Lincolnshire Community Health Services NHS Trust

Peripheral Venous Cannulation Policy (Adults)

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Name of responsible committee / Individual	Effective Practice Assurance Group
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Target audience:	All healthcare staff and Healthcare Students who practice this skill
Distributed via	Internet

Peripheral Venous Cannulation Policy (Adults)

Version Control Sheet

Version	Section / Para / Appendix	Version / Description of	Date	Author / Amended by
1	Whole Document to include Healthcare Students/Revised from guidelines to Policy. Replaces G_CS_18 Cannulation (A Guide to Practice)	Addition of Healthcare Students	02/07/2018	Victoria Pruteanu Val Ronis
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Procedural Document Statement

Background Statement	The purpose of this policy is to provide clear standards and procedures for peripheral venous cannulation. There is a need to provide an efficient service to patients who require peripheral venous cannulation as part of their care.
Statement	The peripheral venous cannulation education programme is a clinical skill based education package aimed at clinical staff, with standardised assessment and risk management guidelines for clinical practice. LCHS is agreeable to accept transferability of training provided by the Higher Education Institutions (HEI) within the East Midlands for student nurses where there is a local agreement between the trust and the education provider.
Responsibilities	It is the responsibility of all managers to ensure that they, and the staff for whom they are responsible, are fully aware of this policy. Individual staff member's accountability and assessor responsibilities are outlined in the document. Managers are responsible for reviewing competency via annual personal development review, through practical observation using the assessment in this document. Managers are also responsible for ensuring that on completion of this competency, that this is recorded on ESR.
Training	Healthcare professionals and Healthcare students are expected to undertake learning and development opportunities to support the development of their competence as required within their clinical area. Development plans will be discussed and agreed with Line Managers within the appraisal process. This training will cover knowledge, skills, competencies and behaviours. On this basis HEI training will be compatible. Student nurses and other healthcare students must be able to present evidence from their HEI of their training competence (LCHS will support the achievement of competence in practice with students) If students are unable to achieve the required standard in this skill, there must also be somewhere the assessor can provide this evidence that the standard has not been achieved. LCHS will also accept evidence of achievement of competencies for healthcare professionals who have achieved these in other partnership organisations, however, must demonstrate

	this observed on 3 separate occasions. Students who work for the organisation and who have acquired this skill through trust training may continue to practice this skill.
Dissemination	Via Trust website
Resource implication	Mannequin arms are available in the training department. Practice based assessors will be identified by the manager with experience and knowledge, and are competent in the procedure. The successful implementation of competency requires individual training and assessment.

1. INTRODUCTION

Peripheral venous cannulation is the process of inserting a small hollow catheter over a needle into a peripheral vein. Peripheral venous cannulation is an invasive intervention that should only be carried out by suitably trained practitioners.

National drivers including the Five Year Forward View (2014) have highlighted the need for care to be delivered differently along with Sustainability and Transformation Partnerships (2016) whose vision is to achieve really good health for the people of Lincolnshire with support from an accessible health service, utilising a broader range of facilities and healthcare professionals. In addition to this, the NMC (2018) standards for pre-registration nursing students have been revised, with an expectation that demonstration of competence in this skill will be required during the three year programme and student nurses will be proficient in this skill on qualification. As a result of this, the organisation needs to be able to provide peripheral cannulation to patients in a setting appropriate to them, predominantly community hospital sites to meet the needs of the local population.

2. PURPOSE

The purpose of this policy is to inform all practitioners about the requirements and processes for peripheral venous cannulation and appropriate aftercare and removal. By using this policy, practitioners will act to reduce the risks to patients and staff associated with pperipheral venous cannulation. These include thrombosis, pain, local or systemic infection; occupational sharps injury and inappropriate cannula insertion.

3. SCOPE

This document sets out the standards to be followed by health care practitioners employed by Lincolnshire Community Health Services and students on practice placements, whose role involves cannulation or cannula aftercare.

4. DEFINITIONS

Adult: for the purpose of this policy this relates to a person over 18 years of age.

