Haemochromatosis Nurse Led Clinic Procedure

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1.0 INTRODUCTION

1.1 Background

Hereditary haemochromatosis is a common genetic disorder resulting in excessive intestinal iron absorption. Excessive quantities of iron absorbed from the diet are deposited in various organs, mainly the liver, pancreas and heart, and the joints, resulting in organ damage and impaired function. Inpatients with hereditary haemochromatosis iron levels remain normal, but the regulation of iron absorption is disrupted, leading to iron overload (Dolbey 2001). Hepcidin (a hormone produced mainly by the liver) is the primary regulator of iron absorption in the intestine and is involved in its delivery to the plasma (Deugnier et al 2008). This is achieved by down regulating intestinal iron absorption and iron release from cells such as enterocytes, macrophages and placenta cells. Clinical manifestations of hereditary Haemochromatosis are related to the degree of iron accumulation (Norris). Accumulation of excessive iron in the organs, joints and pituitary gland, if untreated, may result in organ damage and the manifestations of associated signs and symptoms.

Potential disorders related to Haemochromatosis.

- Diabetes mellitus
- Sexual dysfunction
- Menstrual problems
- Heart disease
- Hypothyroidism
- Osteoporosis
- Liver Cirrhosis
- Hepatocellular Carcinoma

The haemochromatosis clinic was established in 2006 due to increasing clinic numbers and a review of working boundaries in response to improving outcomes guidance. Such clinics are supported by recent government and nursing policy which encourage new collaborative ways of working across professional boundaries.

1.2 Purpose

Patients under the care of a consultant gastroenterologist with a diagnosis of a haemochromatosis over the age of 16.

1.3 Scope

This procedure has been developed to improve the quality of the service provided to patients with haemochromatosis; and to reduce the pressure of workload in the consultant clinics. Improvements seen as a result of this service include:

- Provision of a more flexible service for patients with haemochromatosis in regards to number of appointments available as well as the timing and frequency of appointments
- Reduced outpatient waiting times
- Holistic needs of patients met
- Provision of a more cost effective service for the trust

1.4 Principle Legislation or Guidance Referenced

- Hoffbrand A. V. and Lewis S. M. Postgraduate Haematology, 4th edition (2010)
- Pritchard A. P. and Mallett J. The royal Marsden Hospital Manual of Clinical Nursing Procedures 6th edition (2004)
- NMC (2008) The NMC Code of Professional standards for Conduct, performance and ethics
- NS511 Sheahan O, O'Connell E (2009) Hereditary Haemochromatosis Patient Support and Education. Nursing Standard. 24,3,49-56.
- J Hepatol. 2010 Jul;53(1):3-22. doi: 10.1016/j.jhep.2010.03.001. Epub 2010 Apr 18. EASL clinical practice guidelines for HFE hemochromatosis**.**
- Peripheral intravenous cannulation procedure including PGD (Trust operational procedure) January 2013 – Ref PRC/SH/12/12
- Venepuncture and Blood Culture Procedure (Trust Policy)
- Central venous access in oncology: ESMO Clinical Practice Guidelines B Sousa et al , Annals of Oncology26(supplement 5) v152-v168, 2015

1.5 Standard Supported

- Genetic Haemochromatosis, Guidelines on diagnosis and therapy, British Committee for Standards in Haematology, British Society for Haematology 2000

1.6 Reader Panel

The following formed the Reader Panel that reviewed this document:

Post Title	
Dr Cesar Gomez	Consultant Haematologist

1.7 Trust Values

This Procedure conforms to the Trust's values of putting patients first, aiming to get it right, recognising that everybody counts and doing everything openly and honestly.

1.8 Glossary

The following terms and abbreviations have been used within this Guide:

Term	**Definition**
BSCH	British standards for clinical haematology

1.9 Distribution Control

Printed copies of this document should be considered out of date. The most up to date version is available from the Trust Intranet.

