Endoscopy Unit Practice Standards Clinical Guideline

V1.0

November 2022

Table of Contents

1. Aim/Purpose of this Guideline

1.1. All healthcare professionals have a duty to set a standard by which to practice. With a focus on clinical effectiveness and evidence-based care department staff must be able to demonstrate the ability to audit care and department practice. The care that is delivered and improvements in practice must be based on evidence and best practice guidance.

1.2. The aim of this policy is: to outline the standards of care that must be delivered to each individual patient to ensure high quality of care is provided to patients receiving care in the Endoscopy Unit at the Royal Cornwall Hospital.

1.3. Care Group management recognise that nationally, colleges, professional bodies and speciality associations may define workforce standards for specific clinical activities.

1.4. All staff in the Care Group have a responsibility to ensure, where these exist or become available, it is appropriate to use these to inform these standards and should identify them to their line manager for escalation to the team responsible for ensuring the standards reflect current recommended practice.

1.5. This guideline should be read in conjunction with the following documents:

- Endoscopy Procedure Room Clinical Guideline
- RCHT Five steps to safer surgery
- RCHT Consent Policy
- RCHT Uniform Policy
- RCHT Infection Prevention & Control Policy
- RCHT Safe Handling & Disposal of Sharps
- RCHT Decontamination Policy
- DOH Infection Control in the Built Environment
- RCHT COSHH
- RCHT ANTT Policy

- RCHT Theatre Practice Standards Clinical Guideline V3
- RCHT Waste Management Policy
- PHE Guidance
- AfPP Royal Marsden Manual of Clinical Nursing Procedures
- Principles of Safe Practice within the Perioperative Environment
- RCHT Confidential Waste Policy
- RCHT IT Policy
- RCHT Incident Reporting Policy
- RCHT Policy & Procedure for being Open
- RCHT Consent to Examination or Treatment
- RCHT Disclosure & Barring Checks Policy
- RCHT Management of Corporate & Local Induction
- RCHT Core Training Policy
- RCHT Grievance & Disputes Policy
- RCHT Whistleblowing Policy
- RCHT Dignity at Work Policy
- RCHT Positive Identification Policy and Procedure
- RCHT Fire Safety Policy
- RCHT Medical Devices Policy
- RCHT Risk Management Policy
- NMC Professional Registration

Data Protection Act 2018 (General Data Protection Regulation – GDPR) Legislation

The Trust has a duty under the Data Protection Act 2018 and General Data Protection Regulations 2016/679 to ensure that there is a valid legal basis to process personal and sensitive data. The legal basis for processing must be identified and documented before the processing begins. In many cases we may need consent; this must be explicit, informed, and documented. We cannot rely on opt out, it must be opt in.

Data Protection Act 2018 and General Data Protection Regulations 2016/679 is applicable to all staff; this includes those working as contractors and providers of services.

For more information about your obligations under the Data Protection Act 2018 and General Data Protection Regulations 2016/679 please see the Information Use Framework Policy or contact the Information Governance Team

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2. The Guidance

2.1. Departmental standard No 01: Preparation of personnel within the Endoscopy Unit.

2.1.1 **Standard Statement:** All members of staff working within the Endoscopy Unit should present a professional appearance and conduct themselves in a professional manner at all times and should dress as per the RCHT dress code and uniform policy when in the clinical environment. Nursing staff will wear nurse uniforms appropriate to grade and medical staff will wear appropriate smart dress.

2.1.2. **Refer to:**

- RCHT Uniform policy
- RCHT Infection prevention & control policy
- PHE guidance

2.1.2 **Procedure/Consultation Room Attire**

Patient safety

- Although there is no conclusive evidence that uniforms and work wear play a direct role in spreading infection, the clothes that staff wear should facilitate good practice and minimise any risk to patients
- Uniforms and work wear should not impede effective hand hygiene and should not unintentionally come into contact with patients during direct patient care activity
- Similarly, nothing should be worn that could compromise patient

or staff safety during care, for example false nails, rings, earrings other than studs, and necklaces. A plain band wedding ring is permitted

Public confidence

- Patients and the wider public should have complete confidence in the cleanliness and hygiene of their healthcare environment. The way staff dress is an important influence on people's overall perceptions of the standards of care they experience

- Uniforms should be clean at all times, and professional in appearance. In addition, although there is no evidence that wearing uniforms outside work adds to infection risks, public attitudes indicate it is good practice for staff to change at work

- Staff are not permitted to wear uniforms outside of the hospital grounds

- Patients and visitors also like to know who is who in the care team. Uniforms and name badges can help with this identification

Staff comfort

- As far as possible, subject to the overriding requirements of patient safety and public confidence, staff should feel comfortable in their uniforms. This includes being able to dress in accordance with their cultural practices. For example, although exposure of the forearm is a necessary part of hand and wrist hygiene during direct patient care activity, the uniform code should allow for covering of the forearm at other non-clinical times

- All staff who enter the procedure room must don the attire intended for use within the surgical environment

- Changing rooms are provided with wash and shower facilities. The changing areas must be kept clean, tidy, and dry

- Procedure room clothes consist of a two-piece trouser suit (generally referred to 'theatre scrubs'). These clothes are provided freshly laundered and should be checked that they are in good condition prior to putting on

- Clean procedure room clothing should be protected from contamination during transfer and storage

Technique to don procedure room attire

- Remove outer clothing and jewelry – wash hands

- Place cap/hood over hair

- Don freshly laundered scrub suit and trousers

- Put on clean procedure room footwear
- Hands must be washed before and after donning procedure room attire
- When in the clinical area, Trust ID Badges must be kept on the individual at all times. If the ID badge is secured on a lanyard, it is important that it does not compromise the sterile field and therefore be kept inside the theatre top. When moving about the hospital the Hospital ID badge must be on show. Lanyards should not be worn in a clinical area
- Procedure room attire must be removed if it becomes wet or soiled, and placed into the designated receptacles for contaminated laundry, to reduce the risk of cross contamination
- Perfume and after shave may be worn but these should be light as many patients and staff are affected by strong perfumes
- Minimal make-up may be worn in the operating theatre
- Procedure room PPE must be removed, before leaving the procedure room, and placed into clinical waste bag

Laundering of Procedure Room Attire

All procedure room attire must be sent to the RCHT laundry to ensure laundering of clothing is in accordance with relevant standards. The home laundering of procedure room attire is not permitted.

Headwear

- All head hair should be covered completely by a head cover/cap. All facial hair should be covered by a surgical mask. Disposable headwear and masks are single use, its function is to securely contain the hair and thereby prevent hair and skin particles from the operator contaminating the patient
- Headwear should be changed sessionally, unless it becomes soiled, when it should be changed immediately
- Surgical masks should be changed between patients

Jewellery

- All jewellery should be removed before entering the clinical environment
- Jewellery must be limited to a smooth wedding band only
- All staff must be ‘bare below the elbow’ when in the clinical environment

Fingernails

- Fingernails must be clean, short, and free from nail varnish.

