology Outpatient Department Clinical Guideline

V2.0

October 2025

1. Aim/Purpose of this Guideline

1.1. This guideline has been produced in line with National Safety Standards for Invasive Procedures (NatSSIPs).

1.2. Patients may have joint injection or aspiration performed as a single procedure or they may have both procedures performed on a joint at the same time, as one procedure. These Procedures may be carried out on multiple joints at the same appointment if agreed by the patient and operator.

1.3. This document will specify the required standards to be met, to safely perform joint injections and aspirations by medical, nursing and Allied Health professionals (AHP) at any of the sites where the Rheumatology clinicians provide a clinical service.

1.4. As this procedure is carried out by a single operator it requires an appropriate safety check - a “Stop, Pause and Agree Site” with the patient is an appropriate safety check. A WHO safety checklist is not required.

1.5. Laterality is likely to be relevant for this procedure. If it is not undertaken immediately as a continuation of the initial examination, then the appropriate site to be treated should be marked on the patient’s skin with an arrow adjacent to the site using a semi-permanent surgical marker pen. Once the procedure has been agreed with the patient, the skin will be marked, and all other risk factors considered.

1.6. Verbal consent will be obtained prior to the procedure, according to the RCHT Consent Policy.

1.7. The aim of this document is to outline the recommended practice for managing patients from the time they enter the clinic room (whether at Truro Health Park or another site where the department provides clinics) and as part of their consultation and examination process proceed to have a minor procedure.

1.8. This guideline should be read in conjunction with the following documents:

1.8.1. The Rheumatology Department Practice Standards Clinical Guideline Link.

1.8.2. RCHT Five Steps to Safer Surgery Link.

1.8.3. RCHT Consent Policy Link.

1.8.4. RCHT Infection Prevention and Control Policy Link.

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

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

2. The Guidance

2.1. Staffing

2.1.1. The minimum safe staffing level for carrying out joint injection or aspiration procedure(s) in the Rheumatology OPD is one competent operator and one other healthcare professional within the department (nurse, competent HCA, another rheumatology doctor, pharmacist). The second professional will not be taking part in the procedure but needs to be available in the department to assist in the unlikely event that the patient experiences an adverse reaction to the procedure (e.g., syncope, anaphylaxis). or to support as a chaperone if requested by the patient or HCP.

2.1.2. If the minimum level of experience and staffing cannot be met, the procedure must not be performed.

2.1.3. Training to undertake these procedures must be fully approved locally by a trust governance committee.

2.1.4. Rheumatology medical staff, nurses, pharmacists, and other registered healthcare professionals who have been appropriately trained and deemed competent can carry out aspiration and injection procedures. Staff undertaking the procedure must only treat joints which they have been trained to assess and inject/aspirate.

2.1.5. Non-medical delivery of care will be supported by a local practice standard, with recording of training and competency measures and regular clinical audit of processes and outcomes.

2.1.6. The procedure must only be undertaken by a junior doctor or non-medical practitioner if immediate access to advice from a Consultant Rheumatologist is available.

In most clinics an appropriately trained clinician will be on site but if this is not the case (i.e., West Cornwall Hospital clinic) and there is a very urgent complication that requires escalation then, the HCP should:

- First contact the on-call Consultant Rheumatologist by calling the on-call mobile phone via switchboard.
- If the on-call Consultant is unavailable, try to contact another Rheumatologist or SpR by phone (via switchboard if necessary) or in person.
- If none of the team can be contacted, then the operator should contact the Rheumatology Department at RCH and speak to any member of staff to ascertain which Consultants are available and how to contact them. If appropriate, the member of staff in the Rheumatology department should politely interrupt a consultant or SpR who is in clinic so they can provide urgent advice to the remote operator.
- If it is not possible to contact a Rheumatology Consultant, the healthcare professional should contact the Medical Registrar on-call.
- If a life-threatening complication (e.g., anaphylaxis) occurs, the healthcare professional should summon assistance by calling 2222 (if at Royal Cornwall Hospital, Treliske, West Cornwall Hospital, or St Michael's Hospital. Alternative arrangements may need to be followed at peripheral locations including Truro Health Park – the healthcare professional should ensure they are aware of these arrangements before commencing the procedure.