Asepsis: is recognised as the state of being free from pathogenic microorganisms.

Aseptic, clean procedure: is the means of preventing or minimising the risk of introducing harmful micro-organisms onto key parts or key sites of the body when undertaking clinical procedures.

Disposable Tourniquet - a disposable single use device that promotes vein distension for insertion of a needle, it should remain taut for a maximum of 60 seconds.

Extravasation: administration of vesicant solution into the surrounding tissue.

Infiltration: administration of non-vesicant solution into the surrounding tissue.

Phlebitis: inflammation of a vein, more specifically the inner lining (tunica intima). Signs of phlebitis include; localised redness, heat, swelling and pain. Phlebitis may be mechanical (physical trauma to the vein), chemical (irritation caused by strong medicines) or infection (caused by infiltration of micro-organisms) in origin.

Vesicant: an agent or substance that causes blisters, burns and destruction of internal or external tissue.

5. DUTIES AND RESPONSIBILITIES

Ward/Department/Line Managers: need to ensure adequate stock of equipment for peripheral venous cannulation is held and that all staff members who are required to perform cannulation or care for cannulas post insertion are appropriately trained. Managers must report to via Datix any incidents of unsuitable or dangerous practice.

Individuals undertaking peripheral venous cannulation: should ensure they meet the training requirements, are safe and competent to undertake this skill and follow all relevant Trust policies to support safe practice. Staff must be aware of their roles and responsibilities and must identify and communicate any training needs to their Line Manager.

Healthcare Workers: are responsible for ensuring safe care, access and removal of peripheral cannulas and reporting overdue or inappropriate devices to the Infection Prevention Team

- Clinicians are responsible and accountable for their practice and should always work within their competence in accordance with their relevant professional standards such as The Code (NMC, 2015).

- Clinicians must attend the required training run within house by the Clinical Trainers and education team if new to this skill and also identify to their manager any ongoing training needs.

- Clinicians must seek to refresh their knowledge and skills as required.

- Clinicians should only make **two attempts** to gain venous access with a peripheral cannula without seeking further help.

Health care students: must be supervised by an appropriate trained member of staff when carrying out this procedure and must provide evidence from their HEI of attendance at training signed by a Lecturer. Students must also be able to evidence of previous attempts of cannulation and must declare if a previous mentor has stated that additional observation is required. The student **MUST** complete **5 successful attempts** of peripheral venous cannulation. It is up to the assessor's clinical judgement if more than 5 observations are required and they

must clearly document this in the student record.

6. INDICATIONS FOR PERIPHERAL CANNULATION

Patients **SHOULD NOT** be routinely cannulated within the organisation.

Patients should only be cannulated if:

Indicated by the admitting / referring Doctor / Advanced Nurse Practitioner

The patient is to receive IV medication or fluids

The patient has been assessed as being medically unstable and at risk of acute deterioration or is a medical emergency.

There is a need to replace a cannula to continue treatment.

It is the responsibility of the clinician to justify the need for a cannula when requesting one be placed or when placing it.

The reason for cannulation should be clearly documented in the patients care plan.

PROCEDURE FOR INTRAVENOUS PERIPHERAL CANNULATION

ACTION	RATIONALE & REFERENCE
1. Correctly identify the patient and discuss the procedure with patient /carer and obtain informed consent to the treatment. **Exception Emergency Treatment Only**	To ensure patient safety and ensure that they understand the procedure and gives his or her valid consent. *(LCHS Consent Policy)*
2. Check for patient allergies	To ensure patient safety and reduce the risks of an allergic and anaphylactic reaction. *(LCHS Anaphylaxis Policy)*
3. Assemble all equipment required. Check all expiry dates and that flushes and packaging are not damaged and have been stored correctly. Assess the need for eye protection to be worn as part of PPE. Ensure CE/UN approved sharps container is situated at the point of use. **If inpatient the saline flush is to be checked by two practitioners**	To ensure patient safety, assist with fluidity of procedure and comply with *NMC Standards for Medicines management (2008) and LCHS Intravenous Medication Policy (20)* To ensure appropriate disposal of sharps in a safe system of work.

