Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Patient Controlled Analgesia (PCA)

This procedural document supersedes: PAT/MM 7 v.2 - Policy for the Management of Patient Controlled Analgesia (PCA)

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Executive Sponsor(s):	Chief Nurse
Author/reviewer: (this version)	Ailsa Woodhouse, Lead Pain Nurse, Inpatient Pain Service
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Target audience:	**Clinical areas, Trust-wide where patients receive Patient Controlled Analgesia (PCA)**

Amendment Form

Please record brief details of the changes made alongside the next version number. If the procedural document has been reviewed **without change**, this information will still need to be recorded although the version number will remain the same.

Version	Date Issued	Brief Summary of Changes	Author
Version 3	1 June 2021	• This document has been reviewed and updated • Changes throughout the document, please read in full	Ailsa Woodhouse
Version 2	January 2018	• Reviewed without change.	Lorraine Robinson
Version 2	August 2014	• New Trust format • References updated • Changes throughout the document, please read in full	Lorraine Robinson
Version 1	August 2011	• This document has been reviewed, without change. • Amendment form added.	Lorraine Robinson
Version 1	December 2008	• This is a new procedural document, please read in full	Lorraine Robinson

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1. INTRODUCTION

Patient Controlled Analgesia (PCA) is a method of pain relief that allows a patient to self-administer small doses of analgesia as required, from a locked programmable pump. PCA is appropriate for patients' who have acute pain which is likely to warrant repeated doses of parenteral opioid.

2. PURPOSE

To promote the safe and effective management of patients receiving a patient controlled analgesia system for the management of acute pain (National Patient Safety Agency (2006) Patient Safety Alert (12) Ensuring Safer Practice with high dose ampoules of Diamorphine and Morphine, also Patient Safety Alert (20) Promoting Safer use of Injectable Medicines (2007a).

It is intended to assist both medical and nursing staff to provide safe and effective PCA therapy and to ensure patients receive continuity of analgesia.

This policy should be read in conjunction with the policy for 'Safe and secure handling of controlled drugs part B':

https://www.dbth.nhs.uk/document/patmm1b/

3. DUTIES AND RESPONSIBILITIES

3.1 All clinical staff must:

- Ensure that they are competent in the setting up/use of the PCA pump when caring for a patient with a PCA.
- Ensure when caring for a patient with a PCA, the patient is educated in the use of the PCA.
- Maintain contemporaneous records pertaining to observations and pump monitoring.

- Staff will receive practical instruction on using the equipment from the inpatient pain team and clinical educators. Standard Operating Procedure (SOP) leaflets are available from the inpatient pain team. These act as an aide- memoir and do not replace training. Familiarisation to the operator's manuals (available in the relevant clinical areas/ wards) is essential.

3.2 The senior nurse in charge of the clinical area:

- Ensure their ward staff has been appropriately trained in the use of PCA and have an identifiable Pain Link Nurse.
- The registered nurse/healthcare professional must demonstrate competency in PCA therapy using the identified equipment in accordance with the Trust policy Medical Equipment Training (CORP/RISK 2).

- In collaboration with the matron and other relevant professionals, must investigate all adverse clinical incidents in relation to inadequate analgesia to prevent their future occurrence.

3.3 The Prescriber

- It is the responsibility of the prescriber to ensure that PCA is a suitable analgesic route for the patient. This decision will be based upon clinical condition of the patient requiring the need for a readily available pain relief. The analgesia prescription must be completed by an appropriate prescriber and be signed and dated. Other strong opioids should be considered to ensure good background analgesia is maintained.

4. PROCEDURE - OPIOIDS AND INDIVIDUAL PATIENT FACTORS

4.1 Patient Related Factors

- Contraindications include patient refusal, the inability to operate the device, allergy to opioids, unsafe environment i.e. untrained staff and impaired mental ability.

- Patients with a history of opioid consumption (patients with cancer pain, chronic non-cancer pain, and those with opioid addiction) have higher opioid requirements (Rapp et al 1995). Therefore, deviation from the 'standard' PCA prescription may be needed in this group of patients.