2.0 OBJECTIVE FOR PROCEDURE

This procedure has been developed to improve the quality of the service provided to patients with haemochromatosis; and to reduce the pressure of workload in the consultant clinics. Improvements seen as a result of this service include:

- Provision of a more flexible service for patients with haemochromatosis in regards to number of appointments available as well as the timing and frequency of appointments
- Reduced outpatient waiting times
- Holistic needs of patients met
- Provision of a more cost effective service for the trust

3.0 ROLES AND RESPONSIBILITIES

Consultant Gastroenterologist

- To refer patients to the nurse led Haemochromatosis Clinic with a clear management plan.
- To review all patients annually or earlier if requested by nurse leading the clinic.

Infusional Nurse

- To co-ordinate and run the Haemochromatosis Clinic.
- To undertake phlebotomy and venesection of patients referred to service.
- To ensure the safety of patients at all times and provide an efficient high quality service.
- To keep the Consultant Gastroenterologist fully informed of any change in patients condition.
- To keep accurate documentation of patients care including completion of venesection record.
- To audit the service annually.

4.0 PROCEDURE DETAILS SECTION

Equipment
Alcohol impregnated swab
Gloves
Gauze swab
Adhesive tape
Sphygmanometer
Venesection pack

Method & Rationale

METHOD

1	Explain procedure to patient and ensure that patient has received venesection information leaflet (appendix B)	To inform and obtain verbal consent and co-operation of patient.
2	Record blood pressure	To obtain base line recording
3	Perform venesection according to haemochromatosis clinical guideline (appendix C)	
4	Assess vein accessibility on the non-dominant upper limb. The ante-cubital fossa usually provides the best site. Unused, soft veins that are “bouncy” and refill when palpated are the most suitable for this procedure.	Maintain good venous access essential as a rapid blood flow is required for this procedure.
5	Wash and dry hands and apply well-fitting gloves.	To reduce the risk of infection and avoid contact with any blood.
6	Apply blood pressure cuff to 120mmHg, above puncture site ensuring that it does not restrict arterial blood flow. If you feel a deep vein but are unsure if it is a tendon or vein, feel it with the pressure up and then release the pressure. If it is a tendon you will still be able to feel it with the pressure off.	To distend veins.
7	Clean skin with alcohol impregnated swab and allow to dry.	To decontaminate the skin

8	Insert needle into vein while holding the skin taut, at an angle of 45 degrees depending on the depth of the vein. Once blood flow is apparent, secure the tubing in position. Reduce the pressure reading to 40mmHg.	This allows the blood flow to be maintained by gravity until required volume of blood is collected.
9	After completion of procedure release pressure with needle still in situ.	To avoid unnecessary bruising and blood spillage.
10	Remove needle and cover site with un-sterile cotton wool and press firmly for three minutes or longer if clinically indicated. Secure with tape.	To minimise bruising.
11	Dispose of all clinical waste and sharps safely.	To prevent injury.
12	Allow patient to rest for 10 minutes and provide a drink.	To aid recovery of normal blood pressure.
13	Record blood pressure post venesection.	To ensure patient is well enough to be allowed home.
14	Document amount of blood venesected and any adverse effects during or after procedure and sign both in medical notes.	Adequate documentation maintained.
15	Advise patient to drink an extra 400 mls that evening and to limit strenuous activity.	To facilitate patient recovery post venesection.
16	16 Complete venesection record card (see appendix A)	

4.1 Balanced Venesection

A balanced venesection is the procedure of venesection as above but with replacement fluid running concurrently to ensure the patient remains isovolaemic. The consultant/staff grade will decide if balanced venesection is required.

- Cannulate the patient with 24 gauge needle
- Attach 500 ml bag of normal saline 0.9%
- Run saline concurrently whilst venesecting to the amount venesected.

4.2 Potential problems and complications of venesection

Problem

Missed vein – unsuccessful venesection

Action

It is unacceptable to probe around looking for the vein. This can be very distressing for patients and may cause the patients anxiety to rise and the vein to constrict even further. It may also make the patient feel faint. If the venesection is unsuccessful – pull out after releasing pressure and try again or seek assistance. (**You may only attempt two venesections on the same patient before seeking assistance.)**

Problem

Collapsed vein – this usually occurs in a frail vein.