4. Wash hands with liquid soap and water and dry thoroughly with single use disposable paper towels. Cover any visible broken skin with a waterproof dressing.	To reduce the risk of bacterial contamination during the procedure. To minimise the risk of becoming contaminated by blood, body fluids or micro-organisms *LCHS policy for hand hygiene (2016)*
5. Protect the patients' clothing and surrounding area and support the patients arm with a pillow.	To maximise patient safety and comfort.
6. Identify the appropriate vein and site for cannulation taking into account any specific sites that should be avoided and patient preference. Brief use of a single use tourniquet may be required. Recheck size of safety cannula.	Selection should reflect type and length of treatment. By avoiding compromised sites complications may be reduced. Select the smallest practical device to reduce trauma to the vein. *Royal Marsden Guidelines 9th Edition (2015)*
7. Open all equipment onto sterile field maintaining asepsis. Open flush ready for drawing up. Don protective apron from dressing pack.	Allows for the preparation of equipment prior to the procedure without contamination.
8. Don sterile gloves and prime extension line with 0.9% Saline for injection.	Use of extension lines allow for ease of management of the safety cannula once in situ and reduce risks of cannula mobility. *LCHS Intravenous Medication Policy (2) and RCN Standards for Infusion Therapy (2010)*
9. Cleanse skin prior to inserting cannula using 70% alcohol and 2% Chlorhexidine. Leave to dry for 30 seconds. Remove gloves.	To maintain asepsis by removing skin flora *RCN Standards for Infusion Therapy (2010)*
10. Apply single use tourniquet taking care not to contaminate site of swabbing	To promote venous filling whilst not stopping arterial drainage.
11. Decontaminate hands with alcohol rub and apply new sterile gloves	To minimise risk of infection
12. Remove the needle guard and visibly inspect the device for any faults such as obvious bends or barbs.	To detect faulty equipment that must be reported in case an equipment recall is needed.
13. Stabilise the vein prior to insertion by using your thumb to apply manual traction to the skin 2-3 cm below the proposed site of insertion.	Counter tension facilitates a smooth needle entry and reduces the risk of vein movement. *Royal Marsden Guidelines 9th Edition (2015)*

14. Insert the safety cannula assembly through the skin at an angle of 25-30 degrees. Advance the safety cannula assembly into the vein until there is the first flashback of blood in the flashback chamber	To reduce the risk of passing the cannula through the vein Flashback confirms that the cannula assembly is in the vein. *Royal Marsden Guidelines 9th Edition (2015)*
15.Level the device until it is almost flush with the skin advancing the cannula slightly	To avoid advancing too far and damaging the vein wall. *Royal Marsden Guidelines 9th Edition (2015)*
16. Withdraw the introducer needle 2-3 mm from the safety cannula point and a second flashback of blood will be seen along the shaft of the cannula.	Confirms that the cannula is in the vein. *Royal Marsden Guidelines 9th Edition (2015)*
17. Whilst stabilising the introducer advance the safety cannula forward into the vein. Release the tourniquet and apply finger pressure over the vein **above but not over** the cannula tip.	To prevent blood spillage
18. Remove the introducer and dispose of into a designated CE/UN approved sharps container.	Reduce the risk of sharps injury
19. Attach the primed extension line.	Increases the ease of access to the device and reduces risk of movement. *Royal Marsden Guidelines 9th Edition (2015)and RCN Standards for Infusion Therapy (2010)*
20. Secure the cannula with a sterile transparent IV dressing.	Aids inspection of the cannula site in line with Visual Phlebitis Score *RCN Standards for Infusion Therapy (2010)*
21. Flush with 5mls 0.9% sodium Chloride for Injection using a pulsated flush technique. **This should be authorised via an authority to administer.**	
22. Remove personal protective equipment and dispose of according to local policy. Wash hands with liquid soap and water and dry with a single use disposable towel.	
23. Complete documentation including Cannula checklist.	To ensure as much relevant information is captured in case of untoward event. *NMC The Code (2015)*

7. POST CANNULA INSERTION CARE

All patients who have an intravenous peripheral cannula inserted will be monitored in the following way:

Completion of the Visual Phlebitis Score and Cannula checklist at least twice a day for inpatient settings.