- Morphine is the most commonly used opioid for intravenous PCA. Within this policy other opioids may be used if patients are intolerant or sensitive to Morphine.

- Whichever opioid protocol is prescribed the patient management is the same as with morphine PCA, in relation to observations and monitoring. This is to ensure pain is controlled, minimal side effects and patient safety is maintained.

4.2 Renal impairment

- The clinical effects of opioids are altered by impaired renal function, not only because of altered clearance of the drug, but also the accumulation of toxic or therapeutically active metabolites (Davies et al 1996). This patient group are not excluded from using IV-PCA containing opioids. However, the analgesic drug regime may require alteration or alternative opioids e.g. oxycodone or fentanyl may be considered and prescribed (see appendix 1).

4.3 Morbidly obese/obstructive sleep apnoea (OSA)

- Morbid obesity is associated with OSA (Young et al 1994). PCA, without a background infusion, is a safe and effective method of analgesic delivery. However, if patients are known to have OSA more intensive monitoring is recommended (Levin et al 1992).

4.4 Patients Lacking Capacity

Sometimes it will be necessary to provide care and treatment to patients who lack the capacity to make decisions related to the content of this policy. In these instances staff must treat the patient in accordance with the Mental Capacity Act (MCA 2005).

- A person lacking capacity should not be treated in a manner which can be seen as discriminatory
- Any act done for, or any decision made on behalf of a patient who lacks capacity must be done, or made, in the persons Best Interest.
- Further information can be found in the MCA policy, and the Code of Practice, both available on the Extranet.

There is no single definition of Best Interest. Best Interest is *determined on an individual basis. All factors relevant to the decision must be taken into account, family and friends should be consulted, and the decision should be in the Best Interests of the individual. Please see S5of the MCA code of practice for further information.*

5. DOCUMENTATION OF CONTROLLED DRUGS

5.1 This policy must be read in conjunction with the Trust policy for the Safe and Secure Handling of Medicines – Controlled Drugs - PAT/MM 1 B.

- All syringes must be clearly labelled. The label should not obscure the scale markings.
- The amount of drug remaining in the syringe must be documented as detailed in the "controlled drug transfer section" of the prescription (WPR 31320) when patients are transferred to and between wards.
- Transfer to wards – It is the responsibility of the registered nurse to sign the "controlled drug transfer section" of the prescription (WPR 31320) when patients are transferred to other areas (see Trust Policy PAT MM1 via https://www.dbth.nhs.uk/document/patmm1b/ (Transfer from Theatres to Wards or Between Wards on p.39)).

5.2 Persons authorised to administer PCA

- Only persons who have demonstrated that they are competent to undertake intravenous medicines administration must do so, this includes attaching the pump/giving set to the patient.
- Each registered nurse/practitioner will have the appropriate knowledge and skills to safely manage patients receiving a PCA and perform syringe changes. PCA's will not be issued on wards where there is insufficient trained staff or where staff are unable to maintain their skill and competence.

- The nurse in charge of the clinical area is responsible for ensuring that only competent nurses/ODP's undertake PCA administration and undergo regular re-assessment.

- Two competent staff must verify the PCA infusion device programme and the syringe label against the prescription at commencement of the infusion, every syringe change and after any alteration to the infusion. This should be documented accordingly.

- The PCA which is prepared for administration shall be administered as per professional guidance of the administration of medicine in Health Care Settings immediately by the person who has prepared the PCA or in their presence (RCN 2019).

- Compatible intravenous fluids should be prescribed and administered to ensure venous access, to minimise intravenous irritation and ensure complete delivery of the dose.

- Documentation of the PCA data must occur on the Trusts infusion chart.

Checking of the pump settings must occur at the start of each shift and clearly documented on the infusion chart and JAC.

6. PATIENT CARE

6.1 Pain assessment

Self-reporting of pain should be used whenever appropriate as pain is an individual and subjective experience. Regular assessment of pain leads to improved acute pain management (Gould et al 1992, Level 3). Best practice requires the documentation of pain assessment scores at rest, on movement and deep breathing and coughing, by using the verbal descriptive tool none, **mild** (0-3), **moderate** (4-7), **severe** (8-10) **NB:** The numbers are for documentation purposes only.

