INTRAVENOUS OPIOID ADMINISTRATION (MORPHINE, OXYCODONE AND FENTANYL) BY REGISTERED NURSES AND OPERATING DEPARTMENT PRACTITIONERS POLICY

POLICY

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	X		
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1.0 INTRODUCTION

Effective pain management is an essential aspect of patient care. The implementation of appropriate analgesic protocols not only ensures that patients receive adequate pain relief, but also minimises the risk of medicine prescribing / administration errors and harm.

Whenever there is a need to treat severe acute pain rapidly, an opioid such as morphine, oxycodone or fentanyl administered via small bolus intravenous injection may be indicated as the medicine/route of choice. Opioid analgesia administered intravenously provides a faster onset of action than when delivered via alternative routes; however, the analgesic effect is not necessarily superior and the risk of side effects is often greater. This policy aims to ensure that indicated intravenous opioids (morphine, oxycodone and fentanyl) are administered safely and appropriately in order to minimise side effects and prevent harm.

This policy is written in accordance with and reflects standards set out in the Trust's policies for 'Intravenous Medication and Fluid Therapy Administration Through a Peripheral Venous Catheter and Central Venous Access Device'.

2.0 POLICY STATEMENT

The purpose of this policy is to provide guidance on the correct procedure for the administration of incremental bolus intravenous opioids (morphine, oxycodone and fentanyl). This policy is restrictive and applies to staff working in designated clinical areas/ clinical specialities listed below only. Adherence to this policy will ensure a safe and consistent level of practice.

All registered healthcare professionals, as defined in this policy can check intravenous opioids in accordance with their professional registration, but are prevented from administering this medication unless they have received the Trust's intravenous medicines administration training relevant to their practice (RD04/RD04.4/RD05).

This policy identifies which members of non-medical clinical staff can administer intravenous opioids and further specifies the level of training that the practitioner must complete: its place is to ensure the highest standard of care delivery to patients. Failure to comply with this policy may be regarded as misconduct and dealt with in accordance with the Trust's disciplinary procedures and potentially the practitioner's regulatory body.

This clinical document applies to:

Staff group(s)

- Appropriately trained registered adult nurses working within specialist clinical areas listed below.
- Appropriately trained registered operating department practitioners (Theatre Recovery Team only).
- Specialist nurses / night team leaders / critical care outreach nurses / advanced nurse practitioners experienced in the administration of intravenous opioids.

Specialist clinical area(s)

- Theatre Recovery (Kings Mill and Newark) / Day Case Recovery.
- Emergency Department (Kings Mill Hospital) / Urgent Care Unit (Newark Hospital).
- Critical Care Unit.
- Cardiac Care (Ward 23/24).
- Cardiac Catheter Suite.
- Endoscopy Units (Kings Mill and Newark).

Non-specialist clinical areas

- To be administered by specialist nurses / night team leaders / outreach nurses / advanced nurse practitioners experienced in the administration of IV opioids only

Patient group(s)

- This policy applies to patients aged 17 years and over

Exclusions

- Patients with an allergy or intolerance to an indicated opioid (morphine, fentanyl or oxycodone).
- Patients under the age of 17 years.
- Within clinical areas **not** listed above unless administered by a doctor or specialist practitioner (listed above).
- The administration of intravenous tramadol. This medication can be administered via slow bolus injection by all registered nurses / operating department practitioners who have documented competencies in the administration of intravenous medicines.

3.0 DEFINITIONS/ ABBREVIATIONS/ACRONYMS

Definitions	
The Trust/ SFHFT	Sherwood Forest Hospitals NHS Foundation Trust
Staff	All employees of the Trust, including those managed by a third party organisation on behalf of the Trust
Adult	17 years and over – including pregnant women
Abbreviations/Acronyms	
mg	milligrams
mL	millilitres
IV	intravenous
SC	subcutaneous
PO	per oral
PR	per rectum
SpO2	oxygen saturation measured using a pulse oximeter
VRS	Verbal Rating Score
BPAS	Behavioural Pain Assessment Scale
ODP	operating department practitioner
SmPC	Summary of Product Characteristics (medicine information)
EIA	Equality Impact Assessment
NEWS	National Early Warning Score
ePMA	electronic prescribing and medicines administration
CD	controlled drugs
ACVPU	consciousness scale
ANTT	aseptic non-touch technique
eGFR	estimated glomerular filtration rate (index of kidney function)

4.0 ROLES AND RESPONSIBILITIES

- **Matrons, department managers and service line directors** are responsible for ensuring that all staff accountable to them are aware of this policy and adhere to its statement. It is the managers responsibility to investigate and rectify any discrepancies identified.

- **Ward sister/charge nurses/departmental leader** will act as excellent role models and are responsible and accountable for the policy implementation among staff in practice, and the monitoring of standards and best practice associated with it. They will ensure that all staff in the sphere of their responsibility has access to training to develop the skills and competence. This includes the completion of the associated work books, competency documents and study sessions in a timely manner.

- **All registered healthcare professionals** have a duty of care to their patients. This is a legal and professional requirement of state registration that cannot be delegated. All registered healthcare professionals are personally responsible and professionally accountable for ensuring that they receive training in the safe procedure and observation for the delivery of intravenous therapy. It is the responsibility of the healthcare professional to ensure that patent IV access is available and IV opioids are appropriately prescribed. Both the patient and procedure must be monitored according to guidance set out within this and other related policies.

