

**ADMINISTRATION OF INJECTION THERAPY BY  
PHYSIOTHERAPISTS AND PODIATRISTS PERFORMING  
INJECTION THERAPY POLICY**

(to be read in conjunction with the Infection Prevention and Control Policy, Hand Hygiene Policy, Needlestick and Contamination Injury Policy, and Administration of Injections Policy)

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Date issued:	<b>February 2016</b> <b>April 2018</b> minor amendments
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Applies to:	Physiotherapists and Podiatrists who perform injection therapy

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## DOCUMENT CONTROL

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## 1. INTRODUCTION

- 1.1 Injection therapy is one of the many treatment modalities employed within physiotherapy and the orthopaedic assessment service as part of an integrated approach to the management of musculoskeletal joint and soft tissue inflammation.
- 1.2 Injection therapy is not a standard service routinely offered by the Trust but is a specific treatment modality utilised by the Musculoskeletal (MSK) Physiotherapy Service and the Orthopaedic Assessment Service (OAS).

## 2. PURPOSE & RATIONALE

- 2.1 The purpose of this policy is to provide clinical guidelines for the safe and effective practice of injection therapy for Chartered Physiotherapists and registered Podiatrists working within Somerset Partnership NHS Trust.
- 2.2 This procedure applies to all Physiotherapists and Podiatrists who have completed an approved training course in injection therapy and undertake injection therapy as part of their role.

## 3. DUTIES AND RESPONSIBILITIES

- 3.1 The **Chief Executive Officer** is responsible for the statutory duty of quality and takes overall responsibility for this policy
- 3.2 The **Trust Board** has overall responsibility for the effective prioritisation for participation in national audit and decisions about local audit and delegates executive responsibility to the Director of Nursing and Patient Safety
- 3.3 The **Executive Lead Director** with devolved responsibility is the Director of Nursing and Patient Safety who is the Chair of the Clinical Governance Group, and who will ensure that clinical audit is used appropriately to support the Board Assurance Framework
- 3.4 **Physiotherapy locality leads/designated locality injection therapy leads/OAS team leads** are responsible for:
- Checking evidence of attendance at a validated injection therapy course and competency assessment
  - Checking evidence of 10 hours CPD in the previous two years
  - Check evidence of at least three peer reviewed injections completed each year
  - Inducting new staff into this policy and guidance
  - Ensuring that the steroids and local anesthetics are available for use and are in date
  - Ensuring that appropriate sterile needles and syringes are available for use and that they are currently in date
  - Ensuring that any concerns raised regarding competence to undertake injection therapy is investigated and reported as appropriate
  - Ensuring that all injection therapy incidents are reported using incident reporting forms and for investigating any such incidents/accidents

- 3.5 The **Physiotherapy Manager/OAS Manager** is responsible for:
- Disseminating this policy via the Physiotherapy Locality Leads.
  - Investigating any patterns arising from injection therapy incidents/accidents.
  - Investigating concerns raised regarding competence to carry out injection therapy
  - Ensuring that resources for injection therapy related CPD is highlighted in the training and development plan.
  - Ensuring that services/departments make appropriate equipment available for use.

#### 4. **DEFINITIONS**

DATIX form:	Incident Reporting Form (Intranet)
CPD:	Continued Professional Development
CSP:	Chartered Society of Physiotherapy
SOCP:	Society of Chiropractors & Podiatrists
SOAP:	Subjective, Objective, Assessment, Plan – a form of documentation used within physiotherapy/ podiatry practice
MSK:	Musculoskeletal

#### 5. **LOCATION**

- 5.1 Physiotherapy and Orthopaedic Assessment Services must hold clinics within Somerset Partnership NHS Trust Premises, such as outpatient and Physiotherapy departments.
- 5.2 The clinical environment where injection therapy is to be undertaken must conform to the required standards which include as a minimum:
- A designated clinical room which will be subject to once daily chlorine based clean. Prior to clinic starting.
  - Patient chair or couch to be covered with an intact, impervious washable covering.
  - An accessible clinical hand hygiene sink to be located within the clinic room. With access to alcohol hand rub at the point of patient care.
  - Floor covering to be intact, sealed and made of an impervious washable material with coved edges.
  - A sharps container and clinical waste bin in room.