2.2. Consent

2.2.1. Valid patient consent will be obtained prior to the procedure.

2.2.2. Consent should be obtained specifically for an AHP to perform the procedure if it is carried out by a non-medical operator.

2.2.3. The risks and benefits of the procedure will be discussed with the patient by the operator to ensure they are able to give informed consent. Generally, joint injection and aspiration is effective, safe. Most of the risks are transient and/or minor.

2.2.3. The following risks should be discussed with the patient:

- Acute synovitis: joint pain and swelling may be exacerbated for 24-48 hours post-procedure.
- Septic arthritis: Rare, incidence between 1:14000 and 1:160000. Mortality from septic arthritis is high so it needs to be treated as an emergency.
- Tissue atrophy and depigmentation around the injection site (leading to dimpling and/or lighter coloured patches).

- Nerve damage.
- Tendon rupture.
- Osteonecrosis.
- Cartilage damage.
- Soft tissue calcification.
- Temporary (up to one week) exacerbation of hyperglycaemia in people with diabetes.
- There is also a risk of fainting and anaphylaxis.

2.3. Pre-procedure preparation

2.3.1. As the procedure is unlikely to be identified prior to the patient's consultation, it is not possible for pre-procedure instructions or information to be shared with the patient prior to their attendance.

2.3.2. The clinician and patient will agree on the procedures to be carried out, following the patient's consultation and assessment.

2.3.3. Procedures may be carried out in a suitable room in an out-patient setting, with full aseptic precautions.

2.3.4. In an out-patient setting, the clinic room must have a handbasin.

2.3.5. The room must be set up to include a patient couch for the procedure and staff must have access to both sides of the head of the couch.

2.3.6. Resuscitation facilities should be available in all settings where the procedure is performed.

2.3.7. All staff undertaking the procedure must have current Basic Life Support Training.

2.4. Hand decontamination and PPE

2.4.1. The operator must undergo surgical disinfection of the hands with either 7.5% Iodinated Povidone or 4% Chlorohexidine Gluconate surgical scrub and water or alcohol gel prior to administering IVT.

2.4.2. Non-sterile latex-free gloves should be worn, and the procedure carried out using aseptic non-touch technique (ANTT).

2.5. Equipment required

2.5.1. Blunt tip needles for drawing up medication.

2.5.2. Blunt tip filter needles for drawing up medication from glass ampoules.

2.5.3. Swabs impregnated with chlorhexidine in alcohol.

2.5.4 Suitable needles – length and gauge dependent on the joint to be accessed and patient's body habitus. Needles without an integral safety device should be used, as the safety devices prevent full insertion of the needle, which is essential for the procedure.

2.5.5. Syringe for aspirating fluid – size depends on joint(s) being accessed.

2.5.6. Syringe for injecting medication – size depends on joint(s) being accessed.

2.5.7. Syringe and suitable needle for injecting local anaesthetic pre-procedure (optional).

2.5.8. Specimen pot(s) for synovial fluid.

2.5.9. Small adhesive plaster.

2.5.10. Sterile latex-free surgical gloves.

2.5.11. If the operator is not a prescriber, the operator should ensure there is a valid prescription or patient group direction (PGD) is in place. If a PGD is used, the operator must check the patient meets the inclusion and exclusion criteria.

2.6. Pre-Injection Assessments and Checks

Prior to commencing the procedure, the operator should complete a number of assessment and checks:

2.6.1. Check for the following prior to carrying out the procedure: • Any relevant patient allergies

- Local or systemic infection.
- Febrile patient with cause unknown.
- Sickle cell disease.
- Rash or broken skin at the site of procedure.
- Fracture or unstable joint
- Presence of prosthetic/part-prosthetic joint.
- Uncontrolled coagulopathy

If any of the above are present, do not proceed with the procedure.