Patients should be prescribed and authorised to have 5ml 0.9% Sodium Chloride for injection flush daily to keep the cannula patent should no medication be being administered via the line.

Patients should also be prescribed and authorised to have 5ml 0.9%Sodium Chloride for injection flushes both pre and post bolus / infusion.

Unless clinically justifiable i.e. poor venous access, peripheral venous cannulas should be removed after 72 hours in line with the Visual Phlebitis Score and Cannula checklist.

Once treatment has been completed all peripheral intravenous cannula should be removed and the Visual Phlebitis Score and Cannula Checklist completed.

NOTE: Cannulation incidents are reportable at stage 4 of the VIPs chart – appendix 1; in these circumstances the trust incident reporting policy should be followed.

8. PROCEDURE FOR THE REMOVAL OF AN INTRAVENOUS PERIPHERAL CANNULA

ACTION	RATIONALE & REFERENCE
1. Correctly identify the patient and discuss the procedure with patient /carer and obtain informed consent to the procedure.	To ensure patient safety and ensure that they understand the procedure and gives his or her valid consent. *(LCHS Consent Policy*
2. Assemble all equipment required.	To ensure patient safety and aid fluidity of procedure.
3. Wash hands with liquid soap and water and dry thoroughly with single use disposable paper towels. Cover any visible broken skin with a waterproof dressing.	To reduce the risk of bacterial contamination during the procedure. To minimise the risk of becoming contaminated by blood. *LCHS policy for hand hygiene (201)*
4. Protect the patients clothing and surrounding area and support the patients arm with a pillow.	To maximise patient safety and comfort.
5. Apply fresh non sterile gloves and fresh disposable apron.	To reduce the risk of bacterial contamination during the procedure. To minimise the risk of becoming contaminated by blood. *LCHS policy for hand hygiene (2016)*

6. Remove the dressing from around the cannula and pull back on the cannula to remove it from the vein.	
7. Immediately apply pressure to the puncture site using sterile gauze / cotton wool ball until the bleeding has ceased.	To minimise bruising and haematoma formation.
8. Once bleeding has stopped cover the puncture site with a sterile dressing (Elastoplast or other). Ask about sensitivities / allergies.	To reduce the risk of infection. Mitigate against allergic / sensitive reaction.
9. Inspect the removed cannula to ensure it is complete. Any incomplete cannula must be reported to a Doctor immediately.	To ensure no foreign body is left in-situ.
10. Dispose of cannula into an appropriate CE/UN approved sharps container at the point of use.	To reduce the risk of sharps injury.
11. Remove personal protective equipment and dispose of according to local policy. Wash hands with liquid soap and water and dry with a single use disposable paper towel.	
12. Ensure the patient is comfortable and no further bleeding is evident from the puncture site. Document the removal using the cannulation checklist.	To ensure as much relevant information is captured in case of untoward event. *NMC The Code (2015)*

9. QUICK REFERENCE GUIDE

This policy must be followed in full when developing or reviewing and amending Trust procedural documents.

For quick reference the guide below is a summary of actions required. This does not negate the need for the document author and others involved in the process to be aware of and follow the detail of this policy. *The quick reference can take the form of a list or a flow chart, if the latter would more easily explain the key issues within the body of the document*

1. **Peripheral venous cannulation is an aseptic procedure** and should only be undertaken when there is a clear and immediate need for intravenous access, or there is significant risk of haemorrhage. Cannulation should not be performed as a routine clinical intervention and should only be carried out by suitably trained practitioners

2. Cannulas should be appropriate for the product to be delivered, the intended speed of delivery, the duration of intended therapy and the condition and size of the vein.

3. An upper extremity site is preferable for cannulation. Areas of flexion e.g. antecubital fossa should be avoided where possible.