- False fingernails, including acrylic or gel coated, or fiberglass must not be worn, as these have been shown to harbour micro-organisms such as fungi and gram-negative bacteria even after hand washing; they can also inhibit effective hand washing

Footwear

- Autoclavable anti-static footwear is provided and is available to all personnel. It must be well fitting, supportive, fully enclose the foot or have retaining straps behind the ankle

- It is each individual health worker's responsibility to ensure that their footwear is decontaminated and fit for purpose intended

- Footwear should not be left in a contaminated state or on changing room floors

Surgical Face masks

- Surgical Facemasks must be worn by the procedure team during any invasive procedures

- In additional protective face shields must be worn whenever activities place personnel at risk of splashes or aerosol contamination

- Surgical masks must cover the nose and mouth, fitting the contour of the face and must be tied securely. They must be changed between patients

- Surgical masks should not be touched once applied, if touched following application then it should be replaced

- A used surgical mask must be handled by the tapes / elastics only and must be discarded into a yellow clinical waste bag for disposal after each case, or if soiled / contaminated

- Surgical masks must not be worn around the neck or put into pockets for future use. Hands must be washed following mask removal

- When caring for patients with suspected or confirmed influenza, all healthcare workers need to, prior to any patient interaction, assess the infectious risk posed to themselves and wear the appropriate personal protective equipment (PPE) to minimise that risk: Face masks with shields - Surgical mask with intermediate filter (FFP3) to ensure high protection against bacterial contamination

Personal Hygiene

- Personal hygiene should be of a high standard
- Showers and towels are provided, for staff accidentally contaminated with body fluids whilst on duty

Patient Attire

Patients in preparation for their procedure must wear suitable clothing, a hospital patient gown is not considered necessary for surgical procedures in the procedure rooms.

Visitors to the Endoscopy Unit Procedure rooms

- Relatives (in particular, carers) supporting patients in the procedure rooms can enter the department without changing.
- Students (from various health professions) must comply with RCHT uniform policy.
- Visiting professionals (surgeons etc.) must comply with RCHT uniform policy.
- Allied health professionals (lab technicians, maintenance workers etc.) must comply with RCHT uniform policy.
- Medical device representatives. Must comply with RCHT uniform policy

Compliance: 100%

Exceptions: None

References:

- RCHT Uniform Policy
- RCHT Infection Prevention & Control Policies
- AfPP Principles of Safe Practice within the Perioperative Environment 2011

2.2. Endoscopy Unit Standard No 02 – Documentation

2.2.1. Refer to the NMC standards for documentation

2.2.2. **Standard Statement:** All staff are aware of the required standards for documentation and take responsibility for all their individual documentation of information.

2.2.3. **General Considerations**

Under the Public Records Act 1958 (National ARCHTives, 2009), all NHS

employees are responsible for any records that they create or use in the course of their duties. Thus, any records created by an employee of the NHS are public records and may be subject to both legal and professional obligations

The quality of record keeping is a reflection of the standard of professional practice expected of professional practitioners (AfPP, 2007)

The record must be (NMC, 2009):

- Factual, consistent, and accurate
- Recorded/written as soon as possible after the event has occurred, providing current information on the care and condition of the patient
- Recorded/written clearly and in such a manner that the text cannot be erased, written in a manner that any alterations or additions are dated, timed, and signed such that the original can still be read clearly, with the signature printed alongside the first entry
- Not include abbreviations, jargon, meaningless phrases, and irrelevant speculation
    - If written, recorded in black ink only, so that photocopies are readable

2.2.4. **Records must adhere to the General Caldicott Principles (HSC, 1998) on confidentiality:**

- Justify the purpose(s)
- Don’t use patient-identifiable information unless it is absolutely necessary
- Use the minimum necessary patient identifiable information
- Access to patient-identifiable information should be on a strict need-to-know basis
- Everyone with access to patient-identifiable information should be aware of his or her responsibilities
- Understand and comply with the law
- All entries into the health record, including amendments, should be contemporaneous, clearly dated, timed, signed and the designation of the person making the entry should be clearly recorded
- The Endoscopy Unit Lead will retain copies of signatures of all healthcare professionals who make entries in healthcare records, together with the professional's registration number (NMC or HPC). The register of signatures will be reviewed and updated annually
- All electronic reporting will be traceable via the ‘login’ system

- Swab, Instrument & needle count
- The swab, instrument and needle count must be recorded in the patient's records as well as on the Procedure room white board

2.2.5. **Surgical instruments**

- There is a tracking and traceability system, which exists to allow traceability between instrument set and patient. This identifies which set was used for the patient and the decontamination process it has undergone, in order to trace back in the event of an adverse incident, such as sterilisation failure. The tracing sticker will be removed from the external wrapping/label of the instrument set and placed on the patient's documentation
- Each instrument tray will contain an instrument checklist, which incorporates the information necessary for a recorded programme of use. The instruments on each set should be checked against this list, in accordance with the Swab, Instrument, Needle and Sharps Count Policy. Any discrepancies noted in the instrument count should be recorded on the instrument checklist in addition to completing an incident report
- The instrument checklist must record the name of the scrub practitioner and the second checker and identify the patient through their NHS number only

2.2.6. **Decontamination of equipment prior to service or repair**

Anyone who inspects, services, repairs or transports medical, dental or laboratory equipment, either on hospital premises or elsewhere, has a right to expect that medical devices and other equipment have been appropriately decontaminated; appropriate documentation will be provided to indicate the decontamination status of the item (DOH 1993).

Refer to:

- RCHT Decontamination Policy

2.2.7. **Medical Equipment / Devices**

Staff will maintain relevant records that relate to equipment used in the Rheumatology department.

These records may be linked with other departments such as Medical Physics, estates, medical device companies and SSD and include:

Record of Purchase

- Any product trials information which may be held by the company
- Identification number for individual items for the purpose of tracking and locating

- Working history/maintenance records
- Capital assets register
- Maintenance contract
- Manufacturer's warranties
- Planned preventative maintenance
- Record of defective instruments sent to repair
- Calibration
- Lending of equipment
- Documentation and tracking of instruments used
- An obligation arising from liability ends after ten years and up to one year is allowed for serving a writ. Equipment records of non-fixed equipment, including specification, test records, maintenance records and logs should therefore be retained for a minimum retention period of eleven years (DH 2006)
- The Clinical Nurse Specialist will hold documentation to demonstrate that staff have been adequately trained and authorised in the use of equipment and medical devices
- All staff members using medical devices should do so only once adequately trained and competent to the level required for its use
- All staff are responsible for maintaining their competence for medical devices

2.2.8. **Accident/incident reporting and statement writing**

Refer to:

- RCHT Incident and Serious Incident Policy

2.2.9. **Recording of electrosurgical use and settings**

When electrosurgical equipment is used the following should be recorded in the patient's record:

- Mode (Bipolar or Mono terminal)
- Power setting in watts

This will safeguard the user in the situation where a patient may inadvertently experience an electrosurgical burn.