#### 6. **PATIENT ASSESSMENT**

- 6.1 All Chartered Physiotherapists and Registered Podiatrists who undertake injection therapy as part of their role must:
- Ensure that they only use injection therapy within their scope of professional practice.
  - Ensure they are up-to-date with the latest professional guidelines and practice injection therapy according to these guidelines.
  - Give patients a full explanation of their clinical reasoning for using injection therapy, as well as providing information leaflet (Appendix F) prior to using injection therapy and give patient portion of product information leaflet.

- Consider the contraindications and precautions (Appendix C) before deciding on the use of injection therapy and completing the contraindication/precaution checklist with the patient prior to treatment.
- Obtain written informed consent from individual patients prior to use of injection therapy, using the attached guidelines (Appendix A).
- Document the treatment given in line with the Somerset Partnership documentation standards, the standards laid down by the CSP & SOCP and the attached injection therapy specific standards (Appendix E).
- Notify their Locality/ Team Lead immediately of any accident or incident involving injection therapy and completing an incident report form immediately (in line with Somerset Partnership policy).
- Ensure that they practice injection therapy with regard for health and safety issues including adherence to Somerset Partnership Sharps Control Policy. In addition, they should prior to clinic starting undertake an assessment of the environment to ensure it is appropriate and hygienic, cleaned in accordance with cleaning schedule.
- Use sterile syringes and needles in accordance with the needle risk assessment (appendix I)

6.2 Following a full assessment, the physiotherapist/ podiatrist will decide if injection therapy is an appropriate treatment option for the patient to consider. If other therapeutic options are available the physiotherapist/ podiatrist will inform the patient what they are and allow the patient to make an informed decision as to their ongoing management. In order to aid the decision making process, the physiotherapist podiatrist will give the patient the Injection therapy Patient Information Leaflet (Appendix F) and product information leaflet once drug decision has been made. This discussion will be documented in full (Appendix B Injection therapy Treatment Flowchart).

6.3 As part of the decision making process, the physiotherapist/ podiatrist will consider if there are any contraindications to injection therapy and document this discussion with the patient in the patient's records.

6.4 If the patient has any contra-indications to injection therapy, this treatment choice is not indicated and recorded in the notes.

## 7. **CONSENT**

Prior to using injection therapy, written informed consent must be obtained. A Somerset Partnership Consent Form 3 should be signed, top copy given to the patient and the other retained in the patient's notes. Further guidance can be found, along with the consent form, at Appendix A and in the Trust's Consent and Capacity to Consent to Examination and/or Treatment policy.

## 8. **INFECTION PREVENTION AND CONTROL**

8.1 Unsafe procedures can adversely affect the health of the patient as well as the practitioner. If procedures involving skin penetration are not performed safely and hygienically they can be a means of transmission of staphylococcal and streptococcal infections and infectious diseases, including Hepatitis B, Hepatitis C and Human Immunodeficiency Virus (HIV).

## 8.2 Physiotherapist/Podiatrists undertaking Injection Therapy must

- Undertake the procedure within a designated clinical room, which is subject to a chlorine based clean prior to injection clinic.
- Always use sterile needles (see Appendix I, needle risk assessment).
- Wash hands both before and after giving the injection, and at any other point when clinically indicated during the procedure, as per the '5 Moments for Hand Hygiene' Guidance
- Check the patient's skin before and after treatment paying particular attention to needle sites.
- When aspiration forms part of the procedure it should be undertaken using a sterile dressing pack
- Dispose of all needles into a sharps box immediately after withdrawing them.
- Follow Somerset Partnership's Hand Hygiene and Needle stick and Contamination Injury Policies at all times.