Pain is recognised as the "5th vital sign" (JCAOH 2001) with documentation showing the intensity, action taken and response to intervention. Pain scores must be documented on the Trust Physiological Observations Chart alongside all other observations for the duration of the PCA and twenty-four-hours thereafter. This is to monitor the incidence of delayed respiratory depression.

Observations should include: pulse, blood pressure, respiratory rate, oxygen saturations, conscious level (AVPU), pain score, nausea/vomiting score and be documented on the Trust's physiological observations chart (Physiological Observations and Prevention of deterioration in the acutely ill adult PAT/T33 via https://www.dbth.nhs.uk/document/patt33-2/)

6.2 Observations

- The Electronic observation system must be manually set to the appropriate minimum time to ensure observations are performed safely whilst a PCA is in situ.

- ***The frequency of the above observations should be:***

¼ hourly for the first hour or whilst nursed in recovery
½ hourly for one hour

- ***On return to the ward***

1 hourly for 4 hours
4 hourly thereafter

Informed verbal consent must be obtained from the patient to undertake observations. When a patient refuses, give clear explanations of the importance of observations and why they are necessary. Always document refused consent and refer to Trust Mental Capacity Act policy (PAT/PA 19) via https://www.dbth.nhs.uk/document/patpa19-3/

Repeat attempts to undertake observations at frequencies stipulated in this policy.

6.3 Conscious levels

Increasing sedation may be a sign of impending respiratory depression. If there is concern as to whether the patient asleep or sedated, attempts must be made to rouse the patient.

A – Alert
V – responsive to Voice
P - responsive to Pain
U - Unresponsive

6.4 Oxygen Therapy

- Hypoxaemia occurs in the post-operative period both in the recovery room and after discharge of the patient to the ward.

- Patients receiving a PCA should have supplementary oxygen (4L/minute via face mask or 2L/minute via nasal cannula) for 24 hours post operatively and for when they go to sleep. This must be prescribed unless contraindicated due to the patient's comorbidities.

6.5 Respiratory depression

- Refer to Naxolone Protocol (see appendix 2).

6.6 Pump observations

This information should be recorded, as a minimum, once per shift and when the syringe or prescription is changed.

- Number of demands, number of good demands, total dose used (mg)
- Document the volume of fluid remaining in the syringe on the analgesia prescription and monitoring chart.
- Check for leaks from, or obstruction to, the giving set.
- Ensure the correct dedicated PCA giving set is being used (to be replaced after 72 hours), with anti-syphon and anti-reflux valve.

6.7 Important points

- When the PCA is commenced recovery nurses, anaesthetists, inpatient pain nurses may give an initial loading dose, this will be recorded on the appropriate monitoring chart e.g. recovery chart/controlled drug administration chart.

- Anti-emetics are prescribed PRN as per inpatient pain team protocols on the electronic prescribing system (JAC).

- Patients nursed on critical care may need a small background infusion, in addition to the patient bolus facility. This must be prescribed by the anaesthetist and/or the independent non-medical prescriber with specialist pain knowledge.

- Background infusions will not be routinely used on the wards. However, for patients who routinely take oral morphine, methadone or recreational opioids, a background infusion may be considered. The inpatient pain team must be consulted to ensure a management plan is in place to ensure the safety of the patient and adequate analgesia is delivered.

- If a patient needs a background infusion this will be individualised to meet the analgesic requirements of that patient and amendments made should be documented on the pre-printed PCA prescription label on the in-patient drug card. The effects and the need for the infusion must be reviewed on a daily basis by the inpatient pain team or anaesthetist caring for the patient.

7. TRAINING/ SUPPORT

- A designated link nurse for each ward using PCA's must be identified.

- The Link nurse must attend the Pain Link Nurse Study days.

The following are the minimum requirements of training to be undertaken before an individual is deemed competent/trained in setting up, administering and monitoring the PCA:

- Trust IV package completed – connection can only be made if the individual is IV trained
- Trust Anaphylaxis training completed

- Undertake a period of training and assessment of both theoretical knowledge and practical experience of setting up, monitoring and attaching the PCA

The Inpatient pain team are available Monday to Friday 08.00 – 16.00 and are available to give specialist advice, support and provide appropriate training and education when required.