Action

In this instance it may be resolved by loosening off the tourniquet and withdrawing the needle, as the vein fills up again apply more pressure with the tourniquet. If this does not resolve the problem remove the needle and try again.

Problem

Patient faints while blood is being taken.

Action

Stop taking the blood and withdraw the needle taking care to keep pressure on the site. Place the patient either in the recovery position or lying down with legs raised if still conscious. If they are sat in the chair place their head between their legs until they feel better and then with some assistance, lie them down with their feet up above the waist. During this time ensure the venesection site has pressure applied to prevent bleeding.

5.0 MONITORING COMPLIANCE

Annual audit against BCSH standards for Haemochromatosis will be undertaken by the Infusional nurses.
See Appendix E for the Monitoring Table that will be used to conduct monitoring of compliance for this Procedure.

6.0 STAFF TRAINING

Education will be delivered:

- During clinical practice sessions supervised by the Haematology CNS/ departmental sister
- Self directed study
- Consultant and Specialist Nurse Support

Competency

Competency for the procedure of venesection will be assessed by the haematology clinical nurse specialist.

A copy of the venesection competency to practice statement (appendix D) will be held by the competent nurse and a copy held in the emergency division office.

Clinical supervision
Clinical supervision will be undertaken by the consultant gastroenterologist formally every 12 months

6.1 Criteria for staff carrying out the Procedure

This procedure is limited to the infusional nurses at the James Paget University Hospital. The nurse will be a registered nurse Band 5 or above with up to date phlebotomy and cannulation skills.

6.2 Learning Outcomes

To define his/her legal, ethical and professional responsibilities in the decision to consult and venesect patients with haemochromatosis to demonstrate an awareness and understanding of the following policies:

- Infection control policies
- Health and safety policies
- Guideline for diagnosis and management of HFE(High Iron Fe) Haemachromatosis

Skills

- Demonstrate the ability to communicate with patients
- Demonstrate the ability to consult and venesect patients diagnosed with haemochromatosis safely
- Demonstrate the ability to recognise and act upon any abnormal findings and to refer back to consultants appropriately

6.3 Method of Assessment, Knowledge and Skills

The Infusional Support Nurses will attend the Sandra Chapman Centre weekly for 4 weeks. Practical observation and supervised practice will be undertaken by the Haematology Nurse Specialist mentor and the Sandra Chapman Centre Manager mentor.
A record will be held of all practice and signed by the mentor. The number of practical procedures will be determined by the nurse and mentor but a minimum of ten procedures will be carried out before competency can be confirmed (appendix D).

APPENDIX A

ISOVOLUMETRIC: YES/NO

Referring Consultant …… Frequency of visits ……

Indication for venesection ……..

Other Medical conditions ……

CONSULTANT

Date	Blood Results	Problems	Pre-Vene Observations	Amount Venesected	Volume of Fluid Replaced		Next Visit	Sign
	WCC Hb Hct Pl		P B/P					
	Ferritin							
	%iron							
	WCC Hb Hct Pl		P B/P					
	Ferritin							
	% Iron							
	WCC Hb Hct Pl		P B/P					
	Ferritin							
	% iron							
	WCC							

	Hb Hct Pl		P B/P					
	Ferritin							
	% Iron							
	WCC Hb Hct Pl Ferritin % iron		P B/P					
	Hct		B/P					
	Pl							
	Ferritin							
	% Iron							
	WCC							
	Hb		P					
	Hct		B/P					
	Pl							
	Ferritin							
	% iron							

APPENDIX B

James Paget University Hospitals NHS
NHS Foundation Trust

Venesection Patient Information

Cheryl Pearce, Service Improvement & Quality Lead, Haematology

What is venesection?

Venesection is the removal of a volume of blood, usually about 450 mls, from a patient.

