Day Case Spinal Anaesthesia

This guidance does not override the individual responsibility of health professionals to make appropriate decision according to the circumstances of the individual patient in consultation with the patient and /or carer. Health care professionals must be prepared to justify any deviation from this guidance.

Introduction

This document provides guidance for healthcare professionals to enable them to care for patients undergoing day (zero night stay) surgery under spinal anaesthesia, as part of a package of continuing training and practice. It incorporates criteria for discharge, overnight admission and patient follow up. Measures of patient satisfaction and audit are also outlined.

This guideline is for use by the following staff groups:

Anaesthetists
Nurses
Surgeons
Theatre staff

Lead Clinician(s)

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Approved by Anaesthetic Governance on:	23rd November, 2022
Approved by SCSD Governance on:	25th January, 2023
Review Date:	25th January, 2026
This is the most current document and should be used until a revised version is in place	

Key amendments to this guideline

Date	Amendment	Approved by:
30th Sept 2020	Document approved	SCSD Governance
1/11/2021	Ampres	J Leedham
19/01/2022	Safe to Stand	J Leedham
January 2023	Document approved	SCSD Governance

Introduction

Spinal anaesthesia can be safely used for day surgery. It provides good intra-operative conditions for a range of infra-umbilical operations with prompt recovery of motor and bladder functions, for same day discharge[1]. It is important to consider the option of day case spinal anaesthesia for patients in whom a general anaesthetic (GA) might pose greater risks and necessitate an inpatient admission.

Examples of patients who may benefit from day case spinal anaesthesia are those with:

- Severe post operative nausea and vomiting (PONV) following general anaesthesia
- High BMI
- Significant respiratory disease
- Known or predicted difficult airway
- Severe gastro-oesophageal reflux disease

Pre-assessment Clinic (POAC) is responsible for

- Explaining in broad terms the anaesthetic options, including day case spinal anaesthesia
- Giving instructions for withholding any anticoagulant/antiplatelet medications.
- Performing FBC for potential candidates for day case spinal anaesthesia (if an appropriately recent one is not available)
- Performing a coagulation screen if:
    - Platelet count is $<100 \times 10^{-9}$/l
    - There is any clinical suspicion or family history of bleeding tendency (i.e. previous excessive post surgical or traumatic bleeding)
    - Patient is receiving anticoagulant or antiplatelet medications
    - There is any reason to suspect liver dysfunction (e.g. liver disease, abnormal liver function tests and no recent clotting test results)
    - Patient drinks alcohol to excess
- Explaining that the final decision will be made after discussion between the patient and their anaesthetist on the day of surgery
- Communicating to the surgeon and their secretary that any potential candidate for day case spinal anaesthesia should be operated on during the morning or early afternoon

On the day of surgery

- The anaesthetist will discuss anaesthetic options with the patient
- If day case spinal anaesthesia is agreed, the patient should undergo surgery in the morning or early afternoon
- The day surgery unit should be informed that the patient is being given a day case spinal
- The day case unit must be staffed until 18:00
- Anaesthetic cover must be available to support the day surgery unit until 18:00
- If the patient's anaesthetist leaves before the patient is discharged, they must hand the case over to the starred anaesthetist at KTC/Alex and the CEPOD anaesthetist at WRH. This handover should be documented on anaesthetic chart with contact details provided for the day surgery unit.

Local Anaesthetic drugs for spinal anaesthesia[2/3/4]

Priloketal® - 2% Heavy Prilocaine (an amide local anaesthetic with a good safety record) is the first choice for surgical procedures lasting up to 90mins. It is ideally suited to ambulatory surgery due to its fast onset and intermediate duration of action. It does not require the addition of fentanyl to produce a dense block. Time to discharge is dose-dependent but up to 60mg can be used safely and effectively, even early on afternoon lists whilst still enabling discharge before DSU closes (median offset times are 110mins and 132mins with 40 or 60mg respectively)

The recommended dose range of Priloketal® is 40mg to 60mg, with a maximum licensed dose of 80mg[3]. Its duration of action is dose dependent but it cannot be relied upon to provide surgical anaesthesia for longer than 90minutes. Please consider the additional time required to position, transfer and prepare patients after performing the spinal injection before knife to skin commences. This can significantly erode into the duration of surgical anaesthesia provided by the spinal anaesthetic.

Ampres® - Chloroprocaine hydrochloride 1%. Chloroprocaine is an ester local anaesthetic with a rapid onset and offset of action. The approved indication is for spinal anaesthesia in adults where the planned surgical procedure should not exceed 40 minutes. Reports from other centres suggest that longer operating times of 60-90mins have sometimes been achieved when using 5mls (50mg) of Ampres. However, please err on the side of caution and be conservative because these spinal blocks regress quickly in a similar manner to those produced by 2% Heavy Prilocaine.

Particular notes of caution include: avoiding use in patients with known hypersensitivity to ester-type local anaesthetics or para-aminobenzoic acid based metabolites. In patients with known pseudocholinesterase deficiency (including those with severe liver impairment) metabolism and duration of block might be prolonged.

The recommended dose is 40 – 50mg with a maximum dose of 50mg, to achieve an upper sensory level of T10. Close communication with surgical colleagues and accounting for surgical preparation time is essential in order to facilitate optimum use of this agent (i.e. Surgeon in theatre scrubbed with theatre team ready to position patient immediately after spinal injection)

Ampress is isobaric therefore 2% Heavy Prilocaine should be used instead when a saddle block, block level above T10 or longer duration block is needed. Table 1 provides some suggested dosing regimens.