2.6.2. The following are relative contraindications: • Neutropenia, due to increased risk of infection from the procedure.

- Thrombocytopenia, anticoagulation, or bleeding disorders, due to the increased risk of haemarthrosis post-procedure.

- If any of these factors are present, it may be possible to manage the risks on a case-by-case basis, for example by checking an up-to-date INR before the procedure. This should be discussed with the consultant responsible for the patient.

2.6.3. Check for any previous use of steroid injections in the same joints. It is recommended that each joint is not injected more than once every three months and no more than three times in any 12-month period. If this is the case, then alternative treatment options should be considered.

2.7. Patients taking anticoagulants or antiplatelet medication

2.7.1. Anticoagulant and antithrombotic medications increase the risk of peri- and post-procedure bleeding, which could result in haemarthrosis. However, the risk of vascular events on stopping these medications usually outweighs this.

2.7.2. The operator needs to consider these risks on the day of the procedure and amend or postpone the procedure if they feel there is an unacceptable risk of bleeding.

2.7.3. Consider postponing the procedure for an up-to-date INR check if the patient has recently started warfarin or if their INR has been unstable.

2.7.4. This decision should be made on the day of the procedure following discussion with the patient.

2.8. Verification of Surgical site(s) and planned injection

2.8.1 The operator must review all the patient's relevant and available electronic and / or paper-based medical records, including imaging, examinations, clinical notes and the details provided by the referring clinician.

2.8.2. Once the operator has considered all the available details and carried out their own clinical examination and assessment, they will then discuss with the patient the most appropriate action and procedure (and site) recommended to be carried out.

2.9. Patient positioning

2.9.1. The patient should be positioned appropriately on the couch in the clinic room. Ensuring they are comfortable and ready for the procedure to be carried out. Whether the patient is seated or lying depends on the joint being accessed.

2.9.2. Joints can be supported and kept stable for injection using pillows or rolled towels. A clean pillow or towel should be used for each patient.

2.10. Preparation of equipment and medication

2.10.1. The operator should prepare a blue tray by wiping with a paper towel to remove any dust, then wiping with an alcohol Clinell wipe and leaving to air dry.

2.10.2. While the tray dries, the operator should gather any equipment and medication and place it on the top of the trolley.

2.10.3. After washing their hands and donning gloves, the operator will remove the caps from any vials of medication, wipe all surfaces of any non-sterile equipment (including vials and ampoules) using alcohol and chlorhexidine swabs and place them in the blue tray.

2.10.4. The operator will then open any sterile packaging, placing the items in the blue tray in such a way that they are easily accessible.

2.10.5. If undertaking joint aspiration, attach the appropriate size of needle to an empty syringe, which should remain sheathed.

2.10.6. Use a blunt-fill needle with filter to draw up lidocaine from glass ampoules (a non-filtered needle can be used if plastic vials are used).

2.10.7. Shake the vial containing the steroid suspension for injection. Use a blunt-fill needle to inject lidocacine into the vial. Without withdrawing the needle, shake gently to mix, and then withdraw the liquid into the syringe.

2.10.8. Replace the blunt-fill needle with an appropriately sized needle.

2.10.9. Consider preparing injections out of the sight of needle-phobic patients.

2.11. Marking of injection site

2.11.1. The injection site should be marked by indenting the skin with the tip of the needle cover.

2.11.2. Marking the skin with pen is not recommended as this will be removed by skin preparation.

2.12. Antiseptic skin preparation

2.12.1. Swabs impregnated with chlorhexidine in alcohol should be used to disinfect the injection site. Start at the centre of the injection site and move outward in a spiral motion, wiping an area approximately 10cm in diameter. If a small joint is being injected (e.g. finger) then wipe the entire circumference of the area for 5cm in both directions from the injection site. Allow this to dry before proceeding.