Your consultant will decide a treatment plan for you.

Why is this done?

To indirectly lower the iron by removing red blood cells in patients who are iron overloaded.

How is this done?

The procedure is exactly the same as is used when one is a blood donor and is very simple.

It is performed while you sit in a reclining chair.

- Blood pressure and pulse are checked
- A blood pressure cuff is placed around your upper arm and inflated slightly to make the veins in your arm more prominent.
- The nurse will then choose a suitable vein and clean that area with an alcohol wipe.
- A needle with a blood collection bag attached to it is then inserted into the vein and taped into place. Putting the needle in is uncomfortable but no more than that.
- The blood then flows slowly into the collection bag until the correct amount has been collected. The cuff on your arm is left in place but the pressure is reduced to a low level to help the blood flow.
- When sufficient blood has been collected the needle is removed and a cotton wool dressing applied. You will be asked to apply direct pressure for at least five minutes and it will be taped in place. This should be left in place for a minimum of four hours.
- Then you will be asked to rest for approximately 10 minutes and have a drink
- Blood pressure and pulse are checked before you leave.

How will I feel?

There should be no ill effects if you follow the advice given. Occasionally people complain of thirst during the next 24 hours.

Are there any other side effects?

Side Effects – Bleeding from the venesection site

Occasionally you may bleed from the needle site after you have left the department.

If this happens don't panic, simply apply direct pressure to the site for at least five minutes and the bleeding should stop. Leave dressing in situ for four hours. Avoid any heavy lifting with that arm for the rest of the day.

Side Effects – Bruising

What is bruising?
Occasionally, bleeding under the skin causes bruising.

Why does it happen?
- The most common cause of bruising is bleeding continuing from the needle site until the small hole in the vein closes up. This can be prevented by applying pressure until all signs of bleeding stop.
- When the needle is inserted damage may occur to the opposite wall of the vein allowing blood to escape into the tissues.
- There are tiny fragile blood vessels running just under the skin which can be damaged as the needle is inserted and a small amount of bleeding occurs.

What can be done?
The best method of preventing a bruise is to apply pressure as advised.

If it does occur it may be ugly but is usually harmless and will fade in time.

However if you experience any of the following you should let us know.

- Severe pain
- Numbness or pins and needles in the arm hand or fingers
- Swelling and or redness of the arm
- As we cannot predict who may feel faint following venesection, it is advisable not to drive yourself for the first appointment

Side Effects – Fainting

Some people feel faint after venesection as not everyone can adapt as quickly as others can to the small blood volume loss. Various factors will make you more likely to feel faint:

- If you weigh less than 50 kg
- Drinking alcohol within a few hours of venesection
- Being in a hot room
- Rushing about, taking vigorous exercise
- Missing meals and not replacing fluid loss
- Standing still for long periods following venesection

What do I do if I feel faint?

If you feel faint during the procedure tell the person treating you and they will take appropriate action.

If you feel faint after you have left the hospital either lie down or sit with your head between your knees until the feeling passes. When you get up do so slowly. If you still feel faint sit or lie down again.

You should tell the nurses when you attend for next treatment. It may be necessary to give you intravenous fluids while we take blood. As delayed faints can occur and may place you or others at risk if your work or hobbies could make a delayed faint hazardous eg. train driver, using machinery, do not return to work or engage in hazardous hobbies on the day of venesection.

Main Advice

- Apply pressure to site as advised (no peeking under the cotton wool to see if it has stopped bleeding)
- Rest for period advised and avoid vigorous exercises, rushing around, standing still for long periods and hot environments on day of treatment
- Take plenty of fluid, ensure you eat normally on day of treatment
- Do not smoke or drink alcohol within two hours of treatment
- Please bring any medication that you are currently taking

For more information contact

Renné Ward, Infusion Lead Nurse, Infusion Service
Telephone: 01493 452003 or 01493 452216 (secretary)

APPENDIX C

CLINICAL GUIDELINE FOR THE MANAGEMENT OF HAEMOCHROMATOSIS

1. INTRODUCTION

HFE Haemochromatosis (HFE-HC) is the more prevalent genetic disorder in Caucasians, It is defined as a clinical disorder of iron metabolism that leads to progressive, parenchymal cell iron overload in many tissues of the body, in particular in the liver, pancreas, and heart.