5.0 APPROVAL

This document has been approved and published following consultation with stakeholders listed on the title page and approval via the Trust's Joint Drugs and Therapeutics / Medicines Optimisation Committee.

6.0 DOCUMENT REQUIREMENTS (POLICY NARRATIVE)

The administration of opioids intravenously is on occasion advisable for the management of severe acute pain. Specialist clinical areas such as the Emergency Department, Urgent Care Centre, Cardiac Care, Critical Care Unit, Cardiac Catheter Suite, Theatre Recovery Units and Endoscopy Units use the IV route of opioid administration on a frequent basis; largely due to pathological need and rapid onset of action.

An indicated IV opioid (morphine, oxycodone or fentanyl) must only be considered if the patient is complaining of severe pain and other routes of administration such as SC or PO have been ruled inappropriate. In addition, the IV route should only be used in extreme circumstances and with the presence of a doctor within the ward/department area. The opioids indicated in this policy **must not** be administered intravenously by non-specialist nurses/ODPs on in-patient wards (except Ward 23 or 24) in outpatient areas or on the Day Case Unit (with the exception of Day Case Recovery).

Caring for patients receiving IV opioid therapy requires knowledge of potential side effects and complications (see individual SmPCs hyperlinked in Section 10). Administration via the IV route can result in a high peak effect, leading to respiratory depression. Key indicators of respiratory depression include a slow respiratory rate, low SpO2, hypoxia, and confusion. For this reason, it is imperative that patients who receive any of the indicated IV opioids are closely monitored and protocols for the administration of the indicated medicine (morphine, oxycodone or fentanyl) are strictly adhered to as documented below.

6.1 Patient Observations Pre-Procedure

Prior to administration of the IV opioid, ensure that:

- Pain score assessed at 3 (severe) using;
  - VRS for verbal pain assessment (0-3)
  - BPAS for non-verbal pain assessment (0-3).
- Consciousness score is A, C or V using ACVPU.
- Respiration rate is 8 or above.

In addition, it is mandatory to undertake the following baseline observations and record the findings via Nerve Centre or specialty observation documentation:

- heart rate
- blood pressure
- respiratory rate
- oxygen saturation (via pulse oximeter SpO2)
- temperature
- NEWS

6.2 Administration of Bolus IV Morphine:

- Ensure morphine via the IV route is prescribed on the front of the patient's Medicines Prescription and Administration Record (10mg max dose) as a single dose - or as a single dose via ePMA.
- Using an aseptic non-touch technique (ANTT), draw up 9mL of sodium chloride 0.9% into a 10mL syringe then add 10mg/mL of morphine sulphate, giving a total volume of 10mL (1mg/mL) or choose a pre-filled syringe of morphine 10mg in 10mL of sodium chloride if available.
- If using a self-drawn syringe of morphine, ensure that this is labeled with a blue morphine sticker.
- The amount of morphine bolus to be administered is dependent on the age and weight of the patient; also existing co-morbidities must be considered, as some may affect how morphine is excreted (especially renal impairment). For example, a frail elderly patient of less than 40kg body weight may only require 1-2mg boluses with a total dose of less than 5mg to achieve the desired effect.

Adult patients over 40kg body weight:

- Administer a bolus of IV morphine 2-5mg.
- Wait 3 minutes and re-assess pain score, consciousness score and respiration rate.
- If the patient still has a pain score of 2-3, is not oversedated and their respiratory rate remains greater than 8, administer a further bolus of 1-3mg.
- Wait for 3 minutes and reassess pain score, a further bolus of 1-3mg may be given if required up to a maximum of 10mg.
- Following administration of a maximum of 10mg of IV morphine, repeat the baseline observations and document (via specialty observation chart or Nerve Centre).
- **The patient must be observed by the registered nurse/ODP throughout this procedure.**
- If the patient still has moderate to severe pain after 10 mg of morphine has been administered, medical advice must be sought.
- Any morphine not administered from the 10mg syringe will be discarded and documented as such, and must appear within the CD Register as 'amount wasted'.
- Document the amount of morphine given and time of the first dose administered to the time of the last dose administered on the patient's Medicines Prescription and Administration Record or via ePMA; e.g. 'given between 10.40-11.15'.

Adult patients under 40kg body weight:

- Discard 5mg/5mL from the syringe leaving 5mg/5mL for administration. This must be documented in the CD Register as 'amount wasted'.
- Administer a bolus of IV morphine 1-2mg.
- Wait 3 minutes and re-assess pain score, consciousness score and respiration rate.
- If the patient still has a pain score of 2-3, is not oversedated and respiratory rate remains greater than 8, administer a further bolus of 1-2mg up to a maximum of 5mg.
- Wait for 3 minutes and reassess pain score, a further bolus of 1mg may be given if required.
- Following administration of a maximum of 5mg of IV morphine, repeat the baseline observations and document (via specialty observation chart or Nerve Centre).