8.3 Intra-articular injections should be undertaken using an aseptic, non-touch technique (ANTT) as per Trust Policy and be carried out in a clinical environment which is fit for purpose, that is a room (**not a curtained area**). Robust and regular cleaning schedules should be available to provide assurance that, the risk of cross contamination is being effectively reduced,. There should be evidence that clinical areas where Intra-articular injections are undertaken are subject to a once daily chlorine based clean, There should also be written evidence that reusable clinical equipment is subject to regular cleaning/disinfectant processes.. Consideration should be given to the appropriate use of personal protective equipment such as gloves, disposable aprons and goggles if clinically indicated. (Appendix D)

## 9. TRAINING REQUIREMENTS

9.1 All physiotherapists and podiatrists who undertake this role must have undertaken a Chartered Society of Physiotherapy or Society of Chiropractors and Podiatrists accredited training course in injection therapy. They must also be assessed as competent in the skill by the Lower Limb or Upper Limb ESP Leads, Consultant Physiotherapist or the Musculoskeletal Physiotherapy or Orthopaedic Assessment Service Manager or delegated assessor. Competencies to be completed every two years.

9.2 Additionally, they must:

- Undertake PGD training and passed the course test.
- Undertake Medicines Management training on a yearly basis.
- Complete Basic Life Support training annually and Anaphylaxis Training
- undertake peer review of practice each year

## 10. MONITORING COMPLIANCE AND EFFECTIVENESS

### Process for Monitoring Compliance

10.1 A list of all clinicians undertaking injection therapy is held by the service manager.

- 10.2 Each year there will be a documentation audit against the standards set for treatment and in line with trust policy
- 10.3 All staff injecting will undertake a minimum of three peer reviewed injections each year
- 10.4 All incidents/complaints and feedback relating to this intervention will be monitored by the Injection therapy best practice group. Learning points and good practice will be disseminated by this group to the relevant teams.

## **11. REFERENCES, ACKNOWLEDGEMENTS AND ASSOCIATED DOCUMENTS**

### **11.1 References**

Association of Chartered Physiotherapists in Orthopaedic Medicine (ACPOM).

Clinical Guidelines for the use of Injection Therapy by Physiotherapists (January 1999).

Saunders, S. Longworth, S. (2006) Injection Techniques in Orthopaedic and Sports Medicine 3rd Ed. Churchill Livingstone

Department of Health (2010) Health Building Note 00-03 Clinical and clinical support spaces

Department of Health (2010) Health Building Note 00-10 (Part C: Sanitary assemblies)

Department of Health (2008) the Health and Social Care Act. Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance. London: DH

Department of Health (2008) Board assurance: a guide to building assurance frameworks for reducing healthcare associated infections. London: DH. (2008) Board to Ward – how to embed a culture of HCAI prevention in acute trusts.

Department of Health (2008) Clean, safe care: reducing infections and saving lives. London: DH.

Department of Health (2007) Essential steps to safe, clean care: reducing healthcare-associated infections. London: DH.

Department of Health (2007) Saving Lives: reducing infection, delivering clean and safe care. London: DH.

Richard Wells Research Centre (2013) Epic3: National Evidence-Based Guidelines for Preventing Healthcare-Associated Infections in NHS Hospitals in England



## 11.2 **Cross reference to other procedural documents**

Anaphylaxis Treatment Protocol (Appendix C of the Medical Emergency Management Policy).

Aseptic Non Touch Techniques Policy

Consent and Capacity to Consent to examination and Treatment Policy

Hand Hygiene Policy

Healthcare Waste (clinical Waste) Policy

Infection Control Policy

Learning Development and Mandatory Training Policy

Medicines Policy

Needlestick and Contamination Injury Policy

Record Keeping and Records Management Policy

Risk Management Policy and Procedure

Staff Mandatory Training Matrix (Training Needs Analysis)

Untoward Event Reporting Policy and procedure

All current policies and procedures are accessible in the policy section of the public website (on the home page, click on 'Policies and Procedures'). Trust Guidance is accessible to staff on the Trust Intranet.

## 12. **APPENDICES**

12.1 For the avoidance of any doubt the appendices in this policy are to constitute part of the body of this policy and shall be treated as such. This should include any relevant Clinical Audit Standards.