The proteins altered in haemochromatosis are components of a pathway that controls iron haemostasis according to the body needs.

The identification of the genes that are mutated in haemochromatosis has revolutionised the diagnosis of primary iron overload, by introducing genetic testing that allows early, pre-symptomatic and accurate diagnosis.

Although the genetic alterations are the more frequent origin of iron overload there are other causes which should require treatment (Table 1):

Causes of Iron Overload (Table 1)

1. Hereditary haemochromatosis

Type 1. HFE-related
C282Y homozygotes
C282Y:H63D compound heterozygotes
Rare alternative HFE mutations
Types 2,3, and 4 non-HFE mutations

2. Secondary iron overload

Iron loading anaemias with or without blood transfusion
Chronic liver diseases
Hepatitis B and C
Alcoholic liver disease
Non-alcoholic fatty liver disease
Porphyria cutanea tarda
Dietary iron overload
Miscellaneous causes
African iron overload with or without genetic predisposition
Neonatal iron overload
Aceruloplasminaemia
Atransferrinaemia

The prevalence of iron overload in this country is approximately 0.3% but the frequency (%) of the C282Y mutation is much higher approximately 8%. The target populations for diagnosis of HFE-HC are:

1. Patients with clinical manifestations compatible with HFE-HC
   a. Unexplained liver disease, hepatomegaly, or elevated liver enzymes
   b. Type II diabetes mellitus with associated liver disease, cardiomyopathy, or early-onset sexual dysfunction
   c. Early-onset arthropathy, cardiomyopathy, cardiac dysrrhythmia or sexual dysfunction
2. Patients without clinical manifestations of HFE-HC
   a. First-degree relatives of a patient with identified HFE-HC
   b. Incidental finding of elevated serum iron markers (eg, iron saturation or serum ferritin)
   c. Incidental finding of elevated liver enzymes or hepatomegaly, or a compatible ultrasound, CT or MRI of the liver.

2. PURPOSE

To ensure timely and effective investigation and treatment of patients who have haemochromatosis.

3. SCOPE

All medical and nursing staff at the James Paget University Hospitals NHS Trust

4. RATIONALE

To provide consistent evidence-based treatment to patients with HFE-HC.

5. DIAGNOSIS: (see appendix 1)

1. Recommendations for detection of iron accumulation,
   i) Measure serum iron concentration and total iron-binding capacity and calculate transferrin saturation.
   ii) If transferrin saturation is greater than 50% repeat the measurement on a fasting sample.
   iii) A fasting transferrin saturation of greater than 55% (men and post-menopausal women) or 50% (premenopausal women) indicates iron accumulation.
   iv) Measure serum ferritin concentration.

2. HFE testing C282Y and H63D Is the logical next step after increased transferrin saturation is detected.
   The presence of C282Y homozygosity in the presence of iron overload is diagnostic of HFE-HC.

3. All patients suspected of having HFE-HC should have standard LFT's panel including AST which needs a separate request form as well α-fetoprotein.

4. Patients with normal LFT's may proceed to treatment without a liver biopsy which, however, should no longer be used solely to diagnose HFE-HC. Liver biopsy can be offered to patients with C282 homozygosity that has ferritin > 1000 ug/L, abnormal AST and age > 40. The main advantage of liver tissue acquisition is assessment for liver fibrosis.
   All HFE-HC patients should be screened for chronic viral hepatitis as well as all chronic viral hepatitis patients need screening for HFE-HC. If the HFE-HC patient is found to also have Hepatitis C, phlebotomy treatment should be initiated and iron stores brought to normal before initiating antiviral therapy for hepatitis C.