- **The patient must be observed by the registered nurse/ODP throughout this procedure.**
- If the patient still has moderate to severe pain after 5mg of morphine has been administered, medical advice must be sought.
- Any morphine not administered from the syringe will be discarded and documented as such, and must appear within the CD Register as 'amount wasted'.
- Document the amount of morphine given and time of the first dose administered to the time of the last dose administered on the patient's Medicines Prescription and Administration Record or via ePMA; e.g. 'given between 10.40-11.15'.

6.3 Administration of Bolus IV Oxycodone:

- Ensure oxycodone via the IV route is prescribed on the patients Medicine Prescription and Administration Record (5mg max) as a single dose or as a single dose via ePMA**.**
- Using an ANTT, draw up 9.5mL of sodium chloride 0.9% into a 10mL syringe. Add 5mg/0.5 mL of oxycodone, giving a total volume of 10 mL (0.5mg/mL). Please note that oxycodone ampules contain 10mg/mL – the remaining 5mg/0.5mL will need to be discarded immediately and documented as 'amount wasted' in the CD Register.
- Ensure that the syringe this is labeled with an oxycodone sticker.
- The amount of oxycodone bolus to be administered is dependent on the age and weight of the patient; also existing co-morbidities must be considered as these may affect how oxycodone is excreted (especially renal impairment). For example, a frail elderly patient of less than 40kg body weight may only require 0.5-1mg boluses with a total dose of less than 2.5mg to achieve the desired effect.

Adult patients over 40kg body weight:

- Administer a bolus of IV oxycodone 1-2.5mg.
- Wait 3 minutes and re-assess pain score, consciousness score and respiration rate.
- If the patient still has a pain score of 2-3, is not oversedated and their respiratory rate remains greater than 8, administer a further bolus of 0.5-1.5 mg up to a maximum of 5mg.
- Wait for 3 minutes and reassess pain score, a further bolus of 0.5-1.5mg may be given if required.
- Following administration of a maximum of 5mg of IV oxycodone, repeat the baseline observations and document (via specialty observation chart or Nerve Centre)
- **The patient must be observed by the registered nurse/ODP throughout this procedure.**
- If the patient still has moderate to severe pain after 5mg of oxycodone has been administered, medical advice must be sought.
- Any oxycodone not administered from the 5mg/10mL syringe will be discarded and documentation as such, and must appear within the CD Register as 'amount wasted'.
- Document the amount of oxycodone given and time of the first dose administered to the time of the last dose administered on the patient's Medicines Prescription and Administration Record or via ePMA; e.g. 'given between 10.40-11.15'.

Adult patients under 40kg body weight:

- Discard 2.5mg/5mL from the syringe leaving 2.5mg/5mL for administration. This must be documented in the CD Register as 'amount wasted'.
- Administer a bolus of IV oxycodone 0.5-1mg.
- Wait 3 minutes and re-assess pain score, consciousness score and respiration rate.
- If the patient still has a pain score of 2-3, is not oversedated and their respiratory rate remains greater than 8, administer a further bolus of 0.5-1mg up to a maximum of 2.5mg.
- Wait for 3 minutes and reassess pain score, a further bolus of 0.5-1mg may be given if required.
- Following administration of a maximum of 2.5mg of IV oxycodone, repeat the baseline observations and document (via specialty observation chart or Nerve Centre).
- **The patient must be observed by the registered nurse/ODP throughout this procedure.**
- If the patient still has moderate to severe pain after 2.5mg of oxycodone has been administered, medical advice must be sought.
- Any oxycodone not administered from the syringe will be discarded and documentation as such, and must appear within the CD Register as 'amount wasted'.
- Document the amount of oxycodone given and time of the first dose administered to the time of the last dose administered on the patient's Medicines Prescription and Administration Record or via ePMA; e.g. 'given between 10.40-11.15'.

6.4 Administration of Bolus IV Fentanyl:

- Ensure fentanyl via the IV route is prescribed on the patient's Medicines Prescription and Administration Record as a single dose or as a single dose via ePMA (100 micrograms max).
- Using an ANTT, draw up 8mL of sodium chloride 0.9% into a 10mL syringe and add 100micrograms/2mL of fentanyl, giving a total volume of 10mL (10micrograms/mL).
- Ensure that the syringe is labeled with a fentanyl sticker.
- The amount of fentanyl bolus to be administered is dependent on the age and weight of the patient; also existing co-morbidities must be considered as they may affect how fentanyl is, excreted (especially renal impairment). For example, a frail elderly patient of less than 40kg body weight may only require 10-20microgram boluses with a total dose of less than 50microgram to achieve the desired effect.

Adult patients over 40kg body weight:

- Administer a bolus of IV fentanyl 20-50micrograms.
- Wait 3 minutes and re-assess pain score, consciousness score and respiration rate.
- If the patient still has a pain score of 2-3, is not oversedated and their respiratory rate remains greater than 8, administer a further bolus of 10-30micrograms.
- Wait for 3 minutes and reassess pain score, a further bolus of 10-30microgram may be given if required up to a maximum of 100micrograms.
- Following administration of a maximum of 100micrograms of IV fentanyl, repeat the baseline observations and document (via specialty observation chart or Nerve Centre).