Appendix A	Consent form 3
Appendix B	Injection Therapy flowchart
Appendix C	Contraindications and Precautions for Injection Therapy
Appendix D	Gloves
Appendix E	Clinical Proforma Documentation
Appendix F	Patient Information Leaflet
Appendix G	Audit Tool
Appendix H	Anaphylaxis Management
Appendix I	Needle Risk Assessment

**Consent Form 3**

Patient name/label:

**Patient/parental agreement to Injection Therapy treatment**  
(procedures where consciousness not impaired)

**Name of procedure** (include brief explanation if medical term not clear)

.....  
.....  
.....

**Statement of health professional** (to be filled in by health professional with appropriate knowledge of proposed procedure, as specified in consent policy)

I have explained the procedure to the patient/parent. In particular, I have explained:

The intended benefits

.....  
.....

Serious or frequently occurring risks:

.....  
.....  
.....

I have also discussed what the procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment) and any particular concerns of those involved.

The leaflet/tape has been provided

.....

Signed: ..... Date

Name (PRINT) .....

Job title .....

**Statement of interpreter** (where appropriate)

I have interpreted the information above to the patient/parent to the best of my ability and in a way in which I believe s/he/they can understand.

Signed: ..... Date .....

Name (PRINT).....

**Statement of patient/person with parental responsibility for patient**

**I agree** to the procedure described above.

**I understand** that you cannot give me a guarantee that a particular person will perform the procedure. The person will, however, have appropriate experience.

**I understand** that the procedure will/will not involve local anaesthesia.

Signature .....  
Date .....  
Name (PRINT) .....  
Relationship to patient .....

**Confirmation of consent** (to be completed by a health professional when the patient is admitted for the procedure, if the patient/parent has signed the form in advance)

I have confirmed that the patient/parent has no further questions and wishes the procedure to go ahead.

Signed: .....  
Date .....  
Name (PRINT) .....  
Job title .....

**Top copy accepted by patient: yes/no** (please ring)

## **Guidance to health professionals** (to be read in conjunction with Consent to Examination and Treatment Policy)

### **This form**

This form documents the patient's agreement (or that of a person with parental responsibility for the patient) to go ahead with the investigation or treatment you have proposed. **It is only designed for procedures where the patient is expected to remain alert throughout and where an anaesthetist is not involved in their care: for example for drug therapy where written consent is deemed appropriate.** In other circumstances you should use either form 1 (for adults/competent children) or form 2 (parental consent for children/young people) as appropriate.

Consent forms are not legal waivers – if patients, for example, do not receive enough information on which to base their decision, then the consent may not be valid, even though the form has been signed. Patients also have every right to change their mind after signing the form.

### **Who can give consent?**

Everyone aged 16 or more is presumed to be competent to give consent for themselves, unless the opposite is demonstrated. If a child under the age of 16 has “sufficient understanding and intelligence to enable him or her to understand fully what is proposed”, then he or she will be competent to give consent for himself or herself. Young people aged 16 and 17, and legally ‘competent’ younger children, may therefore sign this form for themselves, if they wish. If the child is not able to give consent for himself or herself, someone with parental responsibility may do so on their behalf. Even where a child is able to give consent for himself or herself, you should always involve those with parental responsibility in the child's care, unless the child specifically asks you not to do so. If a patient is mentally competent to give consent but is physically unable to sign a form, you should complete this form as usual, and ask an independent witness to confirm that the patient has given consent orally or non-verbally.

### **When NOT to use this form (see also ‘This form’ above)**

If the patient is 18 or over and is not deemed competent to give consent, you should use form 4 (form for adults who are unable to consent to investigation or treatment) instead of this form. A patient will not be deemed competent to give consent if:

- they are unable to comprehend and retain information material to the decision and/or
- they are unable to weigh and use this information in coming to a decision

You should always take all reasonable steps (for example involving more specialist colleagues) to support a patient in making their own decision, before concluding that they are unable to do so. Relatives **cannot** be asked to sign this form on behalf of an adult who is not deemed competent to consent for himself or herself.