5. Patients who are H282Y/H63D hetrozygotes or H63D homozygous and have proven iron overload should first be investigated for conditions leading to secondary iron overload. Patients with proven iron overload who test negative for HFE can be tested for non HFE mutations but seek advice of tertiary liver centre as testing is not routinely available.

6. Consider screening of patient's first degree family members.

6. TREATMENT

1. At diagnosis:

Once the diagnosis of hereditary haemochromatosis/iron overload has been made by any of the above tests, the patient should be aggressively phlebotomized once to twice weekly upon tolerance (450–500 ml) by prescription using the subsequent criteria until

serum ferritin (storage iron) is brought to ≤ 20 ng/ml and ideally transferrin saturation is ≤ 16%. Monitor Hb levels every two weeks or when clinically indicated in terms to reduce the rate of quantitative phlebotomy if anaemia develops. Monitor serum ferritin monthly. Measure transferrin saturation as the ferritin concentration drops to 50 ng/ml.

2. Maintenance:

Once the serum ferritin is equal or below 20 ng/ml the patient should go on a maintenance phlebotomy program, usually two to four times annually, depending of the rate of iron accumulation. The aim is to maintain the ferritin in a target rate between 50 and 100 ng/ml. The treatment is for life, however for reasons that remain unclear, not all patients with haemochromatosis reacumulate iron at the end of the first treatment of iron depletion, consequently they may not need maintenance as such and only monitoring possibly in primary care is needed.

3. Patients with HH/iron overload should be warned not to:

(1) Take iron supplements
(2) Take vitamin C supplements
(3) Drink alcohol or if no liver damage at diagnosis, to drink moderately.

6. REFERENCES

1- British Committee for Standards in Haematology. Guidelines on diagnosis and therapy in Genetic Haemochromatosis 2000.
2- British Society of Gastroenterology. Guidelines on the use of Liver Biopsy in Clinical Practice 2004.
3- Brissot P, Troadec M, Bardou-Jacquet E,et al. Current approach to Hemochromatosis. *Blood Reviews. 2008: 22:195-210.*
4- EASL Clinical Practice Guidelines for HFE Hemochromatosis. Journal of Hepatology. 2010
5- Bacon B, Adams PC, Kowdley K, et al. Diagnosis and Management of Hemochromatosis 2011 Practice Guideline by the American Association for the Study of Liver Disease. Hepatology. 2011 54 (1): 328-343.

7. ENDORSEMENT

Dr Kashif Sheikh - Consultant Gastroenterologist
Dr Shalal Sadullah - Consultant Haematologist

8. AUTHOR AND DATES

Authors: Dr Cesar Gomez
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Appendix 1

APPROACH OF HAEMOCHROMATOSIS IN TARGET POPULATION

Symptomatic
Adult 1st Degree
Relative of HH
Asymptomatic
Age > 40 years Ferritin >
1000 and Abnormal

ALT/AST

Fasting Transferring Saturation and

Serum Ferritin

C282Y/C282Y

Age < 40 years Ferritin

< 1000 and Normal

ALT/AST

TS < 50% and
Normal Ferritin
TS and Ferritin
Elevated
Compound Heterozygous

C282Y/H63D

Heterozygote C282Y
or non – C282Y
No Further iron
Elevation
Genotype
Exclude other liver or
Haematological diseases.
±Liver biopsy
Therapeutic
Phlebotomy
Consider Liver Biopsy
for Iron Stain and
Histopathology
± +

Appendix 2

Medical and Nursing Management of Haemochromatosis

At Diagnosis
Date of diagnosis:

Gastroenterologist referral Yes No

Consultant Gastroenterologist……..……

Serum Iron
TIBC (total iron binding capacity)
TS (transferrin saturation)
Ferritin
LFT (Including gamma GT and αFP)
Liver biopsy Yes No
Imaging (MRI/Ultrasound/CT)
Venesection once weekly/every two weeks according to clinical criteria and Hb level until

Ferritin <20 mcg/l + TS <16%.