2.2.10. **Surgical Antiseptic Skin Preparation Solutions**

The chosen skin preparation/antiseptic solution will be documented in the patient's perioperative care plan to comply with the Consumer Protection Act (SI, 1987). This should include lot/batch number.

2.2.11. **Admission and labelling procedure**

Refer to:

- RCHT Positive Identification Policy and Procedure

2.2.12. **The procedure/clinic list**

The clinician should refer and agree the procedure list order in advance (where possible).

The clinician undertaking the procedure must take responsibility for compilation of the list in a recognised printed format; alternatively, by designating a member of their team (AfPP 2011).

The list will include:

- Surname, forename, NHS number, date of birth of the patient
- Procedure/Diagnosis
- Clinician
- Session start time

Abbreviations must not be used.

Compliance: 100%

Exceptions: None

References**:**

- RCHT Medical Devices Policy
- AfPP Principles of Safe Practice in the Perioperative Environment 2011

2.3. Endoscopy Unit Standard No 03 – Safeguarding Patient Information

Standard Statement: Staff must protect and dispose of any confidential information, concerning a patient that is generated for any clinical use.

Refer to:

- RCHT Confidential Waste Policy
- RCHT IT Policy

Method:

Printed clinical lists must be disposed of in an appropriate manner at the end of the session in the RCHT confidential waste receptacle.

- Procedure lists for the following day that must be left face down and placed in the respective Procedure room 'operating list folder'.
- Notes/x-rays remaining which pertains to patients must be removed and delivered to the appropriate area
- Procedure room Record books must be closed at the end of each session
- Paper containing any patient details must not be disposed of appropriately and must never be reused as scrap paper
- All staff are responsible for logging out of the computer when moving away from it

Compliance: 100%

Exceptions: None

References:

- AfPP Principles of Safe Practice in the Perioperative Environment 2011
- RCHT Confidential Waste Policy

2.4. Endoscopy Unit Practice Standard No 04 - Infection control in the Endoscopy Unit

2.4.1. **Standard Statement**: All procedure staff must utilise standard precautions in all aspects of practice to protect self, colleagues, and patients from the risk of health care acquired infection.

2.4.2. **Standard Precautions in the procedure room**

- Management considerations
- Protection and Precautions
- Skin
- Hand Hygiene
- Gloves
- Eyes and Mouth
- Gowns and aprons
- Sharps

- Spillage of blood and body fluids
  See: Revised Healthcare Cleaning Manual

2.4.3. **Accidental exposure/sharps injury/conjunctiva/mucous membrane splash**

All incidents must be reported on the RCHT incident reporting system.

2.4.4. **Waste disposal**

Refer to:

- RCHT Infection Prevention and Control Policies including:
- RCHT Hand Hygiene
- RCHT Safe Handling and Disposal of Sharps
- RCHT Decontamination Policy
- RCHT Generic Waste Management Policy
- RCHT Incident reporting Policy

2.4.5. **The Environment**

- Footfall is not limited within the unit; these areas include reception areas and interview rooms. Out-of-hours access is restricted by swipe card
- Semi-restricted areas – Procedure room footfall is limited to authorised, correctly attired personnel and patients with access restricted to these areas via swipe card

2.4.6. **Procedure Room**

Procedure room doors must remain closed at all times when access/egress are not undertaken.

Footfall: The layout of the procedure room is designed to minimise, restrict, or contain bacterial and viral pathogens. In addition, footfall should be kept to a minimum

Traffic: The purpose of controlling Procedure room traffic (movement within the procedure rooms) is to minimise the movement of bacteria within the environment itself, personnel, and patients

2.4.7. **Environment Cleaning**

Refer to:

- RCHT Cleaning Policy and Standards
- RCHT COSHH policy

- Infection control in the built environment (DOH 2013)

The environment and all working surfaces must be cleaned in accordance with the RCHT infection prevention and control policy and cleaning guidelines (NHS cleaning manual, 2007) prior to use.

- The Endoscopy Unit Lead should maintain records of cleaning schedules
- Daily department staff cleaning records
- Weekly departmental staff cleaning records and Domestic services weekly Procedure room audit
- Monthly departmental staff cleaning records
- Quarterly Domestic services departmental cleaning audit
- 6 monthly Domestic services deep cleaning records
- All records will detail the standards of cleanliness required in each part of the unit including items and equipment, and that a schedule of cleaning frequency is available on request. Work schedules must be displayed in particular work areas

2.4.8. **The Endoscopy Unit Lead Will**

- Determine who in the department should be responsible for each element on the cleaning schedule: cleaning staff, porters, or clinical staff
- Routinely check that cleaning has taken place to a sufficient standard; highlight trends which indicate a downturn in the cleanliness provide investigation and an action plan for improvement, if necessary
- Ensure that all cleaning and decontamination that takes place in the department is conducted according to the recommendations in the Revised Healthcare Cleaning Manual (NPSA, 2009)
- Must agree the service level agreement with the Estates Department that ensures regular programme of maintenance to the Endoscopy Department
- Ensure that the Estates department responds to requests for repair to the structure of the unit in a timely manner and/or pursue where response has been overlooked
- Maintain a transparent process for staff to report problems related to the structure of the theatre environment e.g., indicating areas of wall with peeling paint which must be repainted or covered with a new wall finish, and to record the outcomes of the reporting process

- There must be available a cleaning work schedule for the housekeeping staff and a separate one for the clinical staff, clearly identifying: the tasks normally undertaken; the item; recommended method and frequency. Technical method statements can be found in the Revised NHS Cleaning Manual (NPSA, 2009)

- The RCHT Decontamination Policy provides advice on methods of decontamination

- The clinician must undertake a visual audit of the environment for cleanliness before the commencement of the procedure list and act where appropriate. Results of this audit must be kept and be available for audit purposes

- Disposable gloves must be worn for all cleaning tasks

- Cleaning of the clinical environment must take place via a 'top to bottom', 'out to in' method

- Damp Cleaning of the ledges and shelves will take place prior to every procedure/clinical session

- Cleaning of sterile store's room will take place monthly and include removal of all equipment, to facilitate cleaning of the floors. All portable equipment must be removed from this area. All racks must have equipment/packs/materials removed and be cleaned and replaced

2.4.9. **Cleaning between patients in the consultation rooms and Procedure rooms**

- Surfaces that receive direct patient contact must be cleaned in accordance with the RCHT Decontamination policy