8. MONITORING COMPLIANCE WITH THE PROCEDURAL DOCUMENT

What is being Monitored	Who will carry out the Monitoring	How often	How Reviewed/ Where Reported to
Compliance with the protocols (Appendix 1)	Ward manager	Monthly	Via local clinical governance group
Incidents – via the adverse incident reporting system.	Ward managers and Matrons	On individual incident basis	DATIX, department clinical governance, divisional clinical governance
Complaints – via the complaints procedure	Ward managers and Matrons	On individual complaint basis	Department clinical governance, divisional clinical governance

9. DEFINITIONS

9.1 Patient Controlled Analgesia (PCA)

This refers to a method of pain control that allows a patient to self-administer a pre-programmed amount of intravenous drug (bolus dose) after a set period of time. The syringe is contained in a lockable pump to prevent unauthorised access.

9.2 Multi-modal analgesia

Multi-modal (balanced) analgesia refers to the use of various drugs and modalities to achieve balanced analgesia. Slow release opiates can be prescribed regularly for a short duration (2 days) then step analgesia down to either Tramadol or Codeine regular. By taking advantage of the synergistic effects of the drugs with the differing modes of action we avoid the side effects of using opioids excessively.

The lowest rung on the World Health Organisation (WHO 2002) analgesic ladder consists of non-opioid simple analgesics. The main drugs are Paracetamol and Non-Steroidal Anti-inflammatory Drugs (NSAID's) e.g. Ibuprofen.

Of the NSAID's low dose Ibuprofen (e.g. 1200mg daily or less) has low GI toxicity and does not increase the risk of myocardial infarction (McCarthy 1999). This is 1st line drug to use. When these drugs are prescribed and administered regularly they provide multi-modal (balanced) analgesia.

NB: NSAID's should be prescribed at the lowest effective dose, and the shortest duration of treatment necessary to control pain e.g. the time limited prescription for post-operative analgesia is 72 hours then a review by the acute pain team or parent team is needed.

10. EQUALITY IMPACT ASSESSMENT

The Trust aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are disadvantaged over others. Our objectives and responsibilities relating to equality and diversity are outlined within our equality schemes. When considering the needs and assessing the impact of a procedural document any discriminatory factors must be identified.

An Equality Impact Assessment (EIA) has been conducted on this procedural document in line with the principles of the Equality Analysis Policy (CORP/EMP 27) and the Complaints, Concerns, Comments and Compliments Resolution and Learning Policy (CORP/EMP 4)

The purpose of the EIA is to minimise and if possible remove any disproportionate impact on employees on the grounds of race, sex, disability, age, sexual orientation or religious belief. No detriment was identified. See Appendix 4.

11. ASSOCIATED TRUST PROCEDURAL DOCUMENTS

- Equality Analysis Policy - CORP/EMP 27
- Complaints, Concerns, Comments and Compliments Resolution and Learning – CORP/COMM 4 via https://www.dbth.nhs.uk/document/corpcomm4-complaints-concerns-comments-compliments-resolution-learning/
- Medical Equipment Training Policy – CORP/RISK 2
- Mental Capacity Act 2005 Policy and Guidance, including Deprivation of Liberty Safeguards (DoLs) – PAT/PA 19
- Physiological Observations and prevention of deterioration in the acutely ill adult - PAT/T 33
- Privacy and Dignity Policy - PAT/PA 28
- Safe and Secure Handling of Medicines – Controlled Drugs – PAT/MM 1 B via https://www.dbth.nhs.uk/document/patmm1b/

12. DATA PROTECTION

Any personal data processing associated with this policy will be carried out under 'Current data protection legislation' as in the Data Protection Act 2018 and the UK General data Protection Regulation (GDPR) 2021.