Hb - fortnightly (at time of venesection)
Ferritin - monthly
TS - Measure monthly once ferritin concentration <50 mcg/l
LFT - as per gastroenterologist
αFP - as per gastroenterologist
Once ferritin <20 mcg/l + TS <16% stop venesection + follow up three/four monthly

Maintain Ferritin between 50 to 100 mcg/l

Maintain TS < 50%

APPENDIX D

COMPETENCY TO PRACTISE DECLARATION

I confirm that I am competent to undertake venesection of individuals with diagnosed Haemochromatosis and understand that I am responsible and accountable for my practise.

I can:

1 Explain the underpinning theory of Haemochromatosis.

2 I am aware of the levels of ferritin and iron saturation to be achieved through the treatment and maintenance phases of Haemochromatosis.

3 Demonstrate a knowledge of venesection and am aware of the action to be taken in the event of

- Vasovagal event
- Poor venous access
- Deterioration of blood results outside of normal values

4 Demonstrate an understanding of the Trust's policies on Haemochromatosis and aseptic non-touch technique.

5 I am competent in the procedure of cannulation and am aware of the Trust policy on cannulation.

I am aware of my obligation to maintain my competence by regular monitoring of the literature relating to Haemochromatosis and to seek assistance where I am unable to perform the procedure safely.

Signed:……..(Nurse)

Print name: ……..

Qualifications: ……

Date: ……..

Signed:……..(Assessor)

Print name: ……..

Qualifications: ……

Date: ……..

This statement should be photocopied and held by

1 The individual
2 The Emergency Division

Appendix E - Compliance Monitoring Table

Required changes to practice must be identified and actioned within a specified time period. A lead must be identified to take each change forward and lessons learned must be shared with all relevant stake holders

Element to be monitored	Lead Role	Tool	Frequency	Reporting Arrangements	Action Lead
Audit of haemochromatosis parameters achieved against national guidance	Consultant Gastroenterologist	Haemochromatosis audit	Annual	Reported to divisional audit governance lead on an annual basis via divisional audit committee.	Infusion Lead Nurse

Appendix F - Equality Impact Assessment

Policy or function being assessed: Haemochromatosis Nurse Led Clinic Protocol **Department/Service:** Infusion Service
Assessment completed by: Rachael Conway, Haematology Clinical Nurse Specialist **Date of assessment:** December 2015

1.	Describe the aim, objective and purpose of this policy or function.		This procedure has been developed to improve the quality of the service provided to patients with hemochromatosis; and to reduce the pressure of workload in the consultant clinics.	
2i.	Who is intended to benefit from the policy or function?		**Staff** □ **Patients X** **Public** □ **Organisation** □	
2ii	How are they likely to benefit?		Improvements seen as a result of this service include: • Provision of a more flexible service for patients with hemochromatosis in regards to number of appointments available as well as the timing and frequency of appointments • Reduced outpatient waiting times • Holistic needs of patients met • Provision of a more cost effective service for the trust	
2iii	What outcomes are wanted from this policy or function?		To ensure a safe and efficient nurse led service for patients with a diagnosis of hemochromatosis	
For Questions 3-11 below, please specify whether the policy/function does or could have an impact in relation to each of the nine equality strand headings:				
3.	Are there concerns that the policy/function does or could have a detrimental impact on people due to their **race/ethnicity?**		**N**	If yes, what evidence do you have of this? E.g. Complaints/Feedback/Research/Data
4.	Are there concerns that the policy/function does or could have a detrimental impact on people due to their **gender?**		**N**	If yes, what evidence do you have of this? E.g. Complaints/Feedback/Research/Data

5.	Are there concerns that the policy/function does or could have a detrimental impact on people due to their **disability?** Consider Physical, Mental and Social disabilities (e.g. Learning Disability or Autism).		**N**	If yes, what evidence do you have of this? E.g. Complaints/Feedback/Research/Data
6.	Are there concerns that the policy/function does or could have a detrimental impact on people due to their **sexual orientation?**		**N**	If yes, what evidence do you have of this? E.g. Complaints/Feedback/Research/Data
7.	Are there concerns that the policy/function does or could have a detrimental impact on people due to their **pregnancy or maternity?**		**N**	If yes, what evidence do you have of this? E.g. Complaints/Feedback/Research/Data
8.	Are there concerns that the policy/function does or could have a detrimental impact on people due to their **religion/belief?**		**N**	If yes, what evidence do you have of this? E.g. Complaints/Feedback/Research/Data
9.	Are there concerns that the policy/function does or could have a detrimental impact on people due to their **transgender?**		**N**	If yes, what evidence do you have of this? E.g. Complaints/Feedback/Research/Data
10.	Are there concerns that the policy/function does or could have a detrimental impact on people due to their **age?**		**N**	If yes, what evidence do you have of this? E.g. Complaints/Feedback/Research/Data
11.	Are there concerns that the policy/function does or could have a detrimental impact on people due to their **marriage or civil partnership?**		**N**	If yes, what evidence do you have of this? E.g. Complaints/Feedback/Research/Data
12.	Could the impact identified in Q.3-11 above, amount to there being the potential for a disadvantage and/or detrimental impact in this policy/function?		**N**	*Where the detrimental impact is unlawful, the policy/function or the element of it that is unlawful must be changed or abandoned. If a detrimental impact is unavoidable, then it must be justified, as outlined in the question above.*
13.	Can this detrimental impact on one or more of the above groups be justified on the grounds of promoting equality of opportunity for another group? Or for any other reason? E.g. providing specific training to a particular group.		**N**	*Where the detrimental impact is unlawful, the policy/function or the element of it that is unlawful must be changed or abandoned. If a detrimental impact is unavoidable, then it must be justified, as outlined in the question above.*

14.	**Specific Issues Identified**		
	Please list the specific issues that have been identified as being discriminatory/promoting detrimental treatment		Page/paragraph/section of policy/function that the issue relates to
	1. N/A		**1.** N/A
	2. N/A		**2.** N/A
	3. N/A		**3.** N/A
15.	**Proposals**		
	How could the identified detrimental impact be minimised or eradicated?	N/A	
	If such changes were made, would this have repercussions/negative effects on other groups as detailed in Q. 3-11?		**N**
16.	Given this Equality Impact Assessment, does the policy/function need to be reconsidered/redrafted?		**N**
17.	**Policy/Function Implementation**		
	Upon consideration of the information gathered within the equality impact assessment, the Director/Head of Service agrees that the policy/function should be adopted by the Trust. Please print: **Name of Director/Head of Service:** Dr Anups De Silva **Title:** Consultant Gastroenterologist **Date:** December 2015 **Name of Policy/function Author:** Rachael Conway **Title:** Haematology Clinical Nurse Specialist **Date:** December 2015		

	(A paper copy of the EIA which has been signed is available on request).
18.	**Proposed Date for Policy/Function Review**
	Please detail the date for policy/function review (3 yearly): November 2016
19.	**Explain how you plan to publish the result of the assessment?** *(Completed E.I.A's must be published on the Equality pages of the Trust's website).*
	Standard Trust process
20.	**The Trust Values**
	In addition to the Equality and Diversity considerations detailed above, I can confirm that the four core Trust Values are embedded in all policies and procedures. They are that all staff intend to do their best by: Putting patients first, and they will: Provide the best possible care in a safe clean and friendly environment, Treat everybody with courtesy and respect, Act appropriately with everyone. Aiming to get it right, and they will: Commit to their own personal development, Understand theirs and others roles and responsibilities, Contribute to the development of services Recognising that everyone counts, and they will: Value the contribution and skills of others, Treat everyone fairly, Support the development of colleagues. Doing everything openly and honestly, and they will: Be clear about what they are trying to achieve,

	Share information appropriately and effectively, Admit to and learn from mistakes. I confirm that this policy/function does not conflict with these values. ☑