- Waste, laundry, and instruments must be disposed of according to the RCHT Generic Waste Management Policy

- Trollies that are torn or damaged in any way must be reported immediately to the medical physics department for repair (not taped). If deemed beyond economical repair by medical physics staff then it should be decommissioned, removed from circulation and disposed of by the waste collection team

2.4.10. **Terminal Daily Cleaning Procedures**

- All equipment should be cleaned, and all portable equipment removed from rooms following cleaning

- Windowsills, overhead lights, cabinets, waste receptacles, equipment and furniture should be cleaned with detergent solution and a disposable cloth

- Sinks should be cleaned with detergent and water applied with a disposable sponge/cloth

- Shelves should be emptied, wiped with detergent and water, and dried before replacing supplies

2.4.11. **Management Consideration**

- Surfaces must be kept free from visible dirt, and special attention must be paid to areas that are likely to become heavily contaminated (i.e., upward facing surfaces, including windowsill which must be kept free from clutter)

- Walls must not be allowed to become visibly dirty

- Areas of wall with peeling paint must be repainted or covered with a new wall finish

- For other surfaces, normal housekeeping methods are adequate (e.g., daily damp cleaning of ledges and shelves)

- Floors should be free of litter, dust, marks, water, or spillages

- Floors should be free of floor polish build up

- Specific spillages of blood or body fluids should be dealt with immediately

2.4.12. **Procedure rooms**

- Before equipment is brought into the procedural clinical area, it must be visually inspected for dust and cleaned in accordance with IPAC and manufacturer's instructions

- The air changing ventilation system must be in operation in accordance with policy and best evidence-based practice

- The temperature of the immediate environment ideally should be at a comfortable and static 21°C - 23°C and humidity between 30% - 70%

- Only the number of personnel required to manage the proposed clinical procedure safely should be present in the procedure room

- There should be a restriction on movement and talking within the procedure room

- All doors to the procedure room must remain closed to ensure effective ventilation of the area

- As far as possible all potential equipment and supplies for the proposed clinical procedure should be available in procedure room prior to a clinical procedure commencing. This will then reduce the traffic in and out of the procedure room and therefore maximise

the efficiency of the ventilation system

- Storage of cardboard boxes in the procedure room must be discouraged as cardboard cannot be cleaned effectively
- All stock items stored within the procedure rooms must be stored behind within a suitable cupboard with a functioning door
- Any open containers used to keep items tidy e.g., plastic trays, boxes etc. must be recorded on the cleaning schedule and emptied of contents, cleaned, and replaced, monthly
- Where items are routinely stored in plastic boxes, drawers etc. these must be recorded on the cleaning schedule, the surface underneath must be cleaned, the box/drawer emptied of contents, cleaned, and replaced.
- Movable trolleys e.g., Care Carts, must be cleaned, including removing the contents from the drawers
- The allocated staff member should undertake a visual audit of the environment for cleanliness before the commencement of the procedure list and action taken to rectify any concerns where appropriate

2.4.13. **Cleaning Equipment and Materials**

- All decontaminated equipment should be appropriately labelled with a label advising of its cleanliness status
- Before equipment is brought into the procedural/clinic area it should be cleaned

2.4.14. **Detergents and Disinfectants**

- Detergents and disinfectants should be used in accordance with the manufacturer's instructions
- Disinfectants must be used in the correct concentration and mixed immediately prior to use. Personnel handling disinfectants or using them must be adequately trained and supervised
- Disinfectants must be stored and labelled correctly according to COSHH Regulations

2.4.15. **Spillage of Blood & Body Fluids**
(Extracted from the RCHT Decontamination Policy)

- The spill should be dealt with as soon as possible
- The removal of blood and body fluid spills in clinical areas is the responsibility of the clinical staff in that department, not the cleaning staff. Outside clinical areas responsibility for cleaning should be identified locally and will depend on the size of the

unit/hospital and the personnel available

- Gloves and plastic aprons must be worn as a minimum when dealing with spill of blood or body fluids. If there is any risk of splashing, eye/face protection must be worn
- Where the spillage may contain sharp material, forceps should be used to remove the sharp material, placing it immediately in a sharps bin
- If the spillage is large, soak up the excess fluid using paper towels and carefully place these in a clinical waste bag
- Clean surface with warm water and detergent using a disposable cloth or mop
- If the spill is on a carpeted area this should be disinfected following cleaning using a steam cleaner or wet extract carpet shampooer
- Curtains or loose fabric covers should be laundered or dry cleaned

Compliance: 100%

Exceptions: None

References:

- RCHT Infection Control Policies
- PHE Guidance

2.5. Endoscopy Unit Practice Standard No 5 – Aseptic Technique

2.5.1. **Standard Statement**: Where applicable all staff will practice compliant aseptic technique in all aspects of practice to protect self, colleagues, and patients from the risk of health care acquired infection.

2.5.2. **General considerations**

- Any staff member with infected lesions of the skin or bacterial infections of the upper respiratory system should not participate in any aseptic technique
- All staff must be aware of differences between sterile items and non-sterile items and share responsibility for monitoring aseptic practice
- All Staff must be aware of single use and reusable items

- The environment and all working surfaces must be cleaned according to RCHT Decontamination Policy and the Cleaning Policy

- All practitioners, staff and clinicians working, or who come to work in the Endoscopy Unit are expected to act as role models, demonstrating positive behaviours that actively promote best practice for infection prevention and control

- A ‘zero’ tolerance for breaches to practice for infection prevention and control procedures must be fostered

- All staff are responsible for maintaining their ANTT training and competence

2.5.3. **Equipment and medical devices safeguards**

- All pre-sterilised articles must be checked for evidence of sterilisation, damage, the integrity of packaging, and an expiry date, prior to use. Any packs found to be in an unsatisfactory condition must be discarded

- Items used within a sterile field must be sterile. Any items that fall into an area of questionable cleanliness must be considered non-sterile

- Sterile drapes must be handled as little as possible. The drapes must be applied from the surgical site to the periphery, avoiding reaching over nonsterile areas. Once placed, drapes must not be repositioned to avoid contamination of the sterile field

2.5.4. **Scrubbed personnel**

- Staff participating in an aseptic procedure should present themselves as per the Principles of Safe Practice in the Perioperative Environment and the RCHT Uniform Policy

- If gowns or gloves are contaminated, they must be changed as soon as is reasonably practicable

- Scrubbed personnel should remain close to the sterile field and not leave the immediate area. If personnel leave the sterile field and exit the procedure room, they must re-scrub before returning to the sterile field. Leaving the sterile field increases the risk for potential contamination

- Personnel participating within sterile procedures should stay within the sterile boundaries, and a wide margin of safety should be given between scrubbed and non- scrubbed persons