### **Information**

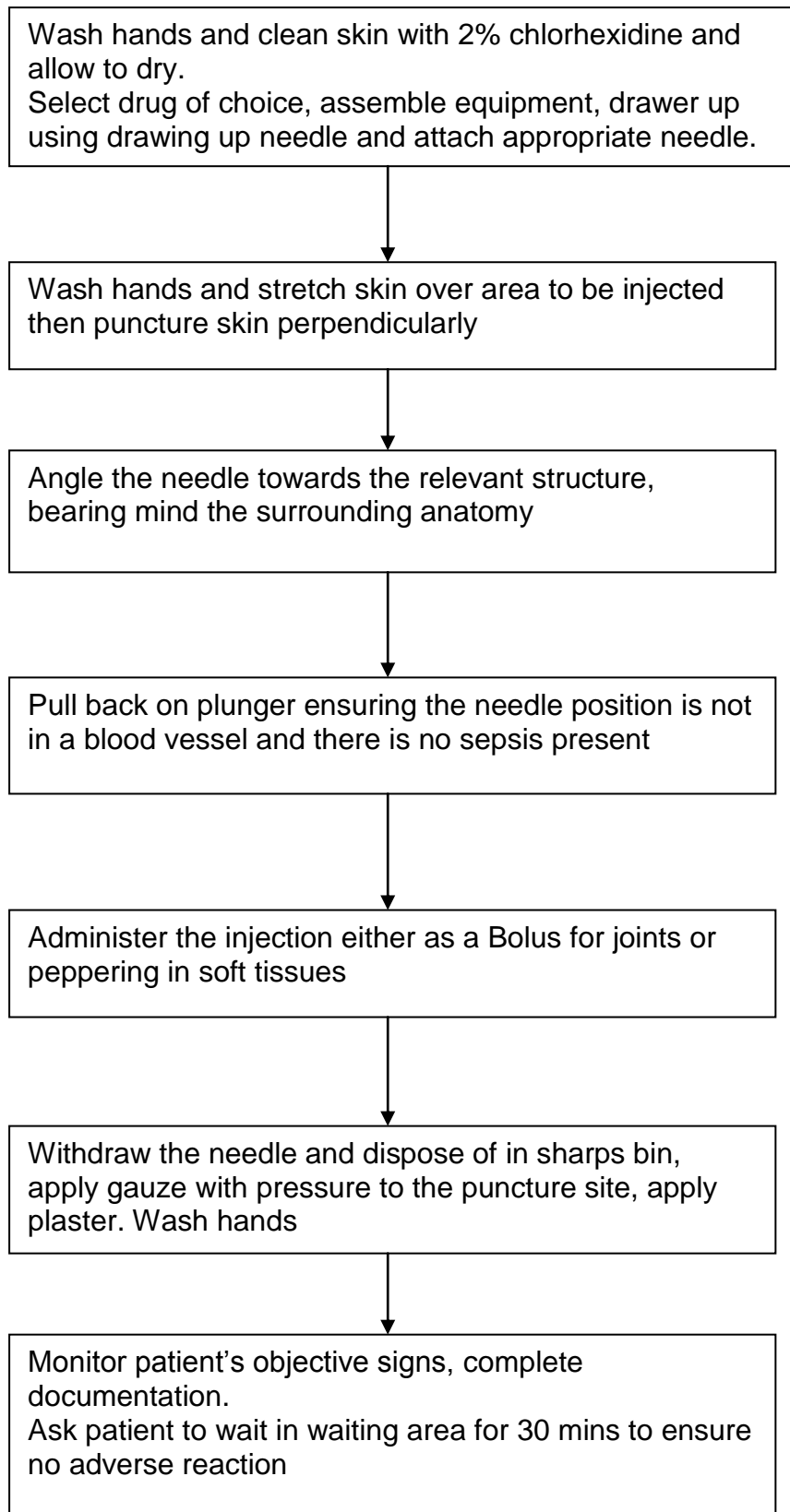
Information about what the treatment will involve, its benefits and risks (including side-effects and complications) and the alternatives to the particular

procedure proposed, is crucial for patients when making up their minds about treatment. The courts have stated that patients should be told about 'significant risks which would affect the judgement of a reasonable patient'. 'Significant' has not been legally defined, but the GMC requires doctors to tell patients about 'serious or frequently occurring' risks. In addition, if patients make clear they have particular concerns about certain kinds of risk, you should make sure they are informed about these risks, even if they are very small or rare. You should always answer questions honestly. Sometimes, patients may make it clear that they do not want to have any information about the options, but want you to decide on their behalf. In such circumstances, you should do your best to ensure that the patient receives at least very basic information about what is proposed. Where information is refused, you should document this overleaf or in the patient's notes.

