Caudal Epidural Injection(s) Standard Operating Procedure UHL Rheumatology (LocSSIPs)

Change Description	**Reason for Change**
☐ Change in format	☒ Trust requirement

APPROVERS	**POSITION**	**NAME**
Person Responsible for Procedure:	Consultant Rheumatologist	Dr Maumer Durrani / Dr James Francis / Dr Vena Patel
SOP Owner:	Head of Service for Rheumatology	Dr M Durrani
Sub-group Lead:	Head of Service for Rheumatology	Dr M Durrani

Appendices in this document:

Appendix 1: UHL Safer Surgery *Department* Checklist.
Appendix 2 : Patient Information Leaflet for *Procedure* Available at:

Introduction and Background:

This LocSSIP is local safety standard for Caudal Epidural procedure. This Standard Operating Procedure is the Local Safety Standard for Invasive Procedures and this is compliant with the National Safety Standards for Invasive Procedures (NatSSIPs) guidance.

This procedure is performed at Day case unit Leicester General hospital by Rheumatologist

Indications for caudal epidural injection

- Severe radicular pain (Sciatica) not adequately controlled by analgesia.
- Leg pain related to spinal stenosis or disc prolapse in a patient not suitable for

surgery Contraindications

Contraindications include the patient not consented properly, allergy to local anaesthetics, active systemic infection or infection at site of injection, inability to insert needle or place probe at the needed area due to a dressing, patient unable to lie in appropriate position for procedure to be

done safely. These are all absolute contraindications.

Patients to be booked on the day case procedure list as and when needed, referred by rheumatology consultants or registrars. Also consultants from rehab and elderly care would be able to referral appropriate patients after discussion with Rheumatology team.

Never Events:

Procedure done on a wrong patient would be a never event

Multi-level ID check is part of the SOP to avoid any never event

List management and scheduling:

Patient will be booked on day case list for half an hour slot, preferably at the start of the list.
Patient will need half hour monitoring post procedure
Admin staff at Day case unit book the patients on the list after appropriate referral received
Standard Rheumatology day case unit form should be used with clear patient identifying information and diagnosis for which Caudal epidural injection is considered.
Request of the procedure should be written in block and not in abbreviations. DNAs would be discharged back to referring physicians
Patients requiring hospital transport should not be listed for late afternoon or out of hour's procedures.

Patient preparation:

Patients will be provided with a 'Caudal epidural' information booklet during their outpatient clinic appointment. This booklet provides the patient with information on what to expect when attending for their Procedure. Patient will complete a consent form with the clinician during their outpatient clinic appointment. If referral from any other subspecialty like rehab, performing consultant make sure the patient has been consented few weeks before to provide enough time for final decision. Patients do not need to fast pre-operatively as the procedures are performed under local anaesthetic.
Patient would have blood pressure, heart rate and saturation checked as well as blood glucose and INR if on warfarin, it should be below 1.5 for procedure to continue.

Functional ultrasound machine with MSK settings is required for consultant doing ultrasound guided procedure.

Patients with special requirements such as:

- Diabetes should have a pre and post procedure blood glucose levels done
- Use of anti-platelet agents (If on dual anti-platelet treatment, discuss with prescribing consultant if one agent could be put on hold)
- Use of anticoagulants (use anti-coagulation bridging guidance for new anticoagulants)

Standard complications and morbidity risks that patients should be informed of in the consent process include:

- Pain or discomfort
- Bleeding or bruising
- Scarring
- Wound Infection
- Headache
- nerve damage
- Possible need for further treatment

Confirmation of consent should be discussed with the patient before their

procedure Infection prevention strategies include:

Prior to any procedure the operating staff should thoroughly cleanse the hands following Trust guidance on hand washing. Before any procedure they should also apply alcohol foam prior to putting on their gloves.

- Aseptic non-touch technique will be utilised for the procedures
- Pre-operative skin prep, a spirit based cleanser e.g. Chloraprep is preferable.
- Sterile gloves
- Aprons
- Sterile Probe cover

Workforce – staffing requirements:

The minimum safe staffing standards for a procedure list include one doctor (operator) and one assistant. The assistant can be a nurse, healthcare support worker or a student that has been deemed competent in the area.
Learners or students will be supervised in the area by either the doctor or the assistant.
Newcomers to the day case unit must be trained and competency assessed by a peer who has previously been deemed competent in this procedure. For both Registered Nurses and Health Care Assistants, this should be recorded in the competency assessment documentation.