Block Height	Suggested 2% Heavy Prilocaine (Priloketal®) Dose	Suggested 1% Chloroprocaine (Ampres®) Dose	Example Procedures
Saddle	20 - 30mg (1 - 1.5mls)	Isobaric therefore not recommended	Perianal fistula/abscess, haemorrhoids, vulval surgery
L1	40 - 50mg (2 - 2.5mls)	40 - 50mg (4 – 5mls)	Knee/ankle arthroscopy
T10	50 - 60mg (2.5 - 3mls)	40 - 50mg (4-5mls)	ERPC, TURP/TURBT, cervical suture
Above T10	60mg (3mls)+	Isobaric therefore not recommended	Epigastric/umbilical herniotomy

Table 1

Heavy Marcaine® 0.5% can be used instead if a surgical procedure is expected to exceed 90mins. However, this should only be used on morning lists to allow sufficient time for recovery of motor function before DSU closes.

Opioids in day case spinal anaesthesia

1. **Intrathecal Morphine and Diamorphine must not be used**

2. The routine addition of Fentanyl (5-20mcg) is unnecessary and can be associated with adverse effects including pruritus, PONV and post operative urinary retention (POUR).

3. Intrathecal Fentanyl dose if used must not exceed 20micrograms to ensure no risk of late respiratory depression.

Suggested method of administration

- The patient should be prepared as for GA, with fasting as per hospital protocol.
- The minimum standards for monitoring, as per AAGBI guidelines, are essential.
- Patent IV access should be obtained prior to performing the spinal anaesthetic.
- Vasopressors and anticholinergics should be immediately available.
- Anaesthetic drugs and airway equipment must be immediately available in the event that conversion to GA is necessary.
- The patient can be positioned either lateral or sitting, depending on the anaesthetist's preference. If the patient is positioned lateral, it is suggested that the operative side should be down because the spread of anaesthetic can be controlled with posture when using hyperbaric solutions.
- When using hyperbaric solutions if you do not want a saddle block lie the patient down quickly. To maximise sacral block, inject slowly and keep patient in sitting position for 1-3minutes.
- After confirming adequate block height, although ideally avoided, the patient may receive sedation. Short acting agents such as low dose propofol TCI (Target Controlled Infusion) should be employed. Oxygen should be administered via $EtCO_2$ sampling facemask e.g. Capnomask® perioperatively when using sedation.
- Respiratory depression with intrathecal fentanyl can occur, although its maximum effect is seen at around one hour from administration with no late onset respiratory depression. Respiratory rates under 10 breaths per minute are seldom seen and treatment with Naloxone is rarely required.
- In addition to the spinal anaesthesia, local anaesthetic infiltration or regional blocks are encouraged to provide more prolonged post-operative analgesia.

- Post-operative analgesia should be managed as it would be for patients undergoing the same procedure under GA.
- Supplementary systemic analgesic (Paracetamol and NSAIDs, when not contraindicated) should be given pre-emptively to cover the spinal analgesia subsiding.
- As with any spinal anaesthetic, complete or partial failure may occur requiring repetition, intraoperative supplementation with local anaesthesia, parenteral opioids or conversion to GA as appropriate.
- To avoid bladder over distension and increased risk of Post Operative Urinary Retention avoid giving intravenous fluid volumes >500mls during surgery unless required to treat hypotension.
- Use caution when sitting patients up after the procedure because a residual sympathetic block can result in significant hypotension. To treat bradycardia and hypotension: raise legs, administer IV ephedrine and/or glycopyrrolate.

Regional Anaesthesia UK have produced a helpful infographic entitled 'Ambulatory spinal anaesthesia in 8 steps'. This summarises many of the above points and is included as Appendix 1.

Abnormalities of coagulation

If there is any clinical suspicion of impaired platelet function or prolonged bleeding avoid spinal anaesthesia.

If platelet count <100 x 10^{-9}/l a coagulation screen should be performed and the risk / benefit of the procedure discussed with a more senior anaesthetist

If platelet count <80 x 10^{-9}/l do not perform day case spinal anaesthesia

A coagulation screen should be checked and INR/APTR 1.4 or below prior to performing spinal anaesthesia if:

- There is any clinical suspicion or family history of bleeding tendency
- There is any reason to suspect liver dysfunction (e.g. Liver disease, abnormal liver function tests and no recent clotting result)
- Patient drinks alcohol to excess
- Patient is receiving anticoagulant or antiplatelet medications (INR and APTR are not reliable tests for assessing the anticoagulant effects of antiplatelet agents, LMWH or direct oral anticoagulant drugs e.g. Rivaroxaban, Apixaban, Dabigatran)

Spinal anaesthesia must only be considered in haematological conditions associated with abnormalities of coagulation after acceptable normalisation of coagulation on the advice of a haematologist.

Postoperative Recovery and Discharge

- The day surgery unit (DSU) should be informed by the anaesthetist of patients who are having day case spinal anaesthesia, and will plan for a slightly longer recovery on DSU. DSU staff should inform the bed manager at this point if an inpatient bed has been reserved.

- First stage recovery care will be given in the post anaesthetic care unit (PACU) within current protocols, although it is anticipated that the median time spent per patient in first stage recovery may be much shorter than that required for GA. No minimum time in first stage PACU is stipulated before return to second stage recovery area. Standard documentation of first stage recovery and discharge from recovery should be completed as at present.