- When changing positions or moving between sterile areas, scrubbed personnel should turn back-to-back or face to face to avoid contamination

- Scrubbed personnel should keep their arms and hands within the sterile field at all times. Contamination may occur if hands are moved below the level of the sterile field

- Scrubbed personnel should only be seated when the procedure is to be performed at that level

- Circulating personnel should not walk between the two sterile fields and should be keep an adequate distance from the sterile field

2.5.5. **Trolley**

- To maintain asepsis, it is essential that all staff are aware of the correct method for opening different sterile packages to avoid the contamination of contents. Circulating persons must open wrapped sterile supplies by opening the wrapper furthest away from them first. The nearest wrapper must be opened last. Outer wrappers must be secured when presenting sterile items, to avoid contamination

- Sterile fields should be prepared as close as possible to the time of use

- Multi-dispensing antiseptic containers e.g., betadine / videne must not be refilled and must be discarded at the end of the day

- Do not prepare sterile trolleys in advance, even with the use of sterile sheets to cover them. The trolleys are subject to contamination over time and removal of sheets without contamination cannot be guaranteed. In addition, unless trolleys are continuously monitored, there is a potential for sterility to be compromised

2.5.6. **Practice**

The following practices will support infection prevention and control for patients undergoing interventional procedures.

- Do not routinely remove hair. If hair must be removed from the operative area, electric clippers are available

- Prepare the skin at the surgical site immediately before incision using an antiseptic preparation

- Maintain the patient's temperature intra-operatively

- Maintain adequate oxygenation and perfusion throughout procedure

- Cover surgical incisions with an appropriate dressing at the end of the operation.

Compliance: 100%

Exceptions: None

References**:**

- AfPP Principles of Safe Practice in the Perioperative Environment 2011 RCHT Trust Decontamination Policy
- RCHT Cleaning Policy Generic Theatre Standard 01

2.6. Endoscopy Unit Practice Standard No 06 - Management of Patients with known Infections or carriers of Infectious Agents

2.6.1. **Standard Statement:** All procedure room staff will have knowledge of the requirements for caring for patients with known Infections or carriers of Infectious Agents in the Endoscopy Unit to protect self, colleagues, and patients from the risk of health care acquired infection.

2.6.2. **General considerations**

Refer to:

- Generic Theatre Practice Standards for specific guidance on infectious agents in the procedure rooms

2.6.3. **Training:**

All staff involved in the care of the patient must be aware of the specific precautions and have received adequate training.

2.6.4. **Briefing**:

This should include a quick check to ensure all staff are aware of the specific precautions, patient's position on the list and sufficient environment/equipment cleaning time all should be highlighted and discussed.

2.6.5. **Communication**:

Is absolutely essential.

2.6.6. **Flow**:

The essence of this is maintaining adherence with infection control policy but also maintaining flow through our procedure room. Sensible and thoughtful application with discussion between all care givers will allow for better flow.

To limit accidental exposure good procedure room practice/technique includes

- Keeping staff to a minimum

- trying to reduce unnecessary movement of personnel from one zone to another
- Raising awareness and keeping only the equipment/items relevant for the current patient
- Standard precautions must be adhered to
- The procedure room doors must be kept closed to aid the efficiency of the ventilation systems
- As far as possible all personnel, surgical instruments and sundries must be sourced prior to the case being undertaken

2.6.7. **Waste:** Contaminated PPE and clinical waste disposed of into yellow bags for incineration. Contaminated clothing and reusable bedding disposed into red bags for infected laundering. Safety gel/granules to be applied to spillages or when carrying possibly infected bodily fluids from theatre to sluice and when disposing, to prevent splash back.

Compliance: 100%

Exceptions: None

References**:**

- Generic Theatre Practice Standards for specific guidance on infectious agents in the procedure/clinical rooms
- AfPP Principles of Safe Practice in the Perioperative Environment 2011
- RCHT ANTT Policy
- RCHT Decontamination Policy

2.7. Endoscopy Unit Practice Standard No 07 – Fire Prevention

2.7.1. Fire Precautions:

Refer to:

- RCHT Fire Safety Policy

2.7.2. **General Considerations**

Alcohol skin preparation

- Alcohol-based skin preparations are known to be flammable
- Risk Assessment must be undertaken for their use and application. Alcohol-based skin preparations can be absorbed into body hair or can pool on the body surface

Alcohol flames are difficult to see under the lights

- The quantity of flammable fluid used to prepare the skin should be kept to a minimum in order to avoid run-off and pooling, either on or around the patient. Precautions should be taken to prevent pooling underneath drapes or in the patient's umbilicus
- Any run-off that occurs must be contained by absorbent material placed around the patient, which is removed before the drapes are applied
- Time must be allowed for the alcohol to evaporate and disperse prior to applying the drapes
- Care must be taken in using sprays with flammable propellants such as butane when electro surgery is planned

Procedure Room - Electro surgery

- In electro surgery, the active electrode is in the surgical site
- Electro surgery units use a high frequency alternating electrical current for cutting and coagulation. They are the main potential ignition source for a fire
- Electro surgery can produce a high temperature electrical arc if carbonized tissue is allowed to build up on the tip of the electro surgery device. It is essential that an electrocautery tip cleaner be applied to remove the build-up of carbonised tissue
- The power setting for the electro surgery unit will be confirmed verbally between the operator and the user prior to activation
- The active electrode must always be stored securely in a non-conductive container when not in use
- The active electrode must only be activated by the person holding the device
- Active electrodes must not be used in the presence of flammable substances, including anti-microbial skin preparations, and tinctures

Staff responsibilities

- All staff must be aware of the trust fire evacuation policy
- All staff must have attended mandatory yearly updates
- All staff must be aware of location of fire escape routes and firefighting equipment in all areas of work
- A local fire Warden will be on duty each day in each clinical area - these individuals will have received additional training on what

actions to take in the event of a fire occurring in the Endoscopy Unit

- All staff have a responsibility not to block fire exists or escape corridors with equipment
- Each area should be checked each day to ensure that fire exit routes are clear and fire doors are not wedged open. Doors left open during the day must be closed at the end of the day before the department is closed

Compliance: 100%

Exceptions: None

References:

- RCHT Fire Safety Policy

2.8. Endoscopy Unit Standard No 08 – Management of Hazardous Materials

Refer to:

- RCHT Infection Prevention and Control policies; including Hand Hygiene and Safe Handling and Disposal of Sharps

2.8.1. **Standard Statement:** All staff in the department must be aware of the measures that need to be taken in the event of the spillage of a hazardous substance.