4. Skin must be prepared with 2% chlorhexidine gluconate in 70% isopropyl alcohol (2% CHG/70% IPA) (Sanicloth) and allowed to dry between each and every cannulation attempt (2 attempts).

5. During cannulation, never re-introduce the needle into the cannula sheath as this may damage the sheath which then has the potential to break and lodge inside the vein

6. Peripheral venous cannula insertion sites must be visually inspected and palpated for tenderness a minimum of once per shift and a Visual Infusion Phlebitis (VIP) score recorded

7. Peripheral venous cannula should be electively re-sited if a non-aseptic insertion is suspected (e.g. emergency situation), if sited in a lower limb or if the cannula is more than 72 hours old

10. CANNULA SELECTION

The safety cannula should be appropriate for:

- The type of infusion / medication / contrast to be delivered
- The intended or required speed of delivery
- The duration of intended therapy
- The condition and size of the vein

Non-ported cannulae may be associated with a reduced risk of infection and should be used for the majority of patients. Ported cannulae should only be used in main and maternity theatres, where rapid sequence induction may be necessary.
Always select the smallest cannula necessary for the task.

Gauge	Catheter length (mm)	Flow Rate (ml/min)	Time to infuse 1L N/S (mins)	Indication
24	14	26	**38**	Neonates / Paediatrics
24	19	22	**45**	
22	25	35	**28**	Long-term medications / fluid therapy
20	25	65	**15**	Large fluid volumes/blood or contrast/dyes
20	32	60	**17**	
18	32	105	**9.5**	Whole blood administration
18	45	100	**10**	
16	50	210	**5**	Rapid infusion of blood or components

11. PREVENTION AND MANAGEMENT OF INCIDENTS AND ADVERSE EVENTS

Peripheral venous cannulation carries a risk of inoculation injury with contaminated sharps.

The following must be adhered to at all times:
Used cannulas must be discarded immediately at the point of use by the person generating the waste into a sharps bin that complies to UN 3921 and BS7320 CE/UN Sharps bins must not be overfilled, and must have the temporary closure mechanism in place when not in use.
Practitioners should not work alone with confused or disoriented patients who may move unexpectedly, contributing to inoculation injuries.

12. CONSENT

Informed consent must be obtained from all patients who have capacity prior to any cannulation attempt. Consent may be given verbally or non-verbally and may be the act of the patient holding out their arm for the practitioner to carry out a procedure, providing the patient has received appropriate information prior to this.
The key principles of informed consent include:

- The patients right to consent voluntarily without pressure or coercion
- The patients right to withdraw consent at any time
- The provision of sufficient information to allow informed consent. This includes:

i. The reason for the procedure
ii. What the procedure involves
iii. Any significant potential complications

13. COMPLICATIONS

Complications of peripheral venous cannulation include:
Prolonged bleeding time (caused by medical condition or drug therapy)
Haematoma (caused by puncturing the front and/or back wall of the vein or failure to apply correct pressure post failed attempt or removal)
Infiltration (see definition)
Extravasation (see definition)
Phlebitis (see definition)
Accidental damage (of adjacent structures including nerves, tendon or artery)
Infection

14. NUMBER OF ATTEMPTS

Only two attempts should be made to cannulate the patient, using new equipment on each occasion.
Never re-introduce the needle into the cannula sheath as this may damage the sheath which then has the potential to break and lodge inside the vein
If unsuccessful, support should be obtained from another member of staff qualified in peripheral venous cannulation. Failed attempts should be documented in the patient notes.

Site selection:
To reduce the risk of device related infection and phlebitis, it is preferable to use an upper extremity site for inserting a peripheral venous cannula in adults and to replace a device inserted in a lower extremity to a site in the upper extremity as soon as possible[4].