2.12.2. The solution is irritant to eyes and mucous membranes. It should be kept away from these areas.

2.13. Joint aspiration without injection

2.13.1. The patient should be instructed to look away from the site of injection.

2.13.2. Administer local anaesthetic (if used). Wait for the anaesthetic to take effect.

2.13.3. Insert the needle into the marked injection site. It should be quickly passed through the skin then advanced into the joint space.

2.13.4. Slightly aspirate to ensure correct placement (e.g., not in a blood vessel).

2.13.5. If the needle is correctly placed, withdraw the plunger and aspirate as much fluid as possible from the joint. It may be necessary to change syringes.

2.13.6. If the needle is incorrectly placed, reposition it then aspirate again.

2.13.7. Once all fluid has been aspirated, withdraw the syringe and needle.

2.13.8. Cover the injection site with an adhesive plaster.

2.14. Joint injection without aspiration

2.14.1. The patient should be instructed to look away from the site of injection.

2.14.2. Administer local anaesthetic (if used). Wait for the anaesthetic to take effect.

2.14.3. Insert the needle into the marked injection site. It should be quickly passed through the skin then advanced into the joint space.

2.14.4. Slightly aspirate to ensure correct placement (e.g., not in a blood vessel).

- If the needle is correctly placed, depress the plunger. Injecting should require minimal effort. Resistance implies the needle is in the wrong place. Stop immediately if injecting causes increased pain.

- If the needle is incorrectly placed, reposition it then aspirate again.

2.14.5. Withdraw the syringe and needle and discard into a sharps bin.

2.14.6. Cover the injection site with an adhesive plaster.

2.15. Joint aspiration followed by injection

2.15.1. The patient should be instructed to look away from the site of injection.

2.15.2. Administer local anaesthetic (if used). Wait for the anaesthetic to take effect.

2.15.3. Insert the needle into the marked injection site. It should be quickly passed through the skin then advanced into the joint space.

2.15.4. Slightly aspirate to ensure correct placement (e.g., not in a blood vessel).

2.15.5. If the needle is correctly placed, withdraw the plunger and aspirate as much fluid as possible from the joint. It may be necessary to change syringes.

2.15.6. If the needle is incorrectly placed, reposition it then aspirate again.

2.15.7. Once all fluid has been aspirated, detach the syringe, and attach the syringe containing the prepared medication.

2.15.8. Slightly aspirate to ensure correct placement (e.g., not in a blood vessel).

- If the needle is correctly placed, depress the plunger. Injecting should require minimal effort. Resistance implies the needle is in the wrong place. Stop immediately if injecting causes increased pain.

- If the needle is incorrectly placed, reposition it then aspirate again.

2.15.9. Withdraw the syringe and needle and discard into a sharps bin.

2.15.10. Cover the injection site with an adhesive plaster.

2.16. Post-Injection

2.16.1. Advise patients to rest the joint for 24 hours, or 48 hours (if possible) for a weight-bearing joint.

2.16.2. Advise that the use of ice packs/cold sprays may help reduce post-procedure.

2.16.3. Re-emphasize possible side effects and action to take if they occur.

2.16.4. If, post-procedure, the patient becomes systemically unwell (with or without pyrexia) and has an acutely painful hot and swollen joint they should contact their GP practice (or 111 if out-of-hours) for urgent review or attend ED.

2.17. Preparation of Samples

It is the responsibility of the operator to generate a pathology request form in Maxims and label the sample correctly. The sample label and request form must specify the type of specimen and the site it was obtained from, e.g., “Synovial fluid, right knee”.

2.18. Clinical record post-injection

The following should be recorded onto the current electronic platform:

- All clinical details relating to the procedure undertaken.

- Batch number of medicines injected.

- Proposed follow up arrangements (this will depend on the procedure and patient's condition).

2.19. Personal Protective Equipment (PPE)

- Minimum PPE for these procedures should include:
- Non-sterile latex-free gloves.
- Disposable apron.