- **The patient must be observed by the registered nurse/ODP throughout this procedure.**
- If the patient still has moderate to severe pain after 100micrograms of fentanyl has been administered, medical advice must be sought.
- Any fentanyl not administered from the 100micrograms/10mL syringe will be discarded and documented as such, and must appear within the CD Register as 'amount wasted'.
- Document the amount of fentanyl administered and time of the first dose administered to the time of the last dose administered on the patient's Medicines Prescription and Administration Record or via ePMA; e.g. 'given between 10.40-11.15'.

Adult patients under 40kg body weight:

- Discard 50microgram/5mL from the syringe leaving 50microgram/5mL for administration. This must be documented in the CD Register as 'amount wasted'.
- Administer a bolus of IV fentanyl 10-25micrograms.
- Wait 3 minutes and re-assess pain score, consciousness score and respiration rate.
- If the patient still has a pain score of 2-3, is not oversedated and their respiratory rate remains greater than 8, administer a further bolus of 10-20micrograms up to a maximum of 50micrograms.
- Wait for 3 minutes and reassess pain score, a further bolus of 10-20micrograms may be given if required.
- Following administration of a maximum of 50micrograms of IV fentanyl, repeat the baseline observations and document (via specialty observation chart or Nerve Centre)
- **The patient must be observed by the registered nurse/ODP throughout this procedure.**
- If the patient still has moderate to severe pain after 50micrograms of fentanyl has been administered, medical advice must be sought.
- Any fentanyl not administered from the syringe will be discarded and documented as such, and must appear within the CD Register as 'amount wasted'.
- Document the amount of fentanyl administered and time of the first dose administered to the time of the last dose administered on the patient's Medicines Prescription and Administration Record or via ePMA; e.g. 'given between 10.40-11.15'.

6.5 Patient Observations Post-Procedure

Following administration of any of the above IV opioids, all baseline observations (as per pre-procedure) must be recorded:

- at 15 minute intervals for the first hour,
- then every 30 minutes for the second hour,
- then hourly for a further 2 hours.

It is important to note that the above are only minimum requirements. Where there is concern regarding the patient's well-being, the nurse should instigate the appropriate level of observation for the individual and when necessary seek advice from medical staff.

If respiration rate falls below 8 per minute; stop administering the IV opioid and call for medical assistance immediately. It may be necessary to administer a bolus dose of IV naloxone 200micrograms, followed by increments of 100micrograms every 2 minutes until respiratory function is 8 or above. Ensure that a clinical incident form is completed via Datix following the administration of naloxone for opioid related adverse reactions.

Due to the sedatory effects of opioid medication, it is common that patients may become sleepy/drowsy post administration. In relation to this policy, naloxone for sedation reversal should only be considered if the patient becomes unrousable with a consciousness score of P or U or has protracted drowsiness.

IV opioids can influence vasodilation that causes the blood pressure to fall. If the patient shows signs of impending or actual circulatory collapse, seek urgent medical assistance.

If the patient requires urgent transport out of the department/ward to another area within one hour of administration of an indicated IV opioid, they must be accompanied by a registered nurse/ODP escort. Mandatory observations must recommence once the transfer destination is reached.

7.0 MONITORING COMPLIANCE AND EFFECTIVENESS

Minimum Requirement to be Monitored (WHAT – element of compliance or effectiveness within the document will be monitored)	Responsible Individual (WHO – is going to monitor this element)	Process for Monitoring e.g. Audit (HOW – will this element be monitored (method used))	Frequency of Monitoring (WHEN – will this element be monitored (frequency/ how often))	Responsible Individual or Committee/ Group for Review of Results (WHERE – Which individual/ committee or group will this be reported to, in what format (eg verbal, formal report etc) and by who)
Competency packs are complete	Ward Leaders	Appraisals, Induction	On going	Department leaders/ ward leaders
Training pack availability	Training and Development	Register of training	On going	Practice development forum
Reported incidents including the administration of naloxone	Deputy Chief Pharmacist Pain Nurse Consultant	Datix	Following each incident	Medicines Safety Group

8.0 TRAINING AND IMPLEMENTATION

Prior to undertaking the administration of the indicated IV opioids (morphine, oxycodone or fentanyl) all registered staff must be able to demonstrate:

- That they have read the Trust Policy for 'Intravenous Medication and Fluid Therapy Administration Through a Peripheral Venous Catheter or Central Venous Access Device'.
- That they are fully conversant with this policy.
- That they have successfully completed the Trust's IV medicines administration package including successful completion the IV therapy medicines calculation test.
- At least **four** supervised practice administrations of IV medicines and documented competencies (assessor's signature) evident. An additional **two** supervised practice administrations is required for those undertaking the administration of IV opioids. Documented competencies (assessor's signatures) must be evident.
- Ward level documented evidence of the above, using the correct assessment packs, with signed records being sent to the professional educators and training team (PETT) in the Training, Education and Development Department. The return of this document will be recorded and inputted onto the Trust Oracle Learning Management training database.
- Newly appointed staff (not preceptorship) and agency staff **must** provide the Trust with an up to date certificate of competency for IV medicines administration and evidence of ongoing professional development for this technique, in addition to being fully conversant with this policy prior to the administration of IV opioids.

9.0 IMPACT ASSESSMENTS

- This document has been subject to an Equality Impact Assessment (Appendix D) and Environmental Impact Assessment (Appendix E).