- The spinal care pathway and observation chart (PF WR5090) must be completed for all patients who receive a day case spinal anaesthetic.

- DSU recovery will continue to be criteria based, rather than time based, acknowledging the wide variation in time to full recovery after Day Case Spinal Anaesthesia. The current nurse led day surgery discharge criteria (Appendix 2) are suitable to be used for patients undergoing Day Case Spinal Anaesthesia. However, it should be noted that patients must also have:

1. **A steady gait with no dizziness. Motor function and mobility level the same as preoperative level (within limits of surgery)**
    - Prior to mobilising the patient should be able to report normal power and sensation in their legs and buttocks i.e. are able to bilateral straight leg raise, have normal sensation in the soles of both feet, have normal proprioception of both great toes (refer to Appendix 5)
    - A nurse should be present on first mobilisation but should not provide physical support for the patient in line with safe manual handling practices.
    - The patient trolley should be fully lowered and an additional chair placed beside the trolley in case of any dizziness or unsteadiness precluding a swift return to the trolley.

2. **Have voided urine prior to discharge**
    - All patients should be asked to void when their bladder feels comfortably full or after a maximum of 4 hours post-surgery.
    - If they are unable to void when ready for discharge an ultrasound bladder scan should be performed to check bladder volume if a patient has any risk factors for developing urinary retention[6]:
        - urology, uro-gynaecology, inguinal or perianal surgery
        - age >70years
        - history of incontinence or voiding difficulty
        - spinal anaesthesia performed with Bupivacaine using doses in excess of 7mg
    - If bladder volume is less than 500mls encourage hydration and observe for a further 2 hours then repeat the bladder scan if required.
    - If bladder volume exceeds 500mls insert a urinary catheter and discharge the patient home with a leg bag and straps (assuming that all other discharge criteria have been met and the patient is in agreement with this catheter management plan).

- When urinary catheterisation is required a trained nurse or relevant surgical team doctor should perform this task initially. Urology advice can be obtained from the on-call team when appropriate via switch board.
- Catheterised patients will need to have this removed and undergo a trial without their catheter (TWOC) after 48hours. If the surgical team have not provided specific instructions to attend a particular TWOC clinic an appointment should be made for the patient to attend KTC Ward 1 to undergo their TWOC. If a Ward 1 patient fails their TWOC, nursing staff should inform the patient's responsible surgeon to ensure that a referral is made to a urologist (this can be done via their secretary). The urology team can also be contacted for advice concerning the further management of these patients.
- In the event that a patient is unable to attend KTC Ward 1 to undergo their TWOC then this should be performed in the community by district nurses instead. A TWOC in the community managed by district nurses which fails will need to be dealt with by the GP or Alexandra hospital urology team. District nurses must notify the urology on call doctor if a patient is sent to the Alexandra hospital to be reviewed.

Incomplete void
If concerned that a patient has been unable to fully void, check their residual bladder volume by performing an ultrasound bladder scan after voiding. The residual volume should be less than 300mls. If the residual volume is more than 500mls patients will need catheter insertion and TWOC in 2 days. If residual bladder volume is 300-500mls observe for a further 2 hours to allow opportunity for further satisfactory voiding.

The bladder management process for all patients at high risk of developing Post Operative Urinary Retention (POUR) is summarised in Appendix 3. Please follow this process unless the surgical team have stipulated different instructions.

Failed mobilisation or unable to void urine
If the patient has not mobilised or passed urine 5 hours after the insertion of the spinal anaesthetic, or by 5pm, the anaesthetist should be contacted for advice.

The list anaesthetist should leave their contact details and specify arrangements on the recovery section of the anaesthetic chart. At this time, the bed manager should be contacted to make arrangements for an inpatient bed in case this is required and the relevant surgical team should be advised if the patient requires admission.

Post Discharge Follow up

- On discharge from DSU, patients must be provided with the trusts 'Spinal Anaesthetic Information Leaflet For Patients' (PF WR1985) and the 'Spinal Follow Up' form (WR2172) must have been completed.
- The patient's contact details should be verified and the process of text message/telephone follow-up at 24hours should be discussed with the patient.
- The patient should be told, that if they have any concerns regarding their spinal anaesthetic during the 2 weeks following their procedure they should contact the DSU between 8am-6pm Monday-Friday. At all other times they should telephone 01905 763333 and ask to speak to the on-call anaesthetist at WRH on Bleep 700. If it is more than 2 weeks following their procedure date they should contact their GP and make them aware that they had a spinal anaesthetic.

Follow up and Audit

It is recommended that all patients receiving day case spinal anaesthesia are followed up to detect any related morbidity (e.g. post dural puncture headache, transient neurological syndrome etc.). It is also highly desirable to measure patient satisfaction. This follow-up, combined with the provision of a Patient Information Leaflet on discharge, should enable detection of any rare events associated with spinal anaesthesia such as infection or haematoma.

- A structured follow-up questionnaire should be completed for all day surgery patients.
- Additional follow up for day case spinal patients is accomplished using the structured questionnaire (Appendix 4).
- The optimal time for follow up is at 24 hours after discharge with subsequent follow up at 48 and 72 hours if required.
- If unable to contact the patient by telephone, this should be recorded on the follow-up document with the date and time that contact was attempted.
- Follow up of patients discharged after a day case spinal is the responsibility of the day case unit which discharged them.
- The first point of contact for the DSU nurse for any problems identified on follow-up should be the anaesthetist who inserted the spinal, or their supervising consultant (they are contactable via the anaesthetic department secretaries at WRH or via the switchboard).

If they are unavailable, the consultant anaesthetist listed below should be contacted instead:

Site of Patient's Surgery	**Point of Contact**	**Bleep number**
KTC	8am-6pm: starred consultant anaesthetist @ KTC. Out of hours: CEPOD consultant @ WRH	NA (Name displayed on theatres info board). Mobile phone via switch board.
Alexandra Hospital	CEPOD consultant anaesthetist @ Alex	Mobile phone via switchboard or Bleep 0907
WRH	CEPOD consultant anaesthetist @ WRH	Mobile phone via switchboard or Bleep 600

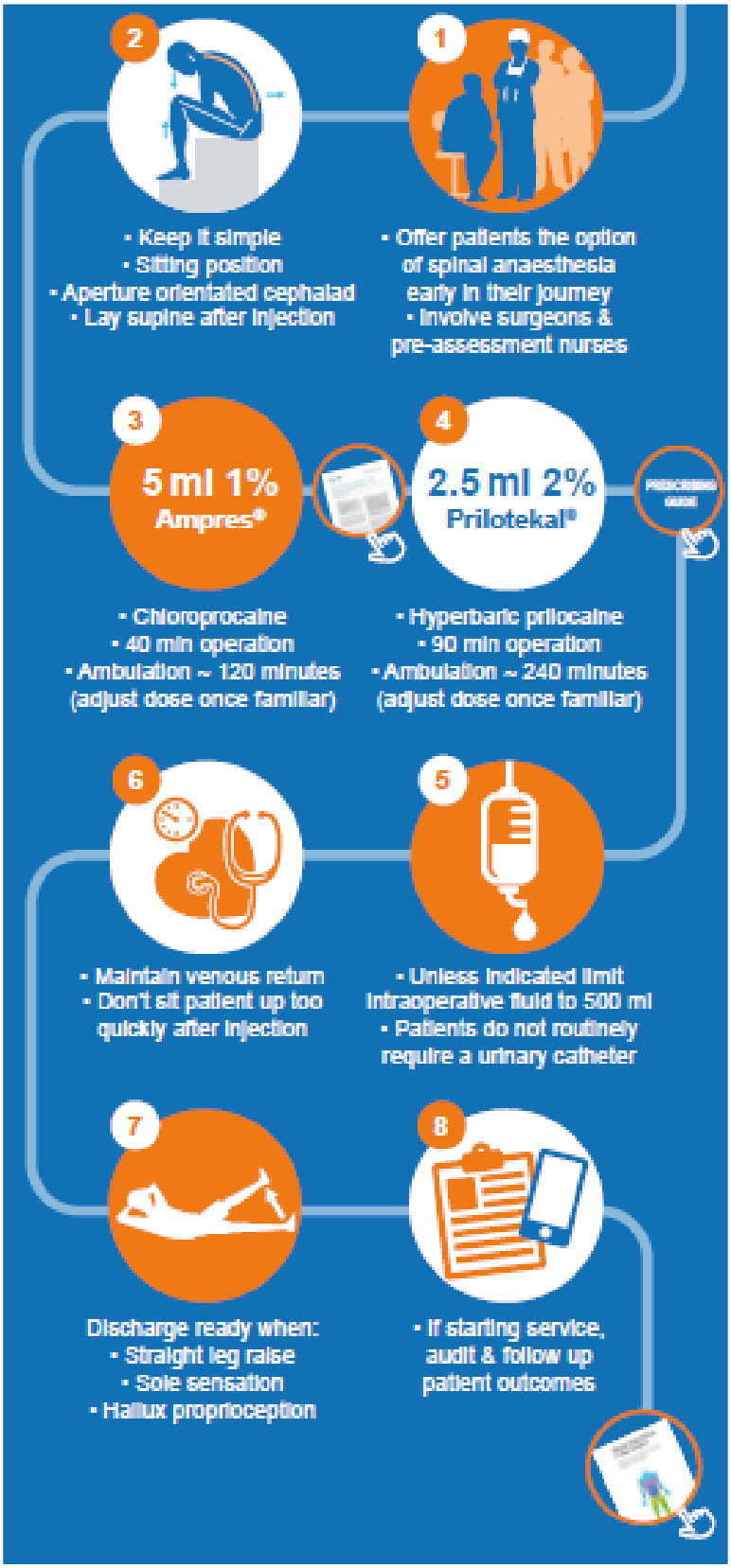
Please note that the countywide anaesthetics department rota is available on the trust's intranet via the anaesthetic department home page.

The above escalation pathway should also be used when patients contact the DSU for advice related to their spinal anaesthetic. In cases where patients contact the DSU, details of the phone consultation, advice given or escalation measures taken, should be recorded. The date and time of the phone call should be clearly recorded.

In the case of a suspected neurological emergency, emergency admission should be arranged under the parent surgical team. The surgical team must be informed and given instructions on the immediate management of the patient. On arrival in the hospital, the patient must be reviewed promptly by a senior member of the anaesthetic and surgical team.

The results of the routine follow up and any major adverse events will be collated and reviewed annually.

Appendix 1 – RA-UK Ambulatory Spinal Anaesthesia in 8 Steps



Appendix 2: WAHT Nurse Led Discharge Protocol for Day Surgery Patients Summarised (KGH-TC-003)

Although a post-operative review by both the operating surgeon and anaesthetist should be encouraged, assessment of when the patient is fit for discharge can, and should be performed by competent nursing staff using the agreed discharge checklist in combination with clear written post-operative instruction by the operating surgeon.

All patients must meet the relevant discharge criteria in order to be suitable for Nurse led discharge.

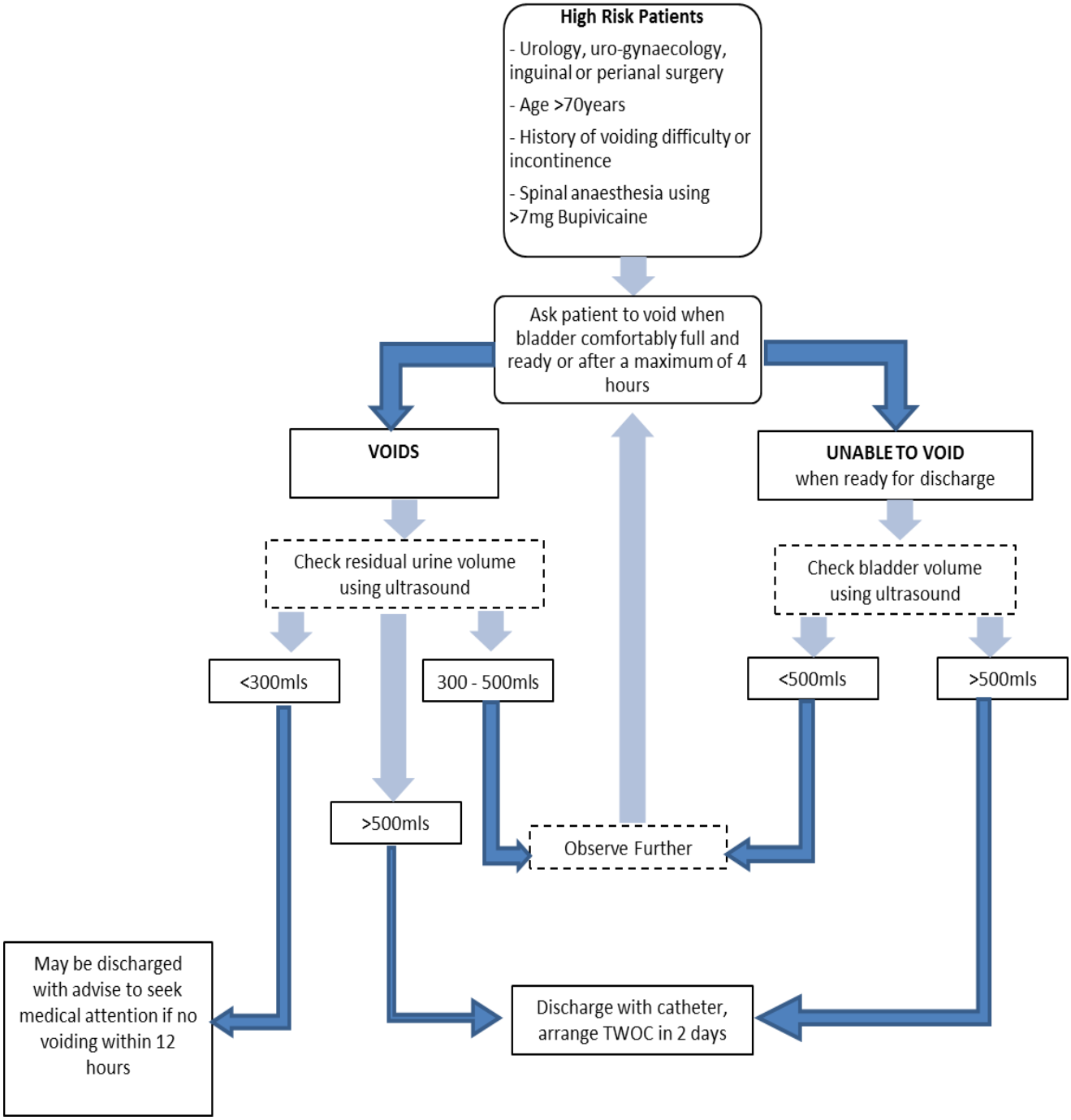
- Vital signs stable and comparable to that on admission
- Comfortable with adequate pain control
- Minimal nausea, vomiting or dizziness
- Correct orientation as to time, place and person or comparable to that on admission
- Tolerated diet and fluids post-operatively
- Cannula removed and PVD form complete
- Operation site checked with minimal bleeding present
- **Urine voided post operatively**
- **Assessed as able to mobilise within their own limits (see Appendix 5)**
- Has a responsible adult to escort them home and a named carer to take responsibility for them 24 hours post discharge
- Discharge letter provided
- Appropriate referrals made e.g District Nurse, physio or TWOC clinic
- Next day phone call organised

Appendix 2 addendum

In the day surgery unit, we recognise that individual patients recover at different rates following their anaesthesia and surgery therefore keeping patients for a fixed time in recovery makes no sense. Once above criteria have been met, the patients can be discharged. Delaying patient's discharge once they have satisfied the criteria does not benefit the patient, nor does it help the smooth running of the unit.

It is particularly important for the following groups of patient to demonstrate the ability to pass urine before discharge: those who have undergone urology, uro-gynaecology, inguinal or perianal surgery; age >70years, history of incontinence or voiding difficulty, spinal anaesthesia performed.