2.8.2. **Hazardous Spillages Method:**

- All staff must adhere to COSHH regulations and be conversant with the Trust COSHH policy for dealing with spillages
- Staff will be conversant with the substances used in the Endoscopy Unit that are considered a risk by COSHH
- All staff handling hazardous substances must receive training appropriate to their role and responsibility
- COSHH training is mandatory on appointment to the Trust, and it is recommended that updates are received every two years
- Staff must wear protective clothing, in adherence with the trust policy, when dealing with disposal of contaminated waste
- Staff will be aware of the measures to be taken in the event of a spillage, regarding appropriate protective clothing, evacuation requirements etc

- All identified hazardous substances will be handled with care and compliance to manufacturer's instructions adhered to.
- Handling of identified hazardous substances will be kept to a minimum
- Any untoward occurrences involving hazardous substances must be reported, with referral to the Occupational Health Department as necessary

2.8.3. **Standard Statement:** Spillages will be dealt with as soon as possible. Each procedure/consultation room must ensure that the equipment to deal with spillage is readily available.

2.8.4. **Non-Hazardous Spillages Method:**

- All staff handling waste or spillage of fluids must receive training appropriate to their role and responsibilities
- Staff will familiarise themselves with the Trust policy on spillages
- Wearing protective clothing i.e. gloves, aprons, mask. Substances will be mopped up using paper roll/towels and discarded into a yellow clinical waste bag. Care must be taken not to contaminate the outside of the bag
- The surface must be cleaned using detergent and water and dried. Staff must dispose of gloves as clinical waste and wash hands

Compliance: 100%

Exceptions: None

References:

- Generic Theatre Practice Standards Clinical Guideline V3.0
- RCHT Infection Prevention & Control
- RCHT COSHH Policy
- RCHT Disposal of Waste
- RCHT AfPP Principles of Safe Practice in the Perioperative Environment 2011

2.9. Endoscopy Unit standard No 09 - Collection of specimens and transportation to the laboratory standard

2.9.1. **Standard Statement**:In the procedure room, specimens are regularly taken during surgical procedures. It is essential that every specimen

reaches the pathology, bacteriology, histology, or cytology department without undue delay and in optimum condition, to facilitate the survival and identification of organisms.

2.9.2. **Method:**

Collection of a sample: Classification of Specimens

Specimens fall into three categories:

- Transfusion specimens
- Retrievable specimens
- Irretrievable specimens

RCHT Pathology has classified irretrievable specimens as:

- Cerebrospinal fluids (CSFs)
- Specified dynamic function tests & specific test requirements
- Bone Marrow specimens
- Amniotic Fluids
- Histological and Cytological samples (excluding voided urines and sputa)
- Some samples from postmortems
- Certain forensic samples under the auspices of a Pathologist
- Clinical Microbiology - Sterile fluids, Outbreak samples other than faeces, specimens from temporary residents, specimens from the operating theatre

All other specimens are considered “retrievable” i.e., able to be repeated

Documentation requirements: Recording of Specimens

- All entries into any health record, including amendments, must be clearly dated, timed, signed and the designation of the person making the entry must be clearly recorded
- It is the responsibility of the scrub practitioner to ensure that the specimen(s) are present, labelled correctly and signed before it leaves unit
- The transportation of the specimen to the histology collection box can be delegated to another member of the team but they must be deemed competent and know how to complete the relevant documentation and checks

- It is the responsibility of the medical practitioner to sign the request form and state what particular investigations are required. This should generally be the surgeon. Whoever provides the detail must supply all information, including clear identification of who they are, their grade, and their contact details

Specimen Identification

- Specimen identification must begin at the time the specimen is removed from the patient. The operating surgeon removing the specimen must clarify what the specimen is including site if relevant

- The scrub person must determine the nature and site of the specimen that is being taken by verifying with the operating surgeon the specimen and site of removal e.g., left breast lump. This information will then guide the circulating practitioner as to the actions that are required for the specific type of specimen being collected

- Action must be taken to prevent drying out of specimens. Specimens and cultures should be handed off the sterile field as soon as they are taken, and the surgeon has given consent

- The scrub person must check with the operator whether the sample should be placed in a container containing preservative or other transport medium, or whether it should be a dry specimen

- The scrub person must relay this information to the circulating person who will assist in the specimen collection process

Specimen Labelling

After checking the patient's records, the following details must be recorded on the specimen pot label:

- Patient's full name, identification number and date of birth
- Ward, hospital, theatre
- Nature of the specimen
- Date/time specimen was taken
- Nature of fixative
- Consultants name

These details must be recorded on an adhesive label that is attached to the body of the specimen container

The same details must also be recorded on the request form, along with the following:

- Medical practitioner's name, clearly and legibly written
- Medical practitioner's signature
- Details of who the report should be submitted to
- It is essential that a member of the perioperative team labels the specimen container. This must be done after the details have been provided but before the specimen is placed in the container. To reduce confusion, the label must not be placed on the lid of the container
- The labelled container must be shown to the scrub practitioner in conjunction with the details as they are confirmed by the patient
- The information on the investigation request form must correspond with the details on the specimen container and the patient's notes. It must also contain relevant clinical information to assist the laboratory staff
- It is vital that all information is checked and accurate before the specimen leaves the procedure room. The specimen must be accompanied by the documentation
- The security and labelling of any operative specimen are the responsibility of the scrub practitioner responsible for the case
- In the event of urgent specimens, the laboratory staff must be notified (Royal College of Pathologists 2005)
- A log must be kept, to track the specimen from the procedure room to the laboratory or pathology department. A signed record must be kept of all specimens dispatched from the perioperative setting. Names must be printed as well as signed

Handling Specimens

- Care must be taken when selecting an appropriate specimen container, in relation to its size and purpose. For histopathology specimens, the container must be large enough to ensure that the specimen floats freely, is completely covered by appropriate fixative and is sealed for transportation
- The circulating person must follow standard precautions when placing the specimen in the container. Precautions must be taken to prevent any contamination of the outside of the specimen container
- All staff must adhere to COSHH regulations and Trust policies for treatment of splash injuries from specimen fixative or body fluids
- All specimens for microbiology must be placed in a specified biohazard bag which is sealed before dispatch

- All staff must adhere to Trust standard precautions when handling specimens in accordance with local policy

- If specimens cannot be taken to the laboratory within the specified time limits (e.g., at night) they must be stored in accordance with the RCHT Pathology Specimen Handbook instructions (Royal College of Pathologists 2005). Some specimens without fixatives may need to be stored in a dedicated specimen fridge at a temperature of 4°C, thus minimising the potential for bacterial growth. However, storage at 4°C is inappropriate for specimens in formalin, as this will delay fixation of the specimen. Blood cultures collected must be transferred immediately to microbiology

- The specimen must be removed from the procedure room before the next scheduled patient arrives

Traceability

- There must be a central point for specimens and specimen forms to be taken to following procedure. A procedure log will hold tracking information that requires filling in with information about the specimen including date, patient's name, hospital number, date of birth, ward, operating theatre, specimen details, number of the specimen (if more than one), details on type of investigation e.g., histology, microbiology, clinical chemistry, confirmation that the specimen label and specimen form match in accuracy