10.0 EVIDENCE BASE (Relevant Legislation/ National Guidance) AND RELATED SFH DOCUMENTS.

- Australia and New Zealand College of Anaesthetists (ANZCA). Acute Pain Management: Scientific Evidence: 5th Edition. 2020: pp 402 - 429
- Hamelm Pharma Ltd. Summary of Product Characteristics. Morphine Sulphate 10mg/mL for Injection. 2020. (Morphine SmPC - medicines.org.uk)
- Hamelm Pharma LTD. Summary of Product Characteristics. Oxycodone Hydrochloride 10mg/1mL for Injection or Infusion. 2020 (Oxycodone SmPC-medicines.org.uk)
- Hamelm Pharma Ltd. Summary of Product Characteristics. Fentanyl Citrate 50mcg/1mL for Injection. 2020 (Fentanyl SmPC - medicines.org.uk)
- Royal College of Anaesthetists. Guidelines for the Provision of Anaesthesia Services (GAPS) Chapter 11: Guidance on the Provision of Anaesthesia Services for Inpatient Pain Management. 2019.

- **Further reading***:* Institute for Healthcare Improvement (2012). How-to Guide: Prevent Harm from High Alert Medications. 2012 MA [online]. Available from: www.ihi.org

Related SFHFT Documents:

- Policy for Consent to Examination, Treatment and Care
- Medicines Policy
- Hand Hygiene Policy ICP 17
- Intravenous Medication and Fluid Therapy Administration Through a Central Venous Access Device Policy.
- Intravenous Medication and Fluid Therapy Administration Through a Peripheral Venous Cannula Policy.

11.0 KEYWORDS

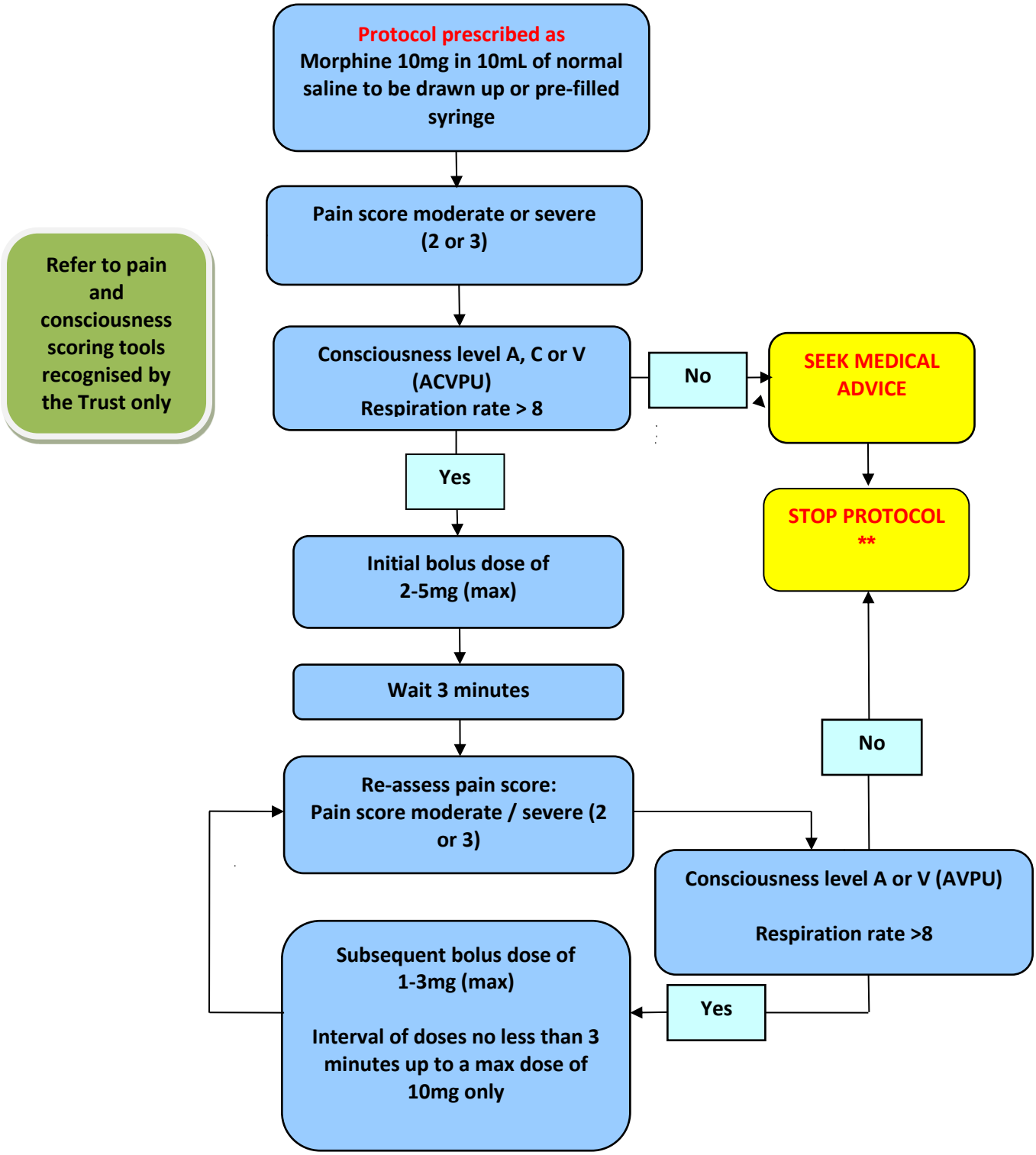
RN, OPD, analgesia, intravenous medicines, incremental bolus opioids