### **The law on consent**

See the Department of Health's *Reference guide to consent for examination or treatment* for a comprehensive summary of the law on consent (also available at [www.doh.gov.uk/consent](http://www.doh.gov.uk/consent)).

## Injection Flowchart



## Contraindications and Precautions for Injection Therapy

### Absolute

- suspicion of infection in joint
- recent trauma and haemarthrosis
- evidence of local sepsis over injection site or generalised sepsis
- hypersensitivity to local anaesthetic or steroid
- into prosthetic joint
- avascular areas, e.g. Achilles Tendon
- children

### Relative

- patient is immunosuppressed by drugs, e.g. steroids
- patient is immunosuppressed by disease, e.g. leukaemia/HIV
- prosthetic joint elsewhere and adjacent to prosthetic joint
- anti-coagulant therapy
- bleeding disorder
- diabetes (poorly controlled)
- psychogenic or anxious patient

## GLOVES

The Chartered Society of Physiotherapists takes the view that:

The wearing of disposable gloves when giving treatment is not indicated for the following reasons:

- It would not be of any additional benefit to the patient since correct Injection technique requires the use of sterile, single-use disposable needles. The portion of the shaft of the needle likely to enter the patient should not be handled in any way when treatment is given.
- Use of sterile gauze only reinforces this lack of contact.
- This type of technique is taught to all members as part of their training.
- It would not be of any additional benefit to the therapist to whom the only risk lies in the possibility of needle-stick injury through careless handling of the needle. Gloves will not prevent this.
- It is clearly indicated in the guidelines that any open areas of skin which might come into contact with the body fluids of the patient must be covered by water proof dressing/gloves before undertaking treatment.
- In any case, all handling of contaminated needles is kept to an absolute minimum by the placing of a 'sharps' disposal box beside the patient.
- Accuracy and skin and needle feel would be seriously impaired by the use of gloves.

(Val Hopwood, iCSP 2006)

(Chartered Institute of Environmental Health book 2001)

It is imperative that robust hand decontamination be observed as per the Five Moments for Hand Hygiene Guidance

Staff should be aware and conversant with the trust hand hygiene policy which contains further advice on glove usage and states:-

. There are two main indications for wearing gloves:

- To protect hands from contamination with organic matter and micro Organisms;
- To reduce the risks of transmission of microorganisms to both patients and health care workers.

Gloves should be worn for:

- invasive procedures;
- contact with sterile sites and non-intact skin or mucous membranes;
- all activities that have been assessed as carrying a risk of exposure to blood, body fluids, secretions or excretions, or sharp or contaminated instruments.



## Appendix E

Documentation

### Injection Clinical Proforma

Patient Name
NHS No

Date.....

Diagnosis.....

Injection performed..... Time .....

- Clinical History – no change if pre assessed     Precautions Checked  
 Consent form completed     Contraindications checked  
 Aseptic technique     Separate syringes Needle size...

Drug	Dose	Batch No	Expiry Date
Triamcinolone Acetonide 40mg/ml			
Triamcinolone Acetonide 10mg/ml			
Methylprednisolone Acetate with Lidocaine Hydrochloride 40mg/ml + 10mg/ml			
Methylprednisolone Acetate 40mg/ml			
Lidocaine Hydrochloride 1% (10mg/ml)			
Lidocaine Hydrochloride 2% (20mg/ml)			

- Uneventful     Immediate response

Signed..... Print name .....

# Joint and soft tissue injections

## *Information for patients*

### Why do I need an injection?

Injections to joints and soft tissue can be very effective in giving pain relief and reducing inflammation. Sometimes injections are given for short term pain relief to aid rehabilitation.