- The staff member who completes the specimen tracking information is responsible for ensuring that the patient labels on both specimen and specimen form tally, that the surgeon has signed the specimen form and that formalin is added if appropriate

- Both the specimen and specimen form must then be placed in the collecting box provided. The box must be lined with a large plastic bag and forms must be put in a smaller plastic bag. The lid of the cool box lid must be replaced. If the specimen is too large for the box, it must be placed in a large bag with the form and put on the floor

- The collecting box will be collected from this central point on a regular basis during the day (or at certain agreed times for each department); the last collection in the afternoon will be while the lab is still open. Any specimens put in the box after that time will stay at the central point until the first collection of the next day

Staff Responsibility

- All staff will receive training before undertaking handling of specimens and will achieve the required levels of competency before undertaking this task

- The scrub person will confirm with the surgeon the nature of the specimen, the site the specimen was taken from, and the analysis

required. The necessary form will be completed in a clear and concise way. It is the duty of the scrub nurse to ensure that the surgeon completes the necessary details on the specimen form at the end of the case

- The circulating person must follow Universal Precautions when handling the specimen/placing in its container

- All staff must adhere to COSHH regulations and be conversant with Trust COSHH policy for treatment in respect of splash injuries from specimen fixative or body fluids

- All specimens must be handled with care to avoid crushing or distortion to anatomical detail

- Specimen containers of sufficient size and strength must be provided for each specimen

- In the event of several specimens, each container must be clearly numbered, and these numbers duplicated onto the specimen form

- The scrub person must ascertain, from the surgeon, whether a fixing medium (Formalin) is required or not

- The circulating person is responsible for completing the label for each container. All details must be checked with the patient's notes, and Galaxy screen NOT the operating list to avoid potential confusion with other patients with similar details. All parts of the label must be completed as fully as possible

- The label must be placed on the container, not the lid, prior to placing the specimen inside. The details on the container can then be shown to the scrub nurse prior to the specimen being placed inside

- Any specimen held in a fixative must be labelled with an appropriate hazard label

- The scrub nurse must not discard of any tissue or fluid until it has been ascertained that it is not required for the laboratory

- Completed specimens and forms must be placed in a sealed bag

- Urgent specimens must be placed in a bag labelled as such and given directly to an orderly for immediate dispatch to the laboratory. These specimens must still be recorded in the specimen logbook and the laboratory forewarned of their arrival

- Specimens will be taken to the specimen collection area and formalin added as necessary. Formalin must cover the entire specimen plus one third

- The patient's details, nature of the specimen, date, and surgeons name must be recorded in the logbook

Compliance: 100%

Exceptions: None

References:

- Generic Theatre Practice Standards Clinical Guideline
- AfPP Principles of Safe Practice in the Perioperative Environment 2011
- The Royal Marsden Hospital Manual of Clinical Nursing Procedures

2.10. Endoscopy Unit standard No 10 - Latex Allergy in the Procedure room

2.10.1. **Statement:** All staff are required to have knowledge and understanding of the requirements for the care of patients with latex allergy. The local practice standards will be included in the induction program for new staff.

2.10.2. **Communication Processes**

Refer to:

- RCHT Guidelines: Procedure for Allergies or Idiosyncrasies to Medicines and Food

The allergy status must be clearly documented in the medical notes, in the allergy box on the drug chart and on any outpatient prescription.

In addition to recording the allergy category, the healthcare professional must also document:

- The name of the drug or food that caused the reaction
- The nature of the reaction e.g., rash, swollen lips etc
- Confirm that this is a 'true allergy' and not a side-effect e.g., nausea
- When the reaction occurred e.g., as a child
- Where the information regarding allergy status came from e.g., confirmed with patient, confirmed in medical notes
- The healthcare professional must sign and date the entry
- It is important that information on patient allergies is communicated to the department at the earliest opportunity to

allow provisions to be made

- Short notice notification of latex allergy may result in a delay to the patient being treated while the appropriate actions are taken

2.10.3. **Intra Procedural:**

- The key is to avoid contact with latex on the skin, intravenously, by inhalation and particularly by contact with mucous membranes, peritoneum and serosa surfaces
- All staff must be aware of the need to maintain a latex free environment
- The single most important precaution is to avoid any member of staff wearing latex containing gloves

2.10.4. **What precautions should be taken with NRL-sensitive staff?**

- Staff who consider that they have a possible hypersensitivity should be referred to Occupational Health for screening.
- All general staff equipment, gloves, masks etc. used in the Dermatology Unit are latex free, and any replacement products considered must also be confirmed latex free before Purchase.
- Staff with known latex sensitivity must have regular review with their line manager and Occupational Health, documented in their personal file.

Compliance: 100%

Exceptions: None

2.11. Endoscopy Unit standard No 11 - 5 Steps to Safer Surgery including WHO Surgical Safety Checklist

2.11.1. **Standard**: Application of the 5 Steps to Safer Surgery including WHO Surgical Safety Checklist (SSC) in all procedure rooms.

2.11.2. **Standard Statement:**

All procedures performed in dermatology procedure room will have the correct and full application of the WHO SSC process completed and documented by the team. Patient safety is paramount all staff are expected to raise concerns if at any point they feel that this process is not being fully supported.

2.11.3. **Method**:

Pre-Briefing

- Prior to the commencement of the procedure list
- Participation by all members of the procedure room team allocated to the list
- The briefing will be documented on the Endoscopy Unit standard template and all elements completed, if any points are considered not relevant, they should be marked as such
- Staff must introduce themselves to each other by name and role. This information will also be recorded on the procedure room white board
- The nurse /practitioner designated “in charge” of the list must be clearly identified on the procedure room whiteboard
- Any changes to the published Galaxy list must be discussed, understood, and agreed by all members of the procedure room team. If changes include laterality or change of procedure, then the list should be amended and reprinted
- Any issues related to the organisation of the list must be discussed

WHO Surgical Safety Checklist Endoscopy procedure rooms only)

- All steps will be read out loud though steps relating to aspiration/airway risks and blood loss may be treated with discretion
- “Silent cockpit” principles should be adopted during all steps, all team members must show respect for the process, be present and fully participate in all steps of the check procedure
- It is the responsibility of the senior operating surgeon and the person in charge of the procedure room to ensure that the dermatology WHO SSC process is completed accurately and diligently

Sign In – As patient enters the procedure room

- The Operator must be present at ‘Sign In’
- The team will verbally confirm out loud all points detailed on the sign in section of the WHO Surgical Safety Checklist. Discretion may be used for questions relating to airway/aspiration risk and blood loss
- They will clearly mark the checklist in the appropriate place to confirm the check has taken place