Veins should be looked for in the following order:

- On the back of each hand
  I. Metacarpal veins
- Lower arm
  I. Cephalic or basilic veins
- Areas of flexion e.g. antecubital fossa should be avoided where possible for patient comfort
- Sites close to existing wounds, or limbs affected by lymph node dissection or renal fistula should be avoided

Inspection will reveal clinical conditions that may prevent the arm being used whilst palpation of the veins will reveal the position of the veins, direction in which they run and their size and other physical features. The vein should be straight and feel soft, cylindrical in shape and 'bouncy' when lightly pressed. Veins that are tender, sclerosed, thrombosed, fibrosed, hard or bruised from previous use should be avoided.

15. EQUIPMENT REQUIRED FOR INSERTION OF A PERIPHERAL VENOUS CANNULA

Cannulation pack, containing;

- Sterile gloves
- Sterile towels x2
- 2% chlorhexidine gluconate in 70% isopropyl alcohol wipe (2% CHG/70% IPA) (Sanicloth)
- 10mL pre-filled Sodium Chloride 0.9% flush
- Single use disposable tourniquet
- Transparent sterile occlusive dressing
- Sterile gauze
- Clinical waste bag
- Appropriate sized safety cannula x2
- Extension set
- CE/UN approved Sharps container
- Dedicated tray or identified prepared area, cleaned with detergent wipe or soap and warm water.

Associated Documentation (Available from the LCHS public Website)

- Handwashing and the use of hand sanitizer
- Blood body spillages
- Infection prevention policy
- Aseptic, Sterile and clean procedures policy
- Consent to examination and treatment policy
- Mental Capacity Act including deprivation of liberty safeguards
- Incident Reporting
- Sharps safe handling and use

16. REFERENCES

Department of Health (2010). *Reference guide to consent for examination or treatment.* London: HMSO (online) available at https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/138296/dh_103653__1_.pdf

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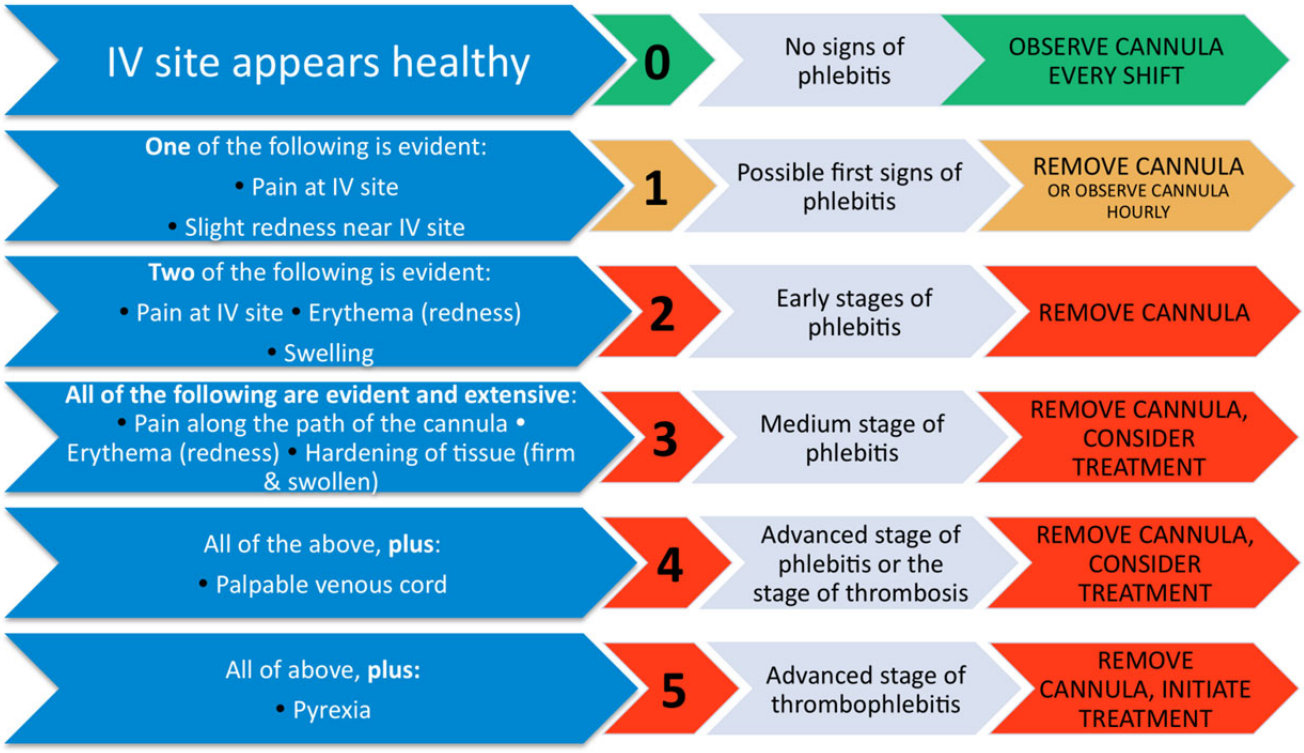
RCN (2016). Standards for infusion therapy. 4th Edition. Royal College of Nursing IV Therapy Forum (online) available at https://www.rcn.org.uk/professional-development/publications/pub-005704