12.0 APPENDICES:

- Appendix A - Administration of Intravenous Morphine (Adults)
- Appendix B - Administration of Intravenous Oxycodone (Adults)
- Appendix C - Administration of Intravenous Fentanyl (Adults)
- Appendix D - Equality Impact Assessment Form
- Appendix E - Environmental Impact Assessment

Appendix A

Administration of Intravenous Morphine (Adults)



- **Only** registered practitioners working within indicated specialist departments as per policy will administer IV morphine to adult patients using this protocol.

- The administrating practitioner must have received full IV training and be able to provide documented evidence of competencies in accordance with Trust policy for the Care of the Patient Undergoing Intravenous Therapy (Bolus, Continuous and Intermittent) prior to using this protocol.

- The patient must remain under close observation during execution of the protocol.

- For patients over 40kg in weight give an initial bolus dose of 2-5mg followed by further 1-3mg bolus doses to a maximum of 10mg morphine if required.

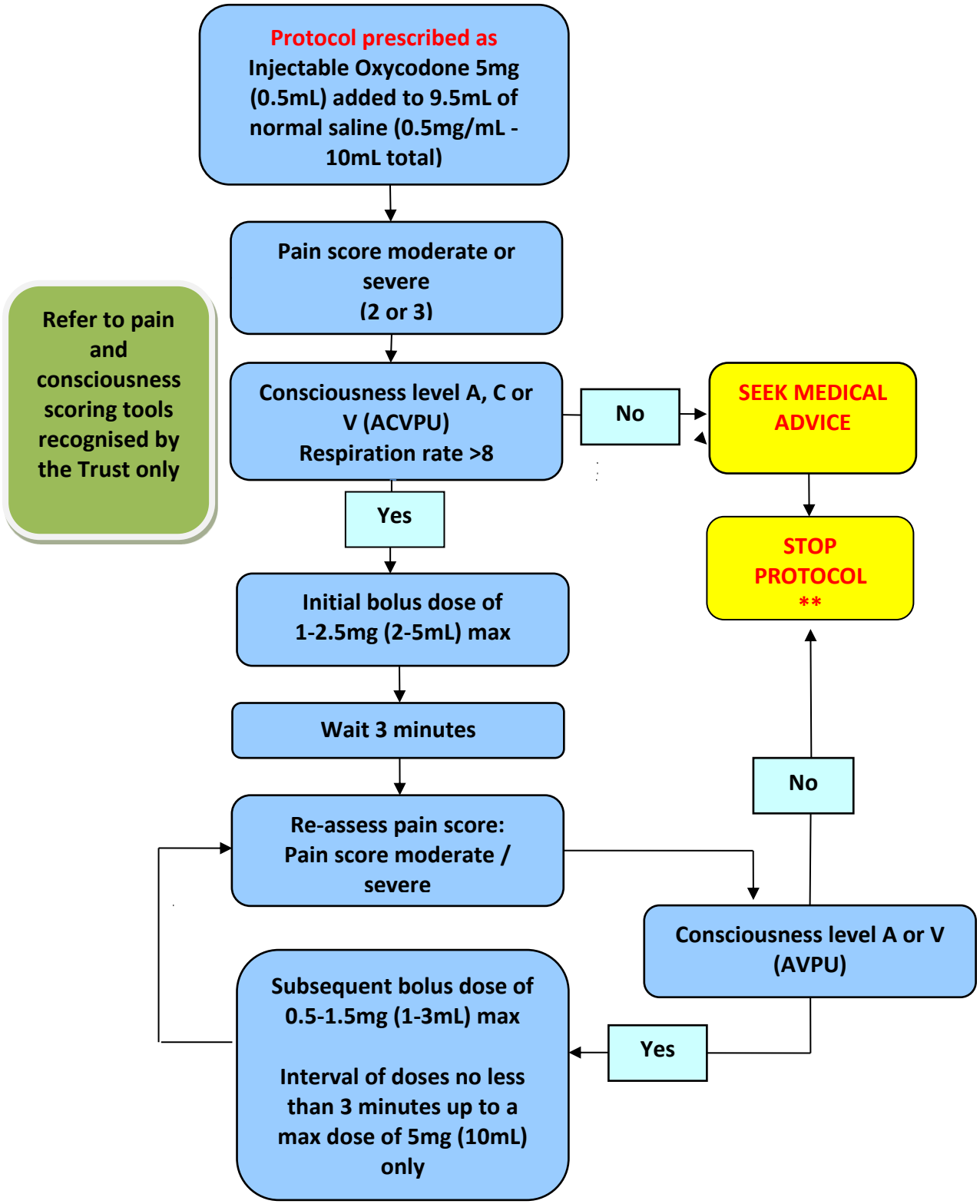
- For patients less than 40kg in weight or patients with renal impairment (eGFR<50) give an initial bolus dose of 1-2mg followed by further 1-2mg bolus doses to a maximum of 5mg morphine if required.

- **If the VRS (verbal rating score) of pain is mild (1) and level of pain is bearable then the protocol may be stopped. Alternatively, if the consciousness level falls to P or U (ACVPU) and/or the respiration rate falls below 8 respirations per minute, then stop the protocol immediately and seek advice from the patient's medical team.

- If pain persists following this protocol, please contact the patient's medical team for further advice.

Appendix B

Administration of Intravenous Oxycodone (Adults)



- **Only** registered practitioners working within indicated specialist departments as per policy will administer IV oxycodone to adult patients using this protocol.

- The administrating practitioner **must** have received full IV training and be able to provide documented evidence of competencies in accordance with Trust policy for the Care of the Patient Undergoing Intravenous Therapy (Bolus, Continuous and Intermittent) prior to using this protocol.

- The patient must remain under close observation during execution of the protocol.

- For patients over 40kg in weight give an initial bolus dose of 1-2.5mg followed by further 0.5-1.5mg bolus doses to a maximum of 5mg oxycodone if required.

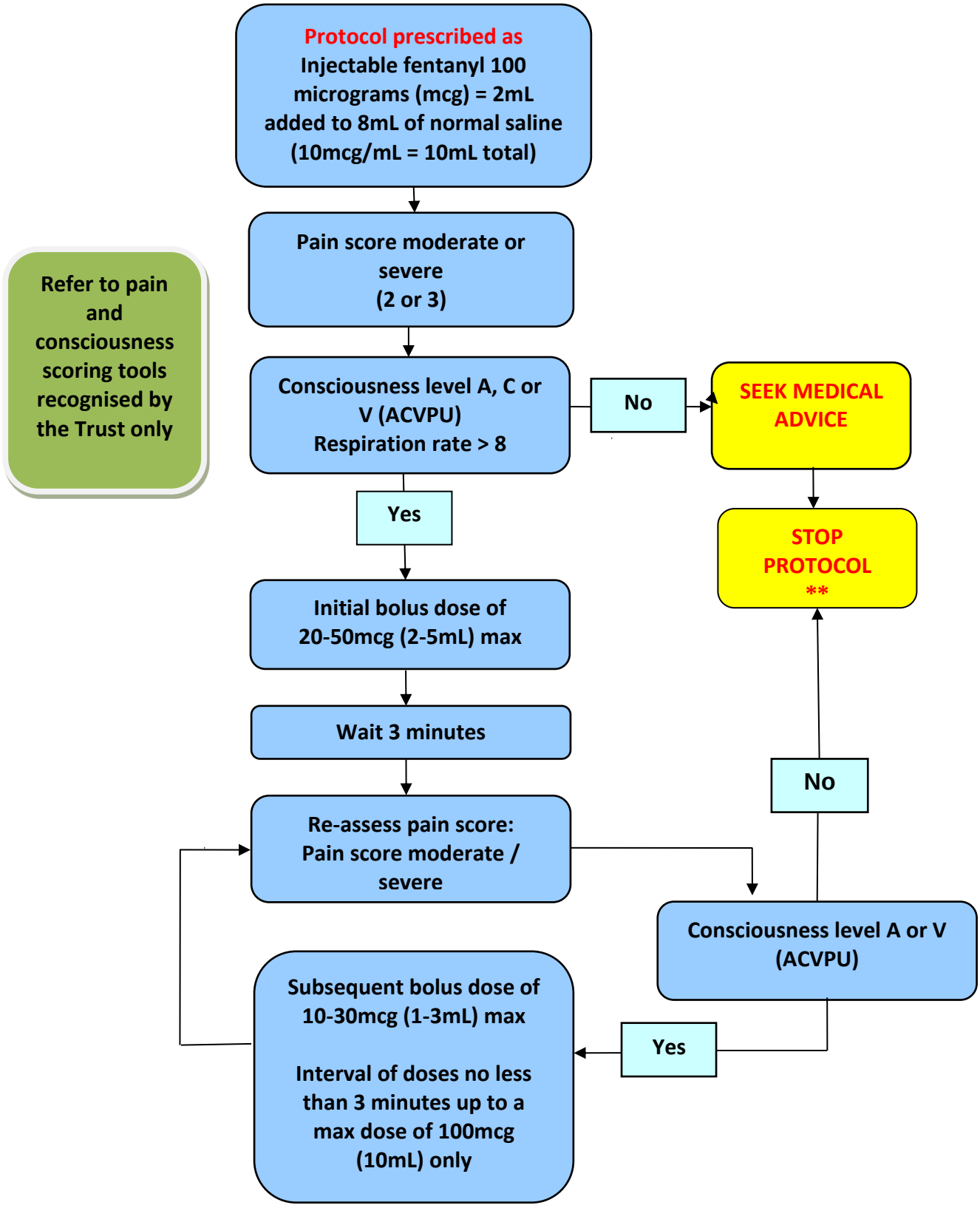
- For patients less than 40kg in weight or patients with renal impairment (eGFR<50) give an initial bolus dose of 0.5-1mg followed by further 0.5-1mg bolus doses to a maximum of 2.5mg oxycodone if required.