Ward checklist, and ward to procedure room handover:

For this procedure- ward team is part of the procedure team and will continue looking after the patient post procedure.
Patient will require 30 minutes monitoring and observation before discharge from the ward.

Procedural Verification of Site Marking:

All patients undergoing Caudal epidural procedure must undergo safety checks that confirm the procedure to be performed.

It is crucial that the team pause from their duties to ensure that their attention can be focused during these checks.
The verification of the intended procedure must involve the doctor, assistant, patient and /or family members/ significant others where possible.
The team must verify that the details on the 'Consent form', 'Procedure request form' correspond with the intended procedure before continuing. A safety check list should be ticked to make sure right procedure is being done for the right patient. Three identifying points should be compared with patient notes and consent form.
Verifications must also be performed at the procedure Safety Check 'Sign in' (detailed below).
Procedure site marking is mandatory for all procedures for which it is possible (Not required for this procedure).

Team Safety Briefing:

The Team Safety Briefing must occur at the start of the procedure session. As many members of the procedural team as possible should attend the briefing, with a minimum of one doctor and one assistant present.
Any team member may lead the safety briefing.
Team members should introduce themselves to ensure that their roles and names are known to encourage people to speak up.
The discussion should include:

- Equipment availability including ultrasound machine if it is ultrasound guided
- Appropriate drugs and monitor

Any additional concerns should be discussed, and contingency plans made.
Every team member should be encouraged to ask questions, seek clarification or raise concerns about any aspect of patient care or the planned procedure.

Sign In:

All patients undergoing caudal epidural block must undergo safety checks beginning with the 'Sign In'. Along with the 'Time Out' and 'Sign Out', this is based on the checks in the WHO Safety Checklist which was launched to address safety issues. The operator and assistant must take part in the checks. The doctor is responsible for leading and signing for the 'Sign In'.
The 'Sign In' is the final safety check that must be completed for all patients undergoing invasive procedures just before injection of local anaesthetic.

The checks performed during the sign in should include, but are not limited to:

- The patient's identity should be confirmed, including name, address and date of birth.
- Confirmation what procedure is planned.
- Completion of a valid consent from in accordance with the UHL Policy for Consent to Examination or Treatment.
- Marking of the site.
- Confirmation of any known allergies.
- Confirmation of any anticoagulant use.

Anaesthesia must not commence unless the 'Sign In' has been completed.

Local Anaesthetic:

Maximum doses for adults of Local Anaesthetic drugs are as follows
(The BNF): Bupivacaine: 150mg (for up to four hours).

Lidocaine: 200mg Maximum volumes in ml of Local Anaesthetics corresponding to the BNF Maximum Doses:

Time Out:

The 'Time Out' is the final safety check that must be completed for all patients undergoing invasive procedures just before the start of the procedure. The assistant is responsible for leading and signing for the 'Time Out'.

- The patient must confirm their identity & confirm the procedure site

The procedure must not commence unless the 'Time Out' has been completed.

Performing the procedure:

Aseptic technique will be used.
Employees have a duty to follow the arrangements set out within the UHL Sharps Management Policy for the safe use of sharps.

Monitoring:

Monitoring include:

- O2 Sats
- Blood Pressure
- Pulse rate
- Respiratory rate
- Temp
- (Capillary Blood Glucose) CBGs

Prosthesis verification:

Before:

- Day case team will make sure a side room, a functional ultrasound machine with MSK setting, probe covers and appropriate size needles are available/ordered in well advance.
- Stock would be checked and ordered by day case nursing team and pharmacy team
- Operator will make sure all required equipment is available before the procedure

During:

- Operator and the nursing team member will check and document in the notes, expiry dates and suitability of the equipment.

After:

- Detailed notes of the procedure and equipment used will be documented in the notes.

Prevention of retained Foreign Objects:

As this is injection procedure no incision is needed. The sharps must be counted by the Doctor at the end of the procedure. The disposal of sharps is the responsibility of the operator and therefore must not be handed to anyone else for disposal.

Radiography:

An ultrasound machine with Doppler capability will be used

Sign Out:

Sign out must occur before the patient leaves the day case suite. The Doctor is responsible for leading and signing for the 'Sign Out'. The sign out should include:

- Confirmation that the procedure has been recorded in the notes/ICE.
- Confirmation that sharps have been disposed of as per trust policy.
- Discussion of post-procedural care with the patient.

Confirmation that the patient has been given an aftercare leaflet.

Handover:

Handover will include procedure details, observation requirements, parameters for safe discharge and after care instructions

Team Debrief:

A verbal team debrief should occur at the end of all procedure sessions. All team members should be present. The Doctor will lead the team debrief.
The content of the debrief should include:

- Things that went well
- Any problems with equipment or other issues
- Areas for improvement

A named person for escalating issues to management.

Post-procedural aftercare:

Patient should be monitored for 30 minutes post procedure. Check blood sugar levels, especially in diabetics. Blood pressure check every 15 minutes. Blood sugar check once post procedure

Discharge:

Patients are discharged from Day case unit by nursing staff if observation are stable and no other concerns A discharge letter should be done on ICE by performing consultant
No follow-up would be provided but clear information provided to patients to seek help in case of complications.

Governance and Audit:

Safety incidents in this area include:

- Incorrect procedure
- Wrong patient
- Sharps injuries

All incidents must be reported on Datix. Incidents will be handled and reported in line with the usual Trust internal clinical incidents reporting mechanisms.
All clinical incidents will be reviewed at the CMG monthly Quality and Safety board and at the quarterly Rheumatology Morbidity and Mortality meetings.
Compliance with this SOP will be monitored by audit on an annual basis.
To submit monthly Safe Surgery Audit and WHOBARS assessment as per Safe Surgery Quality Assurance & Accreditation programme

Training:

Staff will be trained in this SOP by

- Consultant staff

Designated specialist nurses.

Documentation:

Detailed procedure note and observations would be recorded in patient notes. Copy of patient's signed consent form will also be filled. Discharge letter with procedure details will be done on ICE/nerve centre

References to other standards, alerts and procedures:

National Safety Standards for Invasive Procedures, NHS England 2015: https://www.england.nhs.uk/patientsafety/wp-content/uploads/sites/32/2015/09/natssips-safety-standards.pdf
UHL Safer Surgery Policy: B40/2010

UHL Sedation Policy: Safety and Sedation of Patients Undergoing Diagnostic and Therapeutic Procedures B10/2005
UHL Delegated Consent Policy B10/2013
UHL Guideline: Anticoagulation management ("bridging") at the time of elective surgery and invasive procedures (adult) B30/2016
UHL Consent to Treatment or Examination Policy A16/2002
UHL Sharps Safety Policy B8/2013
Shared decision making for doctors: Decision making and consent (gmc-uk.org)
COVID and PPE: UHL PPE for Transmission Based Precautions - A Visual Guide
COVID and PPE: UHL PPE for Aerosol Generating Procedures (AGPs) - A Visual Guide

END

Appendix 1: UHL Safer Surgery *Department* Checklist.

Appendix 2: Patient Information Leaflet for *Procedure* Available at:

Patient Sticker

UHL Safer Surgery Checklist

Rheumatology Caudal Edpidural

LocSSIPs

NHS University Hospitals of Leicester NHS Trust

Caring at its best

TEAM BRIEF

Prior to list with all team members. STOP THE LINE

All members of team have discussed care plan and addressed concerns ☐

SIGN IN

STOP THE LINE

On arrival of patient in procedure room, with all team

Team introduce themselves by name and role ☐

Confirm patient's name, DOB and Hospital Number with patient and against wristband/consent/procedure list ☐

Confirm valid written consent Yes ☐ No ☐ N/A ☐

Confirm valid verbal consent Yes ☐ No ☐ N/A ☐

Confirm procedure and site with patient ☐

Known allergy: Yes ☐ No ☐

_____

Patient Information Leaflet Provided Yes ☐ N/A ☐

Post procedural notes ☐

Techinical Problems

Needle insertion difficulty Yes ☐ No ☐

Number of Attempts

Ultrasound Guided Yes ☐ No ☐

Read out by: (PRINT)

Signed: **Date:**

TIME OUT

Immediately before skin incision or commencement of Procedure STOP THE LINE

Confirm identity checks completed ☐

Confirm site and side of procedure ☐

Read out by: (PRINT)

Signed: **Date:**

SIGN OUT

After counts
Before patient or team members leave room STOP THE LINE

Procedure correctly performed and recorded ☐

Swab, equipment and instrument count correct ☐

Sharps disposed of safely ☐

Any equipment Issues? Yes ☐ N/A ☐

Key concerns for recovery and post-operative management discussed ☐

Patient post procedural information and contact details given. Yes ☐ No ☐

TEAM DEBRIEF

STOP THE LINE

Any concerns from Team Members throughout the Procedure? Yes ☐ No ☐

If yes please identify with follow up actions

Read out by: (PRINT)

Signed: **Date:**