17. APPENDIX A - Phlebitis Score



18. APPENDIX B

<u>Supervised Practice</u> (Minimum of 5 Successful Attempts)

Learner Name:-

Date	Cannula site	Successful Yes/ No	Supervisor Print name and Signature

20 APPENDIX C - Monitoring Template

This template should be used to demonstrate compliance with NHSLA requirements for the procedural document where applicable and/or how compliance with the document will be monitored.

Minimum requirement to be monitored	Process for monitoring e.g. audit	Responsible individuals /group /committee	Frequency of monitoring /audit	Responsible individuals / group / committee (multi-disciplinary) for review of results	Responsible individuals / group / committee for development of action plan	Responsible individuals / group / committee for monitoring of action plan
All staff and Healthcare students carrying out this competency	Initial sign off as competent /annual review of competency via clinical supervision	Individual/Line Manager Effective Practice Assurance Group Infection Prevention	Annual	Department managers Effective Practice Assurance Group Infection Prevention	Local Department Managers Effective Practice Assurance Group Infection Prevention	Local Department managers Effective Practice Assurance Group Infection Prevention

Equality Analysis Carried out by: Victoria Pruteanu

Date: 02/07/18

Equality & Human rights Lead: Rachel Higgins

Date:

Director\General Manager: Lisa Stalley-Green

Date:

***In this template the term policy\service is used as shorthand for what needs to be analysed. Policy\Service needs to be understood broadly to embrace the full range of policies, practices, activities and decisions: essentially everything we do, whether it is formally written down or whether it is informal custom and practice. This includes existing policies and any new policies under development.**

Section 1 – to be completed for all policies

A.	Briefly give an outline of the key objectives of the policy; what it's intended outcome is and who the intended beneficiaries are expected to be	Policy to ensure the practice of Insertion of peripheral venous cannulas and post care management and removal is carried out safely by competent healthcare professionals and healthcare students who have completed the relevant training and can evidence the skills can be performed competently.		
B.	Does the policy have an impact on patients, carers or staff, or the wider community that we have links with? **Please give details**	Yes. Policy related to an invasive procedure which is performed on patients in response to a health need. There is a need for competent practitioners to be able to perform this skills to ensure provision of care to patients and service need. Staff impact relates to sharps injury.		
C.	Is there is any evidence that the policy\service relates to an area with known inequalities? **Please give details**	No.		
D.	Will/Does the implementation of the policy\service result in different impacts for protected?			
		Yes	No	
	Disability		x	
	Sexual Orientation		x	
	Sex		x	
	Gender Reassignment		x	
	Race		x	
	Marriage/Civil Partnership		x	
	Maternity/Pregnancy		x	
	Age		x	

	Religion or Belief		x	
	Carers		x	
	If you have answered 'Yes' to any of the questions then you are required to carry out a full Equality Analysis which should be approved by the Equality and Human Rights Lead – please go to section 2			
The above named policy has been considered and does not require a full equality analysis				
Equality Analysis Carried out by:	Victoria Pruteanu			
Date:	02/07/18			