For further information on data processing carried out by the trust, please refer to our Privacy Notices and other information which you can find on the trust website: https://www.dbth.nhs.uk/about-us/our-publications/information-governance/

13. REFERENCES

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APPENDIX 1 – PATIENT CONTROLLED ANALGESIA PROTOCOLS

Patient Controlled Analgesia Protocols

The following protocols are configured into the pumps:

Alaris PCA pump

Protocol A

Drug: Morphine
Concentration: 2mg/ml
Bolus dose: 1mg/0.5ml
'Stat delivery'
Lock out interval: 5 minutes
Background infusion: Nil

Graseby 3300 PCA Pump

Morphine PCA

Drug: Morphine
Background infusion: Nil
Bolus dose: 1mg/0.5ml
'Stat delivery'
Lock out interval: 5 minutes
Background infusion: Nil

Protocol B

Drug: Fentanyl
Concentration: 50mcg/ml
Bolus dose: 25mcg/0.5ml
'Stat delivery'
Lock out interval: 5 minutes
Background infusion: Nil

Protocol C * THIS IS NOT PATIENT CONTROLLED BUT A CONTINUOUS INFUSION

Drug: Ketamine
Concentration: 2.0mg/ml
Bolus dose: Nil
Lock out interval: Nil
Background infusion: continuous delivery 2mg/hr

Protocol D

Drug: Oxycodone
Concentration: 2mg/ml
Bolus dose: 1mg/0.5ml
'Stat delivery'
Lock out interval: 5 minutes
Background infusion: Nil

APPENDIX 2 – GUIDELINES FOR ADMINISTRATION OF NALOXONE (NARCAN) FOR OPIOID INDUCED RESPIRATORY DEPRESSION

Guidelines for Administration of Naloxone (Narcan) for Opioid induced Respiratory Depression

Respiratory rate less than 8 per min + Conscious level A or V

No → Maintain physiological observations as per hospital policy

Yes

- Stop opioid administration and/or remove PCA/PCEA handset from patient.
- Administer 40% oxygen via face mask.
- Monitor and reassess at regular 15 minute intervals until RR > 8.
- Contact pain team.
- Naloxone administration is not warranted at this stage.

Respiratory rate less than 6 per min + Conscious level P or U

Yes

- Stop opioid administration and/or remove the PCA/PCEA handset.
- Administer 15 litres of oxygen via reservoir face mask
- Attempt to waken patient.
- Administer 100 micrograms naloxone IV immediately.
- Seek urgent assistance from on-call anaesthetist/outreach team/pain team.
- Document in case notes.
- Repeat this dose if no or limited response after 2 minutes.
- Support ventilation by face mask or Ambu-bag if rate declines further or if respiratory depression persists.
- Consider naloxone infusion.
- Be aware that respiratory depression can return as the naloxone may act for a shorter time period than the opioid.

Conscious Level

A – Awake
V – Voice
P – Pain
U – Unresponsive

Preparation & Administration of Naloxone

The ampoules contain 400micrograms/ml of naloxone.

Dilute 1ml of naloxone 400micrograms/ml with 7mls of normal saline to give 8mls of a 50micrograms/ml solution.

Give 2mls (100micrograms) IV of this mixture. If no IV access is available - give IM.

Titrate the dose to reverse respiratory depression without reversing analgesia.

If no response after 2 minutes repeat to a maximum of 400micrograms (8mls).

Preparation for infusion

- Add 2mg of naloxone to 500ml of normal Saline or Dextrose 5% (this gives a final concentration of 4micrograms/ml).
- Usual infusion rate is 25-100ml/hr (100-400micrograms/hr).
- Rate of infusion should be adjusted according to the response, and can be increased up to 200ml/hr (800micrograms/hr).

APPENDIX 3 – DISCONTINUATION OF THE PAC

Discontinuation of the PCA

Points to consider before stopping the PCA

- To ensure continuity of analgesia patients should be prescribed regular oral analgesia (ibuprofen 400mg TDS (if no contraindications) and paracetamol 1g QDS* for 3 days) approximately 24 hours prior to the PCA being discontinued. Oral analgesia can be given when the patient commences oral fluids – 30ml/hr.
- Before discontinuing therapy, assess the patient's pain and Morphine (or other PCA opioid) usage over the previous 12-24 hours.
- If the patient has used less than 20mg Morphine in the previous 24 hours or 10mg Morphine in 12 hours, discontinue the PCA after discussion with the patient.
- If the patient is still using more than 10mg Morphine in 12 hours discuss with the acute pain team and consider continuing for a further 12-24 hours.
- Aim to discontinue the PCA in the day rather than the evening (this prevents pain problems in the night).