Injections may be preceded by aspiration of the joint or soft tissue. Aspiration is the removal of fluid to reduce the swelling, and to determine if the injection should go ahead. If the fluid drawn off indicates that the injection is not recommended then the clinician will discuss with you what happens next.

### What types of injection are there?

There are three types of injections:

- Steroid and local anaesthetic
- Steroid alone
- Local anaesthetic alone

Steroid is used to reduce pain and inflammation and local anaesthetic will numb the area temporarily.

### How quickly will the injection work?

The effect of the steroid is usually seen within a few days, but there may be a gradual improvement over a few weeks.

If a local anaesthetic is used there will be a temporary numbness lasting a few hours.

### How long will the beneficial effects last?

This can vary depending on the condition. The effects may last a few weeks to several months, or sometimes years.

### Are there any side-effects?

Side-effects are rare, but important to be aware of. Here are some examples of possible side-effects:

- **Post injection flare up of pain.** This may last up to 48 hours. Take painkillers, such as Paracetamol if you need them
- **Infection** is rare, but if you develop any of the following symptoms: swelling, redness, warmth around the injection site, or you feel generally unwell, please contact your GP (or out of hours service)
- **Anaphylactic shock** is an extreme but rare allergic reaction. It usually happens quickly, shortly after the injection has been given. We suggest you wait in the clinic area for 30 minutes after your injection in case you experience an adverse reaction

- You may develop a **dimple or an area of depigmentation** (discolouration) around the injection site
- **Facial flushing** may be present for 24 hours after the injection and pre-menopausal females may experience breakthrough menstrual bleeding
- **Fainting.** A few people feel faint after their injection. This usually settles if you lie down for a few minutes. Please advise your clinician if you have a tendency to faint

### Are there any reasons why an injection may not be suitable?

An injection may not be suitable if you have:

- An infection, either at the injection site or a general infection such as flu
- Taken a recent course of antibiotics but may still have an ongoing infection
- A known allergy to either local anaesthetic or steroid

### Are there any reasons why an injection should be given with caution?

An injection will be given with caution if:

- You have diabetes
- You have a bleeding disorder or you take Warfarin. If you take Warfarin, you will need to bring your yellow book to the appointment, so the clinician can check that your INR level is within the therapeutic range
- There has been any recent trauma (within six weeks) or you have bleeding within your joint
- You take oral Prednisolone or have any medical condition which lowers your immune system

### Should I be taking things easy after the injection?

Yes, to gain the most benefit from the injection it is important to follow the advice given, as failure to rest can prevent the injection from working.

Maintain gentle activity for the first week following treatment. Avoid any exercise or activities which have previously worsened your symptoms.

### Can the injection be repeated?

This depends on the condition and also the response to the first injection. A maximum of three injections can be given over a 12 month period.

### Answers to frequently asked questions

- A shoulder injection is often less painful than a blood test
- The injection does not go into bone or tendons
- Not all injections work, but the majority achieve significant benefit

**Audit Tool**

MSK Physiotherapy Injection Group: Notes Audit

	STANDARD	Set 1			Set 2			Set 3			Set 4		
		YES	NO	N/A	YES	NO	N/A	YES	NO	N/A	YES	NO	N/A
1	Is injection therapy the appropriate treatment for the diagnosis reached?												
2	Is it documented that all options for treatment have been discussed												
3	Is the absence of contra-indications recorded?												
4	Are precautions recorded?												
5	If precautions present, has suitable action been taken?												
6	Has the injection leaflet been provided?												
7	If the patient is on anticoagulant therapy is it documented that they have been given the appropriate advice												
8	Has the consent form been completed?												
9	Was the correct injection technique performed?												

	STANDARD	Set 1			Set 2			Set 3			Set 4		
		YES	NO	N/A	YES	NO	N/A	YES	NO	N/A	YES	NO	N/A
10	Is aseptic technique recorded?												
11	Is a suitable dose used?												
12	Are the drugs used recorded including the batch number and expiry date?												
13	Was the injection uneventful?												
14	If not, the adverse effects recorded?												
15	Is appropriate aftercare documented?												
16	Is a plan for further care recorded?												
17	Are all entries signed												
18	Are all entries timed?												

## **ANAPHYLAXIS**

Skin rashes  
Urticaria  
Pallor  
Cyanosis  
\*Tachycardia  
Hypotension  
\*Angio-oedema  
\*Bronchospasm  
\*Apprehension  
Nausea

## **SYNCOPE**

Pallor  
Sweating  
Light headedness  
Dizziness  
Nausea  
Vision “going grey”  
Tinnitus

## **MANAGEMENT**

- summon help
- stop drug administration
- give adrenaline 1:1000  
0.5ml intramuscularly
- summon medical help
- maintain airway

Lying patient in recovery position  
Monitor  
Check pulse

## Risk Assessment Form Needle Use within Injection Clinics

Date of Assessment: 30/8/2017

Service / Department / Speciality OASIS/ Physiotherapy

Person conducting risk assessment: Paul Aldwinckle

<b>IDENTIFY THE RISKS</b> State the risk in terms of a failure Or inability or loss resulting in an outcome	Injections/Aspirations require the use of the standard type hypodermic needles without needle stick guards. The guards affect the safe an accurate placement of the needle as the guard impedes the needle as it enters the skin at an angle.  Risks of needle stick injury for operator and patient.
<b>HAZARDS?</b>	Sharps / needles exposure to Blood Borne Virus (BBV)
<b>WHO MIGHT BE HARMED?</b>	Physiotherapist/ Podiatrist staff, one person at a time
<b>DESCRIPTION OF THE TASK?</b>	Steroid injections to joints and soft tissues.
<b>FREQUENCY OF THE TASK?</b>	Max 10 procedures per session

### Assess the following for each Risk identified:

What controls exist to prevent the risk occurring?	How effective are the current controls?	What can be done to improve controls / Mitigate Risk?
Organisation-level controls (e.g. policies; organisational structure)	Current Sharps disposal policies followed  Very effective	
Speciality-level controls (e.g. speciality structure; protocols)	Injection therapy guidance  Very effective	
Profession-level controls (e.g. special training / knowledge)	All Operators who perform interventional Aspiration and injection therapy are highly trained in performing procedures.  Very effective	

Team-level controls (e.g. Multi-professional working arrangements)	Regular peer review sessions	Very effective	
Technical-level controls (e.g. equipment / techniques / tests)	Blue, Orange, Cream and Green needles used. Drawing up needles Sharps boxes used for disposal at point of care	Current disposal procedures are effective	
Individual-level controls (e.g. staffing levels; experience)	All who perform these examinations are experienced Physiotherapists or Podiatrists with' experience in this field. Peer review of technique	Very effective	



<b>Score the Initial Risk level before any controls or mitigating actions have been identified - Use the Trust Risk Matrix</b>		
<b>Likelihood (L)</b>	1	
<b>Consequence (C)</b>	2	
<b>Overall Risk (L x C)</b>	2	
<b>Score the Actual risk after controls and mitigating actions have been identified - Use the Trust Risk Matrix</b>		
<b>Likelihood (L)</b>	1	
<b>Consequence (C)</b>	2	
<b>Overall Risk (L x C)</b>	2	
<b>Risk Treatment Plan – Depending on the Risks Score identify appropriate actions to address the risk</b>		
<b>Action</b>	<b>Responsibility</b>	<b>Target date</b>
<b>1. Continue to be diligent with regard to sharps disposal</b>	<b>All staff performing injections</b>	<b>now</b>
<b>2. Continue to practice and perform examinations with a high level of care with specific focus on handling sharps</b>	<b>All staff performing injections</b>	<b>now</b>
<b>3. Contact procurement and materials management to ensure supply of needles continues and review new safer needles with company rep</b>	<b>Service manager</b>	<b>August 17/ completed</b>
<b>4. Etc.</b>		
<b>Residual Risk</b>		
Calculate the residual risk that remains once actions are complete		
<b>Likelihood (L)</b>	1	
<b>Consequence (C)</b>	2	
<b>Overall Risk (L x C)</b>	2	