Appendix 3: Bladder management process for all patients at high risk of Post Operative Urinary Retention (POUR). Please follow this unless the surgical team have stipulated different instructions.



Adapted from Queen Elizabeth Hospital Kings Lynn bladder management flowchart

Appendix 4: Day Case Spinal Follow up questionnaire

Have you had any of the following in the last 24 hours? (0 to 10, where: 0 = none of the time [excellent] and 10 = all of the time [poor]		
1. New postural headache (worse on standing, eased by lying down)	None of the time	0 1 2 3 4 5 6 7 8 9 10 — All of the time
2. New or increased lower back pain	None of the time	0 1 2 3 4 5 6 7 8 9 10 — All of the time
3a. Pain travelling down one or both of your legs (sciatica)	None of the time	0 1 2 3 4 5 6 7 8 9 10 — All of the time
3b. If yes, please specify which	Left leg only	Right leg only — Both legs
4a. Weakness in one or both legs	None of the time	0 1 2 3 4 5 6 7 8 9 10 — All of the time
4b. If yes, please specify which	Left leg only	Right leg only — Both legs
5a. Lost sensation or numbness in one or both legs	None of the time	0 1 2 3 4 5 6 7 8 9 10 — All of the time
5b. If yes, please specify which	Left leg only	Right leg only — Both legs
6. Lost sensation or numbness in your anus, genitals and buttocks	None of the time	0 1 2 3 4 5 6 7 8 9 10 — All of the time
7. Lost control of bladder function (leaking/unable to hold urine or retaining/unable to pass urine)	None of the time	0 1 2 3 4 5 6 7 8 9 10 — All of the time
8. Lost control of bowl function	None of the time	0 1 2 3 4 5 6 7 8 9 10 — All of the time
Concerning your day case spinal anaesthetic		
Did you feel pain during your operation?	None of the time	0 1 2 3 4 5 6 7 8 9 10 — All of the time
Were you unhappy with the anaesthetic care you received?	None of the time	0 1 2 3 4 5 6 7 8 9 10 — All of the time
If you were having the same surgical procedure again and were offered the choice of a spinal or General Anaesthetic (being completely unconscious) which would you choose?	Spinal/GA	

ACTION – If you contact an anaesthetist ensure you record who you spoke to, when and their agreed plan for follow up or review

Follow up outcomes					
Discharge		Phone call in 24 hours		Other outcome (please specify)	
Discussed with Anaesthetist			Name		
			Date		
			Time		

If no problems	DISCHARGE
If Transient Neurological Symptoms	CONTACT ANAESTHETIST
If disabling headache despite analgesia	CONTACT ANAESTHETIST
If headache at 48hours follow up	PHONE AT 72 HOURS
If still headache at further follow up	CONTACT ANAESTHETIST

Notes:

Headache:

If strong postural component (i.e. worse on standing up and rapidly relieved by lying down) then likely Post Dural Puncture "spinal" Headache). May have associated neck pain, photophobia and nausea. Reassure and give advice about this likely cause. Recommend regular analgesia with Paracetamol, NSAIDs +/- Codeine (unless contraindicated). Encourage adequate oral fluids, avoid alcohol but caffeine is allowed, advise regarding lying flat for short term relief and planned follow up call. On next follow up call if headache persistent and at all troublesome for patient to contact anaesthetist.

If associated with fever and/or vomiting then contact anaesthetist who may advise hospital review if concerned about possible intracranial pathology or meningitis.

Neurology:

Transient Neurological Symptoms (TNS) are characterised by pain in buttocks, thighs or legs after an initial full recovery from spinal anaesthesia, it is expected with an incidence of less than 1% but should not be associated with progression of symptoms, bowel, bladder or motor deficits. TNS is self-limiting and usually resolves within 72hours.

If new onset pain or unexpected pain presenting with progressive sensory, bladder, bowel or motor deficits, speak personally to the anaesthetist responsible (if unavailable to the CEPOD Anaesthetic Consultant at WRH or AH) for advice regarding emergency hospital review by anaesthetic team). Worsening neurological symptoms or onset after a symptom-free period must both be treated seriously. This implies changing pathology such as increasing compression from an enlarging mass (i.e. haematoma / abscess).

Appendix 5: Safe to Stand Tests post spinal anaesthetic

Affix Patient Label here or record

Name: .....

NHS No:

Hosp No:

D.O.B: D D / M M / Y Y Y Y Male Female

Ward: ..... Cons .....

DAYCASE SPINAL POST-OPERATIVE OBSERVATIONS

NHS
Worcestershire Acute Hospitals
NHS Trust

Please select/fill all that apply and use alongside observation pathway WR5090

Time Spinal Given: __ __ : __ __

1% Ampres®		Test after 2 hours	2% Prilokteal® 3ml		Test after 3 hours
2% Prilokteal® ≤ 2mls		Test after 2 hours	0.5% Bupivacaine ≤ 2mls		Test after 3 hours
2% Prilokteal® 2-2.9ml		Test after 2.5 hours	0.5% Bupivacaine > 2mls		Test after 4 hours

Preconditions for Safe to Stand tests:

1. Adequate time from spinal as above
2. Systolic BP > 100mmHg
3. Pain and nausea controlled

Time first able to stand: __ __ : __ __

Time first passed urine: __ __ : __ __

Time discharged home: __ __ : __ __

Safe to Stand Tests

1. Straight leg raise

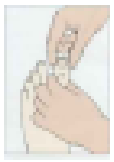
The patient should be able to lift their leg off the bed at the hip, against gravity.

2. Sole sensation.

The patient should feel cold sensation on the sole of the foot. It should feel the same as on their arm.

3. Great toe proprioception

The patient should be able to feel if the distal joint of their great toe is being moved up or down without looking.



Maximum pain score recorded on ward: 0 (nil) 1 (mild) 2 (moderate) 3 (severe)

Post op complication(s):

Urinary Retention | Severe Pain | Headache | Unplanned admission | Other please specify below

.....

.....

.....

Many thanks for completing this form, please make additional comments above

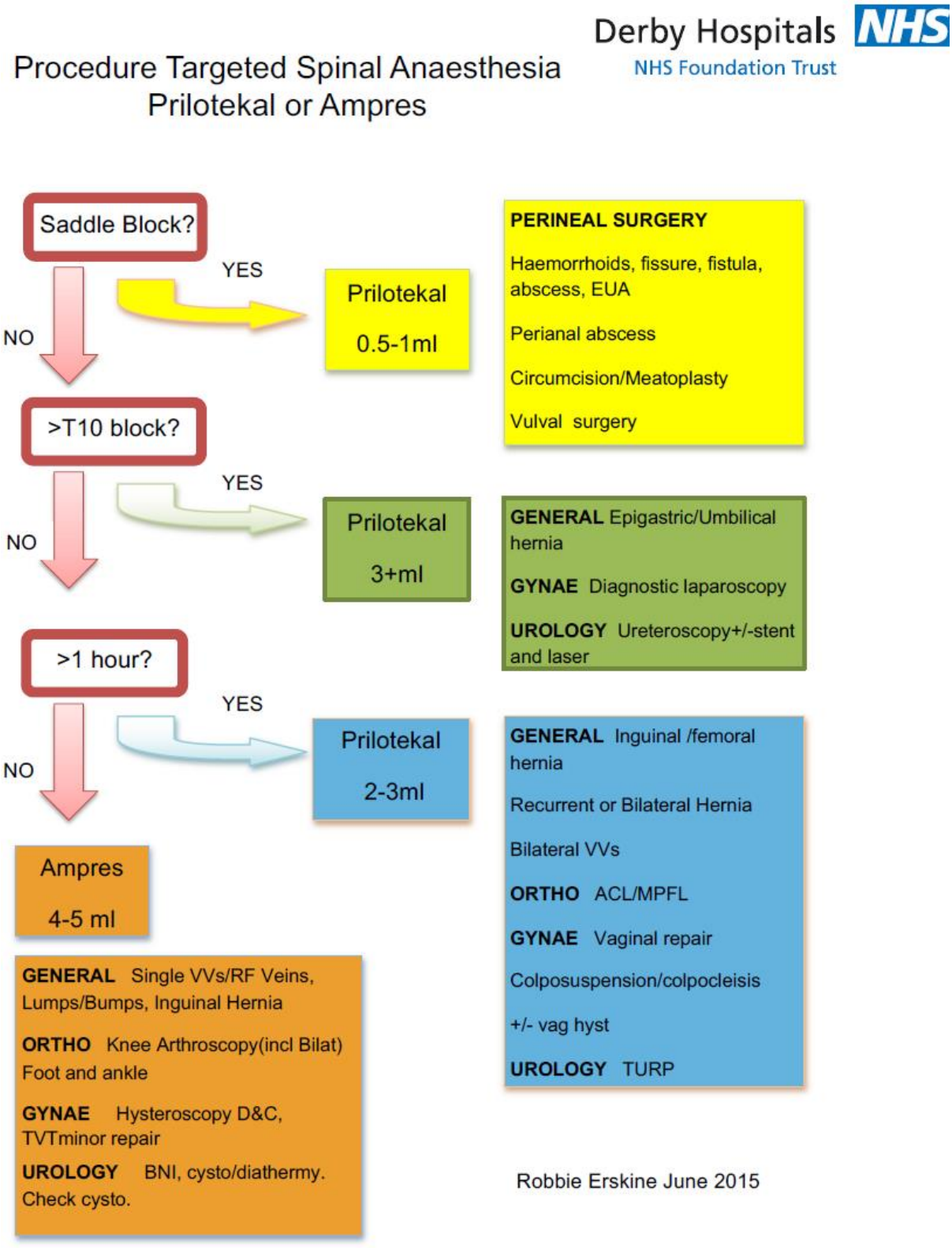
Proof Only Do Not Scan

Name:	Designation:	
Sign:	Time:	Date:

Proof Only Do Not Scan

RI WR5017 Daycase Spinal Post-Operative Observations Version 1 Page 1 of 1

Appendix 6: Prescribing Guide for Targeted Spinal Anaesthesia



Monitoring

Page/ Section of Key Document	Key control:	Checks to be carried out to confirm compliance with the Policy:	How often the check will be carried out:	Responsible for carrying out the check:	Results of check reported to: *(Responsible for also ensuring actions are developed to address any areas of non-compliance)*	Frequency of reporting:
	WHAT?	**HOW?**	**WHEN?**	**WHO?**	**WHERE?**	**WHEN?**
	These are the 'key' parts of the process that we are relying on to manage risk. We may not be able to monitor every part of the process, but we MUST monitor the key elements, otherwise we won't know whether we are keeping patients, visitors and/or staff safe.	What are we going to do to make sure the key parts of the process we have identified are being followed? (Some techniques to consider are; audits, spot-checks, analysis of incident trends, monitoring of attendance at training.)	Be realistic. Set achievable frequencies. Use terms such as '10 times a year' instead of 'monthly'.	Who is responsible for the check? Is it listed in the 'duties' section of the Policy? Is it in the job description?	Who will receive the monitoring results? Where this is a committee the committee's specific responsibility for monitoring the process must be described within its terms of reference.	Use terms such as '10 times a year' instead of 'monthly'.
	Unexpected admission following planned day case spinal anaesthetic	Audit	Ongoing process	Day case lead clinician	Pre-op, day case and TAU governance meeting	Bi-annual

References

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5. Chee YL et al. Guidelines on the assessment of bleeding risk prior to major surgery or invasive procedures. British Journal of Haematology 2008: 140 (5).
6. W. Rattenberry, A. Hertling and R. Erskine. Spinal anaesthesia for ambulatory surgery. BJA Education 19(10):321-328 (2019). https://bjaed.org/article/S2058-5349(19)30107-6/pdf

Contribution List

Contribution List

This key document has been circulated to the following individuals for consultation;

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This key document has been circulated to the chair(s) of the following committee's / groups for comments;

Committee
Ms Suzsanna Hicks (Pre-op, Day Case & TAU Governance Meeting)
WAHT Medicines Safety Committee

Supporting Document 1 - Equality Impact Assessment Tool

To be completed by the key document author and included as an appendix to key document when submitted to the appropriate committee for consideration and approval.

Please complete assessment form on next page;

Worcestershire Acute Hospitals NHS Trust

Herefordshire & Worcestershire STP - Equality Impact Assessment (EIA) Form
Please read EIA guidelines when completing this form

Section 1 - Name of Organisation (please tick)

Herefordshire & Worcestershire STP		Herefordshire Council		Herefordshire CCG	
Worcestershire Acute Hospitals NHS Trust		Worcestershire County Council		Worcestershire CCGs	
Worcestershire Health and Care NHS Trust		Wye Valley NHS Trust		Other (please state)	

Name of Lead for Activity	

Details of individuals completing this assessment	**Name**	**Job title**	**e-mail contact**
Date assessment completed			

Section 2

Activity being assessed (e.g. policy/procedure, document, service redesign, policy, strategy etc.)	**Title:**			
What is the aim, purpose and/or intended outcomes of this Activity?				
Who will be affected by the development & implementation of this activity?	❑ Service User ❑ Patient ❑ Carers ❑ Visitors		❑ Staff ❑ Communities ❑ Other _____	
Is this:	❑ Review of an existing activity			

	❑ New activity ❑ Planning to withdraw or reduce a service, activity or presence?
What information and evidence have you reviewed to help inform this assessment? (Please name sources, eg demographic information for patients / services / staff groups affected, complaints etc.	
Summary of engagement or consultation undertaken (e.g. who and how have you engaged with, or why do you believe this is not required)	
Summary of relevant findings	

Section 3

Please consider the potential impact of this activity (during development & implementation) on each of the equality groups outlined below. **Please tick one or more impact box below for each Equality Group and explain your rationale**. Please note it is possible for the potential impact to be both positive and negative within the same equality group and this should be recorded. Remember to consider the impact on e.g. staff, public, patients, carers etc. in these equality groups.

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Age				
Disability				
Gender Reassignment				
Marriage & Civil Partnerships				
Pregnancy & Maternity				
Race including Traveling Communities				
Religion & Belief				
Sex				
Sexual Orientation				
Other Vulnerable and				

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Disadvantaged Groups (e.g. carers; care leavers; homeless; Social/Economic deprivation, travelling communities etc.)				
Health Inequalities (any preventable, unfair & unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental & economic conditions within societies)				

Section 4

What actions will you take to mitigate any potential negative impacts?	Risk identified	Actions required to reduce / eliminate negative impact	Who will lead on the action?	Timeframe
		.		
How will you monitor these actions?				
When will you review this EIA? (e.g in a service redesign, this EIA should be revisited regularly throughout the design & implementation)				

Section 5 - Please read and agree to the following Equality Statement

1. Equality Statement

1.1. All public bodies have a statutory duty under the Equality Act 2010 to set out arrangements to assess and consult on how their policies and functions impact on the 9 protected characteristics: Age; Disability; Gender Reassignment; Marriage & Civil Partnership; Pregnancy & Maternity; Race; Religion & Belief; Sex; Sexual Orientation

1.2. Our Organisations will challenge discrimination, promote equality, respect human rights, and aims to design and implement services, policies and measures that meet the diverse needs of our service, and population, ensuring that none are placed at a disadvantage over others.

1.3. All staff are expected to deliver services and provide services and care in a manner which respects the individuality of service users, patients, carer's etc, and as such treat them and members of the workforce respectfully, paying due regard to the 9 protected characteristics.

Signature of person completing EIA	
Date signed	
Comments:	
Signature of person the Leader Person for this activity	
Date signed	
Comments:	

Supporting Document 2 – Financial Impact Assessment

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

	Title of document:	Yes/No
1.	Does the implementation of this document require any additional Capital resources	N
2.	Does the implementation of this document require additional revenue	N
3.	Does the implementation of this document require additional manpower	N
4.	Does the implementation of this document release any manpower costs through a change in practice	N
5.	Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programmes or allocated training times for staff	N
	Other comments:	

If the response to any of the above is yes, please complete a business case and which is signed by your Finance Manager and Directorate Manager for consideration by the Accountable Director before progressing to the relevant committee for approval.