** JAC protocols exist for the appropriate dose reduction for patients weighing less than 50kg*

Discontinuation of the PCA

- Ensure the final readings and observations are recorded on the controlled drug administration chart.
- Switch off the PCA machine.
- Detach PCA from the patient

Remove syringe and record surplus opioid, with a witness, in the CD register (see Trust Policy PAT MM1 via https://www.dbth.nhs.uk/document/patmm1b/ (Disposal of Controlled Drugs from a PCA on p.40)).

Disposal of controlled drugs

This policy must be read in conjunction with the Trust policy for the Safe and Secure Handling of Medicines – Controlled Drugs - PAT/MM 1 B.

Record the surplus opioid in the CD register with a witness and sign the CD register.
Any surplus opioid remaining after the PCA has been discontinued shall be measured and disposed of by adding directly to an approved **Controlled drug Disposal Kit.** To be returned to pharmacy for disposal with the pharmaceutical waste.

A separate entry shall be made in the ward Controlled Drug Record book under the heading e.g. "Morphine Sulphate 100mg/50ml as PCA syringes waste" or the name of the opioid wasted. The entry shall record:

- Date and time of disposal
- Patients name
- The volume remaining in the syringe which is waste
- The signature of the nurse disposing of the solution
- The signature of the nurse witnessing the disposal

Return the pump complete with patient demand button to recovery. If it cannot be returned immediately, ensure it is plugged in.

All pumps must be handled with care. Any damage incurred will be charged to the ward responsible.

Pain assessment/documentation should be continued regularly (4-hourly) for the next 24 hours then “routine monitoring” can be resumed as per Trust policy (PAT/T 33).

APPENDIX 4 - EQUALITY IMPACT ASSESSMENT PART 1 INITIAL SCREENING

Service/Function/Policy/ Project/Strategy	Care Group/Executive Directorate and Department	Assessor (s)	New or Existing Service or Policy?	Date of Assessment
Patient Controlled Analgesia (PCA) – PAT/MM 7 v.3	Anaesthetics	Ailsa Woodhouse	Existing	March 2021

1) Who is responsible for this policy? Ailsa Woodhouse –Lead Nurse

2) Describe the purpose of the service / function / policy / project/ strategy? It is intended to benefit nursing/medical staff to provide safe and effective Patient Controlled Analgesia (PCA) therapy and to ensure continuity of effective analgesia

3) Are there any associated objectives? National Patient Safety Agency, Essence of Care.

4) What factors contribute or detract from achieving intended outcomes? – Staff knowledge and skills in the ability to prescribe, use of the pump.

5) Does the policy have an impact in terms of age, race, disability, gender, gender reassignment, sexual orientation, marriage/civil partnership, maternity/pregnancy and religion/belief? No

- **If yes, please describe current or planned activities to address the impact** [e.g. Monitoring, consultation] –

6) Is there any scope for new measures which would promote equality? [any actions to be taken] No

7) Are any of the following groups adversely affected by the policy?

Protected Characteristics	Affected?	Impact
a) Age	No	
b) Disability	No	
c) Gender	No	
d) Gender Reassignment	No	
e) Marriage/Civil Partnership	No	
f) Maternity/Pregnancy	No	
g) Race	No	
h) Religion/Belief	No	
i) Sexual Orientation	No	

8) Provide the Equality Rating of the service / function /policy / project / strategy – tick outcome box

Outcome 1 ✓	Outcome 2	Outcome 3	Outcome 4

If you have rated the policy as having an outcome of 2, 3 or 4, it is necessary to carry out a detailed assessment and complete a* **Detailed Equality Analysis form in Appendix 4

Date for next review: April 2024

Checked by: Lee Wilson **Date: March 2021**