3. Monitoring compliance and effectiveness

Information Category	Detail of process and methodology for monitoring compliance
Element to be monitored	Availability of equipment in the clinic rooms, Compliance with documentation requirements.
Lead	Rheumatology Clinical Lead, Clinical Matron, Rheumatology Clinical Governance Lead.
Tool	Local audit tool. The clinic rooms will be audited through "spot checks"; patients who have had a procedure will be identified from data captured on PAS and the lesser of 5% or 10 sets of procedure documentation will randomly selected for audit.
Frequency	Monthly audit.
Reporting arrangements	Audit results will be fed back to the Rheumatology Business and Governance meetings on a quarterly basis if fully compliant or monthly if non-compliant.
Acting on recommendations and Lead(s)	Rheumatology Clinical Lead, Clinical Matron, Rheumatology Clinical Governance Lead. Required actions will be identified and completed in a specified timeframe.
Change in practice and lessons to be shared	Required changes to practice will be identified and actioned within appropriate. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders.

4. Equality and Diversity

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

4.2. Equality Impact Assessment

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

Appendix 1. Governance Information

Information Category	Detailed Information
Document Title:	LocSSIPs for Joint Injection and Aspiration in the Rheumatology Outpatient Department Clinical Guideline V2.0.
This document replaces (exact title of previous version):	LocSSIPs for Joint Injection and Aspiration in the Rheumatology Outpatient Department Clinical Guideline V1.0.
Date Issued/Approved:	October 2025.
Date Valid From:	October 2025.
Date Valid To:	October 2028.
Directorate/Department responsible (author/owner):	Andy Pothecary - Rheumatology Pharmacist and Clinical Governance Lead.
Contact details:	01872 252202.
Brief summary of contents:	Standards for joint injection and aspiration.
Suggested Keywords:	Intravitreal Injection Therapy, standards, LocSSIPs.
Target Audience:	**RCHT:** Yes **CFT:** No **CIOS ICB:** No
Executive Director responsible for Policy:	Chief Medical Officer.
Approval route for consultation and ratification:	Rheumatology Specialty Tri, Rheumatology Business and Governance members, Care Group Governance Meeting, Care Board Meeting.
Manager confirming approval processes:	Ian Moyle-Browning, Head of Nursing (HoN), Specialist Services and Surgery.
Name of Governance Lead confirming consultation and ratification:	Michele Reed.
Links to key external standards:	None required.
Related Documents:	Rheumatology Department Practice Standards Clinical Guideline - Link.

Information Category	Detailed Information
Training Need Identified?	No.
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet and Intranet
Document Library Folder/Sub Folder:	Clinical / Rheumatology.

Version Control Table

Date	Version Number	Summary of Changes	Changes Made by
August 2022	V1.0	Initial issue.	Andrew Pothecary (Lead Pharmacist and Clinical Governance Lead, Rheumatology).
October 2025	V2.0	Full review – no updates.	Andrew Pothecary (Lead Pharmacist and Clinical Governance Lead, Rheumatology).

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:	LocSSIPs for Joint Injection and Aspiration in the Rheumatology Outpatient Department Clinical Guideline V2.0
Directorate and service area:	Rheumatology, Specialist Services and Surgery.
Is this a new or existing Policy?	Existing.
Name of individual completing EIA (Should be completed by an individual with a good understanding of the Service/Policy):	Andrew Pothecary, Clinical Governance Lead for Rheumatology.
Contact details:	Andy.pothecary@nhs.net

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)	This guideline is written for members of staff in the RCHT Rheumatology Department, who are responsible for managing patients undergoing joint injection and aspiration procedures as an out-patient.
2. Policy Objectives	To standardise practice.
3. Policy Intended Outcomes	All staff to reflect the policy standards in practice.
4. How will you measure each outcome?	Local Audit.
5. Who is intended to benefit from the policy?	Staff and patients.

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:** Safer Surgery Group.
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	
Marriage and civil partnership	No	

Protected Characteristic	(Yes or No)	Rationale
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: Andrew Pothecary, Clinical Governance Lead for Rheumatology.

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