- **If the VRS (verbal rating score) of pain is mild (1) and level of pain is bearable then the protocol may be stopped. Alternatively, if the consciousness level falls to P or U (ACVPU) and/or the respiration rate falls below 8 respirations per minute, then stop the protocol immediately and seek advice from the patient's medical team.

- If pain persists following this protocol, please contact the patient's medical team for further advice.

Appendix C

Administration of Intravenous Fentanyl (Adults)



- **Only** registered practitioners working within indicated specialist departments as per policy will administer IV fentanyl to adult patients using this protocol.

- The administrating practitioner **must** have received full IV training and be able to provide documented evidence of competencies in accordance with Trust policy for the Care of the Patient Undergoing Intravenous Therapy (Bolus, Continuous and Intermittent) prior to using this protocol.

- The patient must remain under close observation during execution of the protocol.

- For patients over 40kg in weight give an initial bolus dose of 20-50micrograms followed by further 10-30micrograms bolus doses to a maximum of 100micrograms fentanyl if required.

- For patients less than 40kg in weight or patients with renal impairment (eGFR<50) give an initial bolus dose of 10-25micrograms followed by further 10-20micrograms bolus doses to a maximum of 50micrograms if required.

- **If the VRS (verbal rating score) of pain is mild (1) and level of pain is bearable then the protocol may be stopped. Alternatively, if the consciousness level falls to P or U (ACVPU) and/or the respiration rate falls below 8 respirations per minute, then stop the protocol immediately and seek advice from the patient's medical team.

- If pain persists following this protocol, please contact the patient's medical team for further advice.

Appendix D - EQUALITY IMPACT ASSESSMENT FORM (EQIA)

Name of service/policy/procedure being reviewed: POLICY FOR THE ADMINISTRATION OF INTRAVENOUS OPIOIDS (MORPHINE, OXYCODONE AND FENTANYL) BY REGISTERED NURSES AND OPERAING DEPARTMENT PRACTITIONERS			
New or existing service/policy/procedure: Existing policy			
Date of Assessment: 17/11/2021			
For the service/policy/procedure and its implementation answer the questions a – c below against each characteristic (if relevant consider breaking the policy or implementation down into areas)			
Protected Characteristic	**a) Using data and supporting information, what issues, needs or barriers could the protected characteristic groups' experience? For example, are there any known health inequality or access issues to consider?**	**b) What is already in place in the policy or its implementation to address any inequalities or barriers to access including under representation at clinics, screening?**	**c) Please state any barriers that still need to be addressed and any proposed actions to eliminate inequality**
The area of policy or its implementation being assessed:			
Race and Ethnicity	No		
Gender	No		
Age	No		
Religion	No		
Disability	No		
Sexuality	No		
Pregnancy and Maternity	No		
Gender Reassignment	No		
Marriage and Civil Partnership	No		
Socio-Economic Factors (i.e. living in a poorer neighbourhood / social deprivation)	No		

What consultation with protected characteristic groups including patient groups have you carried out? • **N/A**
What data or information did you use in support of this EqIA? • **N/A**
As far as you are aware are there any Human Rights issues be taken into account such as arising from surveys, questionnaires, comments, concerns, complaints or compliments? • **No**
Level of impact From the information provided above and following EQIA guidance document Guidance on how to complete an EIA (click here), please indicate the perceived level of impact: Low level of Impact For high or medium levels of impact, please forward a copy of this form to the HR Secretaries for inclusion at the next Diversity and Inclusivity meeting.
Name of Responsible Person undertaking this assessment: Clare Burton
Signature: C.L. Burton
Date: 17th November 2021

Appendix E - ENVIRONMENTAL IMPACT ASSESSMENT

The purpose of an environmental impact assessment is to identify the environmental impact, assess the significance of the consequences and, if required, reduce and mitigate the effect by either, a) amend the policy b) implement mitigating actions.

Area of impact	Environmental Risk/Impacts to consider	Yes/No	Action Taken (where necessary)
Waste and materials	• Is the policy encouraging using more materials/supplies? • Is the policy likely to increase the waste produced? • Does the policy fail to utilise opportunities for introduction/replacement of materials that can be recycled?	No No No	
Soil/Land	• Is the policy likely to promote the use of substances dangerous to the land if released? (e.g. lubricants, liquid chemicals) • Does the policy fail to consider the need to provide adequate containment for these substances? (For example bunded containers, etc.)	No No	
Water	• Is the policy likely to result in an increase of water usage? (estimate quantities) • Is the policy likely to result in water being polluted? (e.g. dangerous chemicals being introduced in the water) • Does the policy fail to include a mitigating procedure? (e.g. modify procedure to prevent water from being polluted; polluted water containment for adequate disposal)	No No No	
Air	• Is the policy likely to result in the introduction of procedures and equipment with resulting emissions to air? (For example use of a furnaces; combustion of fuels, emission or particles to the atmosphere, etc.) • Does the policy fail to include a procedure to mitigate the effects? • Does the policy fail to require compliance with the limits of emission imposed by the relevant regulations?	No No No	
Energy	• Does the policy result in an increase in energy consumption levels in the Trust? (estimate quantities)	No	
Nuisances	• Would the policy result in the creation of nuisances such as noise or odour (for staff, patients, visitors, neighbours and other relevant stakeholders)?	No	