Section 2 - Equality analysis

Title:
Relevant line in:

What are the intended outcomes of this work? *Include outline of objectives and function aims*
Who will be affected? *e.g. staff, patients, service users etc*

Evidence *The Government's commitment to transparency requires public bodies to be open about the information on which they base their decisions and the results. You must understand your responsibilities under the transparency agenda before completing this section of the assessment.*
What evidence have you considered? *List the main sources of data, research and other sources of evidence (including full references) reviewed to determine impact on each equality group (protected characteristic). This can include national research,*

surveys, reports, research interviews, focus groups, pilot activity evaluations etc. If there are gaps in evidence, state what you will do to close them in the Action Plan on the last page of this template.
Disability *Consider and detail (including the source of any evidence) on attitudinal, physical and social barriers.*
Sex *Consider and detail (including the source of any evidence) on men and women (potential to link to carers below).*
Race *Consider and detail (including the source of any evidence) on difference ethnic groups, nationalities, Roma gypsies, Irish travellers, language barriers.*
Age *Consider and detail (including the source of any evidence) across age ranges on old and younger people. This can include safeguarding, consent and child welfare.*
Gender reassignment (including transgender) *Consider and detail (including the source of any evidence) on transgender and transsexual people. This can include issues such as privacy of data and harassment.*
Sexual orientation *Consider and detail (including the source of any evidence) on heterosexual people as well as lesbian, gay and bi-sexual people.*
Religion or belief *Consider and detail (including the source of any evidence) on people with different religions, beliefs or no belief.*

Pregnancy and maternity *Consider and detail (including the source of any evidence) on working arrangements, part-time working, infant caring responsibilities.*
Carers *Consider and detail (including the source of any evidence) on part-time working, shift-patterns, general caring responsibilities.*
Other identified groups *Consider and detail and include the source of any evidence on different socio-economic groups, area inequality, income, resident status (migrants) and other groups experiencing disadvantage and barriers to access.*

Engagement and involvement Was this work subject to the requirements of the Equality Act and the NHS Act 2006 (Duty to involve) ? (Y/N)
How have you engaged stakeholders in gathering evidence or testing the evidence available?
How have you engaged stakeholders in testing the policy or programme proposals?
For each engagement activity, please state who was involved, how and when they were engaged, and the key outputs:

Summary of Analysis *Considering the evidence and engagement activity you listed above, please summarise the impact of your work. Consider whether the evidence shows potential for differential impact, if so state whether adverse or positive and for which groups. How you will mitigate any negative impacts. How you will include certain protected groups in services or expand their participation in public life.*

Now consider and detail below how the proposals impact on elimination of discrimination, harassment and victimisation, advance the equality of opportunity and promote good relations between groups.

Eliminate discrimination, harassment and victimisation *Where there is evidence, address each protected characteristic (age, disability, gender, gender reassignment, pregnancy and maternity, race, religion or belief, sexual orientation).*

Advance equality of opportunity *Where there is evidence, address each protected characteristic (age, disability, gender, gender reassignment, pregnancy and maternity, race, religion or belief, sexual orientation).*

Promote good relations between groups *Where there is evidence, address each protected characteristic (age, disability, gender, gender reassignment, pregnancy and maternity, race, religion or belief, sexual orientation).*

What is the overall impact? *Consider whether there are different levels of access experienced, needs or experiences, whether there are barriers to engagement, are there regional variations and what is the combined impact?*

Addressing the impact on equalities *Please give an outline of what broad action you or any other bodies are taking to address any inequalities identified through the evidence.*

Action planning for improvement *Please give an outline of the key actions based on any gaps, challenges and opportunities you have identified. Actions to improve the policy/programmes need to be summarised (An action plan template is appended for specific action planning). Include here any general action to address specific equality issues and data gaps that need to be addressed through consultation or further research.*
Please give an outline of your next steps based on the challenges and opportunities you have identified. Include here any or all of the following, based on your assessment

For the record Name of person who carried out this assessment:
Date assessment completed:
Name of responsible Director/ General Manager:
Date assessment was signed: