Surrey and Sussex NHS
Healthcare NHS Trust

An Organisation-Wide Clinical Guideline for the peri-operative management of oral anticoagulants in patients having elective surgery

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Approved Sponsor Group:	
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Owner:	Dr Barry Jackson
Owner's job title	Haematology Consultant
Author:	Dr Barry Jackson
Author's job title:	Haematology Consultant
Equality Analysis completion date:	dd/mm/yyyy
Date issued:	dd/mm/yyyy
Review date:	August 2017
Replaces:	
Unique Document Number:	

Equality statement

This document demonstrates commitment to create a positive culture of respect for all individuals, including staff, patients, their families and carers as well as community partners**.** The intention is, as required by the Equality Act 2010, to identify, remove or minimise discriminatory practice in the nine named protected characteristics of age, disability, sex, gender reassignment, pregnancy and maternity, race, sexual orientation, religion or belief**,** and marriage and civil partnership. It is also intended to use the Human Rights Act 1998 to promote positive practice and value the diversity of all individuals and communities. This document is available in different languages and formats upon request to the Trust Procedural Documents Coordinator and the Equality and Diversity Lead.

Please do not delete the Equality Statement. It's presence in your Guideline helps the Trust to demonstrate its Equality Obligations.

Contents

When completing the Contents Page, please:

1) Provide your main guideline content in chapter 1. Give this chapter a relevant title.
2) List any subsections on the contents page (do not use more than one decimal point).
3) As required, add extra lines for additional subsections to chapter 1
4) Add page numbers to the final draft
5) Delete this explanatory text box.

How to add extra lines to the Contents Page (chapter 3 only):

1) Position the curser to the left of the table
2) Left-click the mouse to highlight a line in the table
3) Right-click the mouse and choose ‘insert rows’
4) A new row will be inserted above the line that you highlighted
5) To delete a row that you have created, repeat steps 1 to 3 above and choose ‘delete rows’*.

1 Guideline for the peri-operative management of oral anticoagulants in patients having elective surgery

1.1 Introduction

The purpose of this document is to provide recommendations for the management of peri-operative anticoagulation for patients on oral anticoagulant therapy who require an INR of less than 1.5 prior to the procedure.

When patients on anticoagulation require elective surgery or an invasive procedure, the risks and benefits of stopping or continuing anticoagulation must be carefully considered. In many cases it is necessary to stop the oral anticoagulant (most commonly warfarin but also rivaroxaban, dabigatran and apixaban) and replace it with low molecular weight heparin (LMWH). This is known as “bridging anticoagulation”.

1.2 Pre-operative assessment

Assessment of elective patients should be carried out at pre-operative assessment. Patients should be identified as either low risk or moderate/high risk for thrombotic complications (see below).

The bleeding risk of the surgical procedure also needs to be reviewed as some patients can safely continue with their anticoagulation in the peri-operative period where the bleeding risk is low. This includes simple dental procedures, joint and soft tissue aspiration and injections, cataract surgery and endoscopic procedures with or without biopsy.

If a decision is made to interrupt anticoagulation therapy then clear instructions that warfarin should not be taken for 5 days prior to surgery should be given (i.e. last dose on day -6). For other oral anticoagulants see below. Patients or carers will need to be trained in the administration of enoxaparin as they are likely to be on it during the peri-operative phase. If this is not possible then the patient’s district nurse will need to take over this arrangement.

If the patient is taking rivaroxaban, the eGFR should be assessed. If eGFR <30ml/min, the bleeding time could be prolonged and the use of rivaroxaban should be reconsidered. If the patient is having low bleeding risk surgery then rivaroxaban should be omitted on the day prior to surgery. If the patient is having high bleeding risk surgery then rivaroxaban should be omitted for 2 days prior to surgery. Rivaroxaban cannot be monitored using the INR. On the day of surgery a Prothrombin Time (PT) should be measured via a venesection sample. If the PT is normal it would suggest that there will be no increased risk of bleeding. If the PT is abnormal please discuss with haematologist and surgeon.

A copy of form 1.7 or 1.8 should be inserted into the patients notes in order to document how the bridging decision was made. In addition insert a copy of the bridging proforma into the notes and give a copy to the patient

If the patient is taking apixaban, please discuss the case with a haematologist.

1.3 Pre-operative investigations

A full blood count must be taken in the week prior to surgery (this may be performed at the same time as the pre-op INR). If the patient has thrombocytopenia (platelets less than 100 x 10^9/L) then discussion with a haematologist is recommended.

A U&E must be taken within 6 weeks prior to surgery. If the eGFR is <30 ml/min then the patient should be treated with unfractionated heparin (UFH) rather than LMWH (enoxaparin). If low molecular weight heparin is indicated on pre-operative assessment, the patient will require admission 1 day prior to operative procedure for intravenous unfractionated heparin. UFH should be continued until the INR is therapeutic.

An accurate up-to-date weight for the patient is required so that LMWH dosing can be carried out correctly.

An INR should be checked from day -14 to -6. If INR> 5.0 discuss with haematology as it may be appropriate to give vitamin K or stop warfarin sooner.

An INR should be checked on the morning of surgery. If INR > 1.5 then discuss with anaesthetist/surgeon if they feel it is safe to proceed otherwise surgery will have to be postponed

If surgery is cancelled, then patient should be commenced on treatment dose LMWH until surgery has been rescheduled (if less than a week)

1.4 Post-operative management

Commence **prophylactic** dose LMWH 8-10hrs post-operatively only if haemostasis is secured.

Patients who are deemed at having very high risk of post-operative bleeding such as radical prostatectomy or spinal surgery should have an individualised post-operative decision to recommence LMWH. It may be appropriate to delay LMWH for 24-48 hours.

In patients who have a moderate/high thrombotic risk give **prophylactic** dose enoxaparin (40mg) for the first 2 days and then **therapeutic** dose LMWH can be recommenced 48 hours after surgery if haemostasis is secured.

Warfarin should be restarted as soon as possible post-operatively if haemostasis is secured, risk of haemorrhage is low and the patient is able to take medications orally.

Give usual warfarin maintenance dose for 2 days then check INR on day 3 and dose accordingly. If INR is in target range then patient should continue their usual maintenance dose. If any delay in checking their INR (i.e. weekend) then place patient on usual maintenance dose until INR check (must be within 5 days).

If spinal or epidural anaesthesia/analgesia is used post-operatively, this should be inserted/removed at least 16 hours after the last dose of enoxaparin is given

Continue with LMWH until INR is back in the therapeutic range.

For patients on rivaroxaban/dabigatran, this can be restarted on the evening of surgery if haemostasis is secured and not at a very high bleeding risk. If the patient cannot tolerate oral medication then start on prophylactic dose LMWH. If patient is not taking oral medication beyond 48 hours post-operative then discuss with haematologist

1.5 Thrombotic Risk

The list below gives the most common reasons as to why patients are on anticoagulation. For any other indication, discuss with the relevant specialty consultant. If the patient has

had a VTE within the past 1 month, then delaying the procedure or inserting an intra-venacaval filter should be considered

Risk	High	Moderate	Low
Mechanical Heart Valve	- Any mechanical mitral valve - Older mechanical aortic valve model - Recently placed mechanical valve - Recent CVA/TIA (< 6 months)	- Bileaflet aortic valve and one risk factor (AF, prior CVA/TIA, hypertension, diabetes, heart failure, age > 75 years)	- Bileaflet aortic valve without AF and no other CVA risk factors
Atrial Fibrillation (see CHADS2 score)	- CHADS2 score 5 or 6 - With mechanical heart valve - With rheumatic valvular disease - With recent CVA/TIA (< 3 months)	- CHADS2 score 3 or 4	- CHADS2 score 0-2
Venous Thromboembolism	- VTE within previous 3 months - With severe thrombophilia (Protein C, S or antithrombin deficiency, Antiphospholipid syndrome, Homozygous factor V leiden)	- VTE 3-12 months ago - Recurrent VTE - VTE with non-severe thrombophilia (e.g. Heterozygous Factor V Leiden) With active malignancy	- Single VTE > 12 months ago

Although the CHA_2DS_2-VASc score has superseded the $CHADS_2$ score for assessing CVA risk in atrial fibrillation, it use has not been validated in peri-operative care and, thus, the $CHADS_2$ score is used for this purpose.

C	Congestive Heart Failure	1
H	Hypertension- BP consistently > 140/90 or treated Hypertension on medication	1
A	Age ≥ 75 years	1
D	Diabetes	1
S2	Prior stroke or TIA or thromboembolism	2
CHADS2 score		…..

Atrial Fibrillation - Annual Stoke Risk		
CHADS2 score	Annual Stoke risk %	95% CI
0	1.9	1.2 - 3.0
1	2.8	2.0 - 3.8
2	4	3.1 - 5.1
3	5.9	4.6 - 7.3
4	8.5	6.3 - 11.1
5	12.5	8.2 - 17.5
6	18.2	10.5 - 27.4

1.6 Bleeding risk

When considering when to restart anticoagulation post operatively it is imperative that haemostasis is achieved. It also important to consider the bleeding risk of the surgery as, in certain very high risk bleeding operations, it may be advisable to delay low molecular weight for 24-48 hours. The table below is not exhaustive and should be used as a guide to making this decision.

Very High risk	High risk	low risk
Spinal Surgery	Urological/gynaecological surgery	Diagnostic endoscopy ± biopsy
Radical prostatectomy	Colonic polyp resection	Minor dermatological surgery
	Surgery in highly vascular organs	Minor dental surgery
	Bowel resection	Minor ophthalmological surgery
	Cancer surgery	
	Joint/bone surgery	

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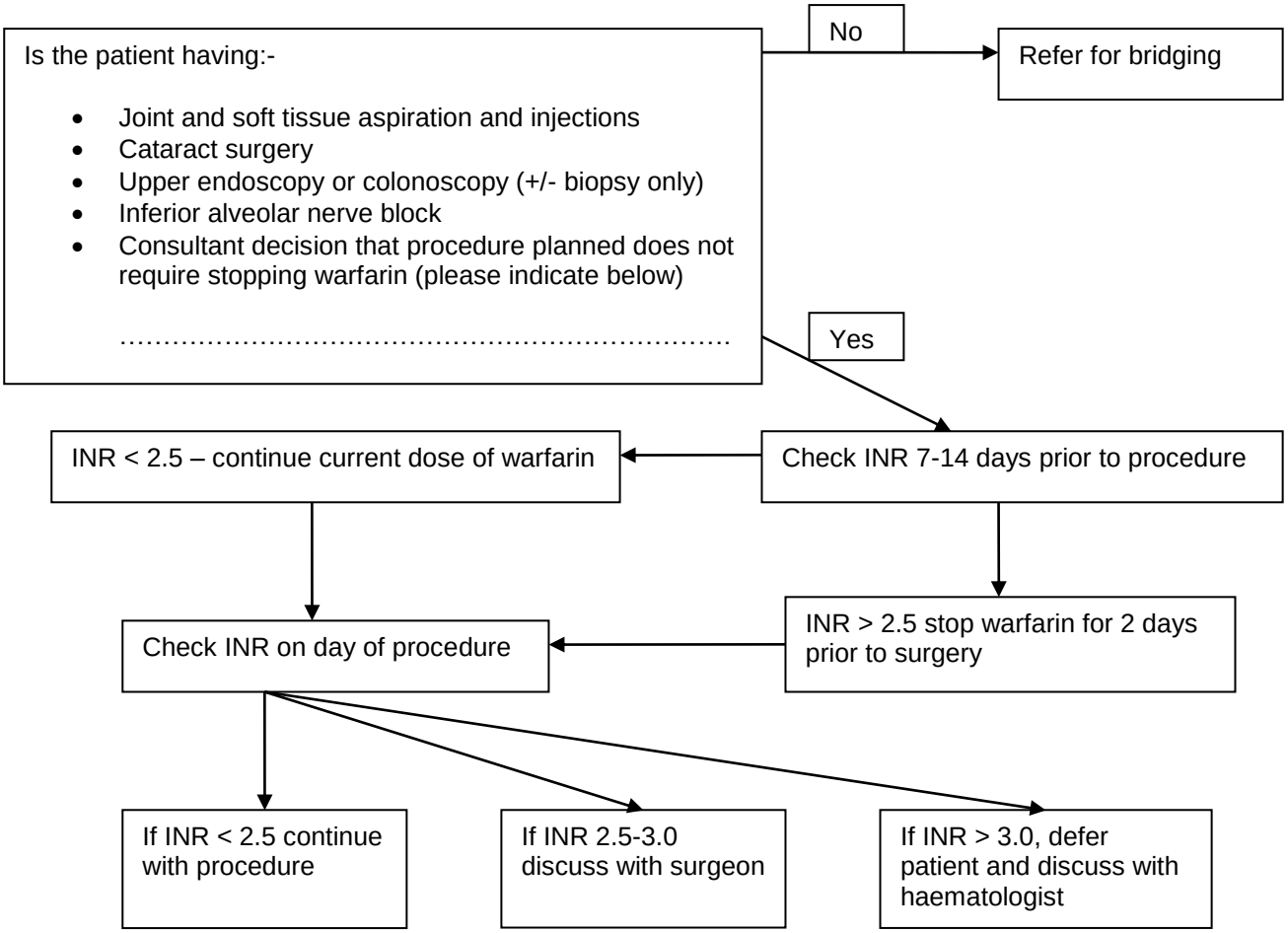
1.7 **MINOR SURGICAL PROCEDURES**



Post procedure

Restart patients usual maintenance warfarin dose 6-8 hours post procedure when haemostasis secured
Ensure patient has INR check approx 7-10 days post procedure and dose accordingly

Dental Procedures (including extractions)

The risk of significant bleeding from dental procedures on oral anticoagulation is very small and, therefore, if the INR is stable between 2-4 there is no need to discontinue anticoagulation.
Risk of bleeding can be minimised using 5% tranexamic mouthwash QDS for 2 days
If an inferior alveolar nerve block is required follow above guidance

Insert a copy of this into the notes to document how decision for bridging was made

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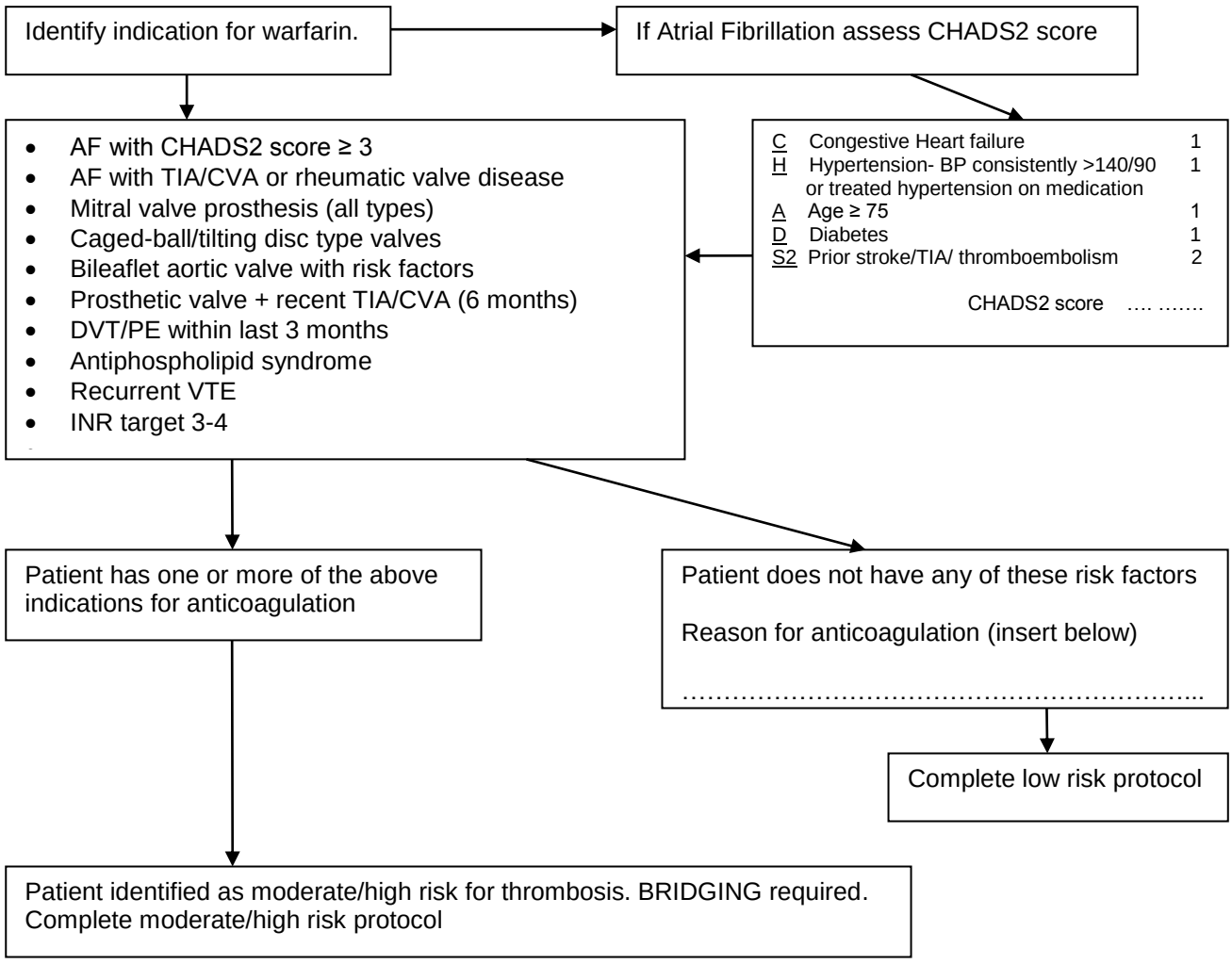
1.8 Assessment of patients on oral anticoagulation in Pre-Operative Assessment Clinic



Insert a copy of this into the notes to document how decision for bridging was made

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1.9 PROFORMA FOR LOW RISK WARFARIN PATIENTS NEEDING BRIDGING FOR ELECTIVE SURGERY

Indication for anticoagulation/bridging ……

Therapeutic range ……

Surgical procedure ……

Name of surgeon ……

Pre-operative assessment date ……..

Pre-operative assessment nurse ……

Weight …… Kg eGFR ……..ml/min

	D-14 to D-6	D-5	D-4	D-3	D-2	D-1	Procedure date	D+1	D+2	D+3/4/5
Date										
Warfarin dose	✓	No warfarin to be taken					*	✓	✓	✓
INR test required	✓	No need to check					✓	x	x	✓
Enoxaparin 40mg od 09.00 (PROPHYLACTIC dose) or UFH 5000units BD (if eGFR < 30mls/min)	No need to be given						*	✓	✓	✓

*Restart warfarin (at usual maintenance dose) on the evening of the procedure together with enoxaparin 40mg or UFH 5000 units BD waiting at least 6 hours post op ONLY if haemostasis is secure. Continue enoxaparin/UFH until INR is in therapeutic range. Check INR day 3-5 post op.

✓ = Action required

Name ……

Hospital Number ……..

Date of Birth ……..

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1.10 PROFORMA FOR MODERATE/HIGH RISK WARFARIN PATIENTS NEEDING BRIDGING FOR ELECTIVE SURGERY

Indication for anticoagulation/bridging ……

Therapeutic range ……

Surgical procedure ……

Name of surgeon ……

Pre-operative assessment date ……..

Pre-operative assessment nurse ……

Weight …… Kg eGFR* ……ml/min

** eGFR must be ≥30ml/min- if <30 pt do not use this protocol, pt will need admitting for UFH*

	D-14 to D-6	D-5	D-4	D-3	D-2	D-1	Procedure date	D+1	D+2	D+3/4/5
Date										
Warfarin dose		No warfarin to be taken					*	✓	✓	✓
INR test required		No need to check					✓	X	X	✓
Enoxaparin 1.5mg/kg =…….(Treatment dose) time 09:00	No need to be given		✓	✓	✓	X	X	X	✓	✓
Enoxaparin 40mg (Prophylactic dose) time 09.00	No need to be given						*	✓	X	X

*****Restart warfarin (at usual maintenance dose) on the evening of the procedure together with enoxaparin 40mg at least 6 hours post op ONLY if haemostasis is secure. Continue enoxaparin until INR is in therapeutic range. Check INR day 3-5 post op

✓ =Action required

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1.11 PROFORMA FOR PATIENTS ON RIVAROXABAN REQUIRING ELECTIVE SURGERY

Indication for anticoagulation/bridging ……

Surgical procedure ……

Name of surgeon ……

Pre-operative assessment date ……..

Pre-operative assessment nurse ……

Weight …… Kg eGFR* ……ml/min

** eGFR must be ≥30ml/min for patient to continue on rivaroxaban*

	D-14 to D-6	D-5	D-4	D-3	D-2	D-1	Procedure date	D+1	D+2	D+3/4/5
Date										
Rivaroxaban dose	✓	✓	✓	✓	±	X	*	✓	✓	✓
Clotting screen required	No clotting screen required						If normal PT proceed with surgery	No clotting screen required		
Enoxaparin 40mg (Prophylactic dose)	No enoxaparin required						*	*	*	*

*****If the patient is unable to tolerate oral medications post-op then commence patient on enoxaparin 40mg od or UFH 5000unit bd (if eGFR <30ml/min). Otherwise commence rivaroxaban at least 6 hours post-op ONLY if haemostasis secured. If patient is not taking medications orally beyond 48hrs discuss with haematologist. Please ensure that patient is not concurrently taking both rivaroxaban and enoxaparin

± If the patient is at a high risk of post-op bleeding or eGFR < 30 ml/min, omit rivaroxaban on D-2 and D-1

✓ =Action required

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Name ……

Hospital Number ……..

Date of Birth ……

1.12 PROFORMA FOR PATIENTS ON DABIGATRAN REQUIRING ELECTIVE SURGERY

Indication for anticoagulation/bridging ……

Surgical procedure ……

Name of surgeon ……

Pre-operative assessment date ……..

Pre-operative assessment nurse ……

Weight …… Kg eGFR* ……ml/min

** eGFR must be ≥30ml/min for patient to continue on dabigatran*

	D-14 to D-6	D-5	D-4	D-3	D-2	D-1	Procedure date	D+1	D+2	D+3/4/5
Date										
Dabigatran dose 9am & 9pm	✓	✓	✓	✓	±	X	*	✓	✓	✓
Clotting screen required	No clotting screen required						If normal APTT proceed with surgery	No clotting screen required		
Enoxaparin 40mg (Prophylactic dose)	No enoxaparin required						*	*	*	*

*****If the patient is unable to tolerate oral medications post-op then commence patient on enoxaparin 40mg od or UFH 5000unit bd (if eGFR <30ml/min). Otherwise commence dabigatran at least 6 hours post-op ONLY if haemostasis secured. If patient is not taking medications orally beyond 48hrs discuss with haematologist

± If the patient is at a high risk of post-op bleeding or eGFR < 50 ml/min, omit dabigatran on D-2 and D-1

✓ =Action required

CANCELLATION OF SURGERY

Cancellation of surgery will increase the length of the bridging period and if not carefully managed will put the patient at increased risk of thrombotic complications.

If the patient in delayed by greater than one week, dose patients as per the post-operative instructions of both warfarin and enoxaparin. If the surgery is delayed by less than one week then continue treatment dose enoxaparin and omit this one day prior to surgery.

In warfarin has been discontinued for more than 10 days then a reloading warfarin dose should be considered.

2 Rationale

The purpose of this document is to provide recommendations for the management of peri-operative anticoagulation for patients on oral anticoagulant therapy who require an INR of less than 1.5 prior to the procedure.

When patients on anticoagulation require elective surgery or an invasive procedure, the risks and benefits of stopping or continuing anticoagulation must be carefully considered. In many cases it is necessary to stop the oral anticoagulant (most commonly warfarin but also rivaroxaban, dabigatran and apixaban) and replace it with low molecular weight heparin (LMWH). This is known as “bridging anticoagulation”. If this process is not done in a standardised way there is a risk that the patient could be placed at an unnecessary risk of thrombotic complications.

This guideline is based on National Patient Safety Alert 18- Actions that can make anticoagulant therapy safer.

3 Scope

This guideline is designed for all adult patients undergoing the temporary interruption of oral anticoagulation for an elective operation or procedure including endoscopic procedures. It does not cover the interruption and/or reversal of anticoagulation for emergency surgery

4 Responsibilities

Consultant Haematologist- They have expertise in giving advice on bleeding and thrombotic conditions and giving advice on oral anticoagulation

Pre-operative assessment nurses- They are responsible for ensuring that patients identified as being on warfarin are seen in pre-operative assessment clinic. A pre-operative plan should be made in conjunction with the patient in accordance with the policy.

Consultant surgeon/anaesthetist- They are responsible that surgery goes ahead with an INR appropriate for the relevant procedure. They are also responsible for ensuring that the patient is prescribed enoxaparin/heparin according to protocol

Junior doctors- Responsible for ensuring that any in-patients are given appropriate anticoagulation post-operatively in accordance with this policy. Also responsible for ensuring that the patient is discharged with appropriate anticoagulation and that a follow up INR check is arranged for 3-5 days post operation.

5 Compliance Monitoring arrangements

Monitoring policy implementation

This guideline will be monitored on a 3 yearly basis in accordance with the haematology clinical governance team meeting.

Measurable standards

Number of patients that have cancellation in surgery due to out of target INR

Number of patients who are on pre-operative warfarin that develop VTE one month post surgery

Number of patients who are on pre-operative anticoagulation for atrial fibrillation that develop TIA/CVA one month post surgery

Monitoring approval, amendments and document control

6 Training to ensure compliance with this guideline

All pre-operative assessment nurses should be made trained on using these guidelines, led by Trish Brook pre-assessment nurse lead.

Junior doctors should be aware of how to access all these guidelines at their induction meeting.

7 References and associated documents

References

Organisation	Author	Date of publication	Title of document
Chest Journal	Douketis et al	Feb 2012	Perioperative Management of Antithrombotic Therapy 9th ed: American College of Chest Physicians Evidence-Based Clinical Practice Guidelines Perioperative Management of antithrombotic therapy.pdf
British Committee for the Standardisation of Haematology	Keeling et al	Feb 2011	Guidelines on oral anticoagulation with warfarin – fourth edition Guidelines on oral anticoagulation with warfarin-4th Edition.pdf
Gut 2008;57:1322–1329.	Veitch et al	May 2008	Guidelines for the management of anticoagulant and antiplatelet therapy in patients undergoing endoscopic procedures Guidelines for the management of anticoagulant and antiplatelet therapy in patients undergoing endoscopic procedures.pdf
National Patient Safety Agency		March 2007	National Patient Safety Alert 18- Actions that can make anticoagulant therapy safer NPSA Anticoagulant safety alert 18[1].pdf

Associated documents

Organisation	Author	Date of publication	Title of document

8 Glossary explanation of terms used in this document

Acronym/ Abbreviation/ Term	Meaning
AF	Atrial Fibrillation
BD	Twice daily
CVA	Cerebral Vascular Accident
eGFR	Estimated Glomerular Filtration Rate
INR	International Normalised Ratio
LMWH	Low Molecular Weight Heparin
OD	Once daily
PT	Prothrombin Time
QDS	Four times daily
TIA	Transient Ischaemic Attack
UFH	Unfractionated Heparin
VTE	Venous Thrombo-Embolism

9 Document Control

This procedural document supports:

Standard(s)/ Key Lines of Enquiry:	Para/ I.D. no.	Standard/title
NHS Litigation Authority (NHSLA)		
Care Quality Commission (CQC)		
NICE Guideline		
Other national guidance (e.g. Royal College Guidance) - please list:		

Consultation record

Relevant service	Speciality, Sponsor or User Group name	Individual's name	Job title	Date consulted	Date feedback received
Pharmacy					
Radiology					
Cancer Services					
Pre-operative assessment team		Patricia Brook	Pre-operative assessment nurse lead	April 2014	April 2014
Endoscopy		Rosemary Goodchild	Endoscopy Unit Manager	April 2014	April 2014

9 Document Control (continued)

Change History

Version	Date (DD/MM/YYYY)	Author/ Lead	Job title	Details of Change	Ratif
1.0	Oct 2007	Dr S Stern and Dr F Lamb	Haematology consultant and anaesthetic consultant		

Appendices

Appendix 1 Equality Analysis (EqA)

By completing this document in full you will have gathered evidence to ensure, documentation, service design, delivery and organisational decisions have due regard for the Equality Act 2010. This will also provide evidence to support the Public Sector Equality Duty.

Name of the policy / function / service development being assessed	
Date last reviewed or created & version number	
Briefly describe its aims and objectives:	
Directorate lead	
Target audience (including staff or patients affected)	
Screening completed by (please include everyone's name)	**Organisation**

Equality Group ***(Or protected characteristic):***	**What evidence has been used for this assessment?**	**What engagement and consultation has been used**	**Identify positive and negative impacts**	**How are you to address i identified?**
Age				
Disability				
Gender reassignment				
Marriage & Civil partnership				
Pregnancy & maternity				
Race				
Religion & Belief				

Sex				
Sexual orientation				
Carers				

When answering the questions across the top of this page, cells can be merged where the same answer applies to several equality groups or protected characteristics (in column 1). To do this, highlight the blank cells to be merged, right click on the mouse and choose 'merge cells'. Then add your answer.

Appendix 2 *Title*

Temporary pages

(These pages will be deleted by The Corporate Governance Officer immediately prior to publishing on the intranet).

Approval and Ratification Checklists

This checklist is to be used by the Sponsor Group to assess readiness for submission to Management Board for ratification:

	Sponsor Group Approval Checklist (Authors can also use this checklist to confirm that the document is ready for approval)	Policy for Procedural Documents (further information)
	Administration	
1	Was the document authorised at the correct level and does it avoid duplication with national guidance?	1.1, 1.3 Fig 1
2	Has the most appropriate type of document (strategy/ policy/ guideline) been selected?	1.2, 1.4 Fig 2
3	Has the author checked with Corporate Affairs to determine whether specific NHSLA requirements relate to this document?	2.1
4	Has the correct Sponsor Group been identified?	2.2, 5.1, 5.2 Appendix B
5	Has the correct approved template been used?	3.1
6	Are the document Control pages up to date?	3.4
7	Does the version number follow the recommended format?	3.5
8	Does the version number match the details in the Change History box?	3.4, 3.5
9	Is the review date and review frequency identified on the front of the document?	6.6 Fig 5
	Technical detail	
10	Does the 'Rationale' and 'Scope' reflect why a local level document is necessary and how it avoids duplication of national advice?	4.2
11	Strategies: are the objective(s) and intended outcomes of the document clear and unambiguous?	4.3
12	Have all relevant sources and supporting documents been cited in full in the main text and included within 'References'?	4.6
13	Does the Sponsor Group agree that the technical content is correct and up to date?	5.1 to 5.5
	Consultation	
14	Have all relevant specialities, Heads of Service and Divisional groups within SASH been consulted?	5.1/ 5.2
15	Have all relevant service users and staff groups for whom the document is intended been consulted?	5.3
16	Has the incorporation of stakeholder comments been discussed by the Sponsor Group?	5.4
	Monitoring and training	
17	Are arrangements for monitoring clearly stated?	4.4
18	Are there measurable standards and / or KPIs appropriate and sufficient?	4.4

19	Is there an audit tool or plan within the document to review SASH compliance?	4.4
20	Does the plan include the necessary training/ support to ensure compliance?	4.4, 4.5
21	Are the required resources in place to implement the procedure and if not, is there a business plan to accompany it?'	1.3, 4.1, 4.4, 4.5
	Preparing for approval	
22	Has the final draft been proof read for technical / clinical content?	5.5
23	Has the final draft been proof read for formatting and layout?	5.5
24	Is the Content's page easy to cross-reference with the main text?	-
25	Has the final draft been subject to an equality analysis EqA? (Evidence must be prepared at the planning stage and the analysis completed prior to submission to management board for ratification).	2.5 Appendix C
26	Revised documents: has the agreed pathway for approving key changes and/ or minor amendments been followed?	6.3/ 6.4 Fig 3
27	Is the document being sent to the correct ratifying body?	6.2 Fig 4
28	Is the document due to be published in the correct location?	6.2 Fig 4
	Dissemination and Publication	
29	Is there an outline plan to identify how this will be done and by whom?	7.1 to 7.3

This checklist is to be used by Management Board to guide the ratification process:

	Management Board Ratification Checklist Is Management Board assured that:	Policy for Procedural Documents (further information)
	Approval	
1	The correct, approved Sponsor Group has approved the document as suitable for ratification?	Appendix B
2	Consultation on the document has been sufficiently wide?	5.1 to 5.3
3	The correct approval pathway has been followed?	Figures 3 and 4
	Content	
4	The document is clear and accessible and the correct approved template has been used?	3.1, 3.2, 3.3
5	Controversial or difficult issues are (a) clearly stated and (b) suitably resolved?	4.7
	Monitoring and Training arrangements	
6	Monitoring and training arrangements are clearly stated in the document and have been properly embedded at ward/ office level?	4.4, 4.5
7	The required resources are in place to implement the procedure? If not, has a business plan been submitted?	1.3, 4.1, 4.4, 4.5
	Dissemination	
8	The posts that will be responsible for dissemination (and associated timescales) are clearly stated?	7.1

Draft control

Draft details

Draft Number	Date (DD/MM/YYYY)	Details of Change

*Use the above table to record **draft** version details, to avoid confusion with approved version numbers.*

Technical Content Proof Reading

I confirm that I have proof-read the technical / clinical content of this draft procedural document	
Proof Reader's name (please print)	
Proof Reader's job title (please print)	
Proof Reader's signature	
Date:	