- On completion the nominated person (must be a registered nurse or Doctor) will clearly print their name and Sign to confirm completion of the sign in check

- The nominated person (must be a registered nurse or Doctor) will confirm that the correct patient details are completed on the dermatology WHO Surgical Safety Checklist (a patient identity label may be used)

Time Out – Before start of procedure including skin preparation

- To be completed by the whole operative team - the senior operating surgeon retains the accountability to ensure that this check is fully completed. All relevant staff should be present

- A delegated member of the theatre team will confirm all team members are present and initiate the checklist by reading out loud all points contained in the timeout section of the checklist. Discretion may be used for questions relating to blood loss if the patient has a local or regional anaesthetic

- If at any point during completion of the checklist a member of the team is required to leave the theatre the checklist should be suspended and recommenced when all are present

- If at any point during completion of the checklist the team is interrupted by an individual external to the team, the checklist should be suspended and recommenced when all team members can pay full attention to the process

- Any concerns or queries raised by any team member must be resolved before procedure commences

- If at any point any member of the team feels the process is not safe, they are expected and will be supported to say STOP

- The delegated team member will clearly mark the checklist in the appropriate place to indicate the point has been discussed

- The delegated team member leading the dermatology WHO SSC must print their name and sign to confirm the ‘Time-Out’ check is complete

- If at any point during the procedure a member of the team is replaced or a further member of staff joins the team they will be introduced by name and designation and be briefed on the procedure, given any necessary information and have sight of the consent form

- To be completed by the whole operative team

- A delegated member of the team will confirm all team members are present and initiate the checklist by reading out loud all points

contained in the sign out section of the checklist

- If at any point during completion of the checklist a member of the team is required to leave the procedure room the checklist should be suspended and recommenced when all are present

- If at any point during completion of the checklist the team is interrupted by an individual external to the team, the checklist should be suspended and recommenced when all team members can pay full attention to the process

- Any concerns or issues that have arisen during the procedure must be reported on Datix where necessary

- The team formally acknowledges any concerns for recovery and postoperative management of the patient

- The dermatology WHO Surgical safety Checklist must be signed by the team member leading the check and the senior operating surgeon

Sign-out

- Should be performed by a designated member of the surgical team at the end of the procedure but before the patient or any of the team leaves the procedure room

- "Silent cockpit" must be observed

- Verbal confirmation that the name and site of the procedure have been accurately recorded

- That any specimens have been labelled correctly

- That instrument and swab counts are correct

- Postoperative instructions have been given and understood by the patient

List Debriefing

- The whole team including debrief at a suitable interval to review the procedures undertaken on the procedure list.

- The list de-brief should be recorded on the standard template and when complete saved to the shared governance file for audit.

- The whole team acknowledges:

    - What went well?

    - Any challenges or concerns about the list

    - Communication, skill-mix, issues outside theatre, timing

issues

- Any specific equipment issues that needed to be addressed before the next list
- Anything that could have been done to make the list safer
- Anything that could have been done to make the list more productive

- Any issues should be reported to the Endoscopy Unit Lead or nominated deputy and an incident report raised if necessary.
- Any issues of shared learning must be included for the following days departmental “safety huddle”

Compliance: 100%

Exceptions: None

References:

- RCHT Five steps to safer surgery

2.12. Endoscopy Unit standard No 12 - Application of the 5 Steps to Safer Surgery (including the Endoscopy unit specific) WHO Surgical Safety Checklist (SSC) in all procedure rooms

2.12.1. **Standard Statement:** All operative procedures performed in the Endoscopy department procedure rooms will have the correct and full application of the Endoscopy WHO SSC process completed and documented by the procedure room team.

2.12.2. **Method:**

- Audit of Compliance with 5 Steps to Safer Surgery, including Endoscopy WHO SSC.
- 100% compliance is expected with application of the 5 Steps to Safer Surgery - this will be monitored by:

Departmental Safety Huddle

- The department “Safety Huddle” will be completed daily by all RCHT departments and incorporates the principles of Team review
- All staff on-duty (except those staff whose clinical session has commenced early) are expected to attend - the Endoscopy Unit Lead or Nurse-in-charge leading the huddle is expected to ensure that all available staff are present. (Unavailable staff are expected to retrospectively review the huddle details when their session has completed)

- The safety huddle discussion will be documented on the standard OPD template provided and will include any issues identified for learning from the previous days

- The practitioner leading the safety huddle will ensure that all staff are given the opportunity to raise concerns for the days planned activity

- Any issues raised will be documented and held for any staff commencing duty later to enable them to be briefed

- The completed record will be returned to the department sister's office and held in the Unit safety huddle folder

- The completed record will within 7 days, be saved to the shared governance file for evidence

Operating List Briefing – step 1 of 5 Safer Surgery

- Each procedure list will have a Pre-briefing before the start of the session

- The procedure list briefing will be structured following the standard template

- The procedure list briefing may be led by any member of the team, but the operating surgeon must be present

- All team members must be involved in the discussion and able to raise any concerns regarding the planned activity

- All individual cases must be discussed, and any specific requirements or anticipated problems documented on the briefing sheet

- The briefing sheet will be retained in the procedure room for the briefing of staff joining the team, new information may be added during the session

- The completed record will within 7 days, be saved to the shared governance file for evidence.

WHO Surgical Safety Checklist - steps 2, 3 & 4 of 5 steps to safer surgery

- Every patient undergoing an invasive procedure will have a fully completed Endoscopy WHO SSC.

- The dermatology WHO SSC is retained in the medical notes and forms part of the procedure record.

- Completion of each phase of the Endoscopy WHO SSC (see practice standard).

- Incomplete WHO SSC will be returned to the relevant procedure room for completion before the patient leaves the operating department.

WHO Surgical Safety Checklist - steps 2, 3 & 4 of 5 steps to safer surgery Audit of Quality

- The process for completion of the WHO SSC is detailed in Procedure Room Endoscopy Practice Standard within this document
- The quality of the WHO process will be directly observed and assessed as per the audit tool for application, engagement and completion at each stage of the WHO
- For one week in each month every procedure room will complete a direct observational assessment of every WHO process for each patient
- Completed assessment forms will be returned to the divisional governance office before the final day of each month for entry to the WHO SSC database and compilation of the monthly specialty and location report
- Departmental assessments will be supported by senior team assessment and peer assessments from other skilled and competent department sisters / charge nurses
- All completed assessment forms will be entered into the WHO SSC database for inclusion in the monthly report
- The monthly report will report compliance by site, procedure room and specialty
- Individual reports related to clinicians can be provided

Debriefing - step 5 of 5 steps to safer surgery

- Each list will have an operating list debriefing at the end of the session and before team members leave the procedure room.
- The debriefing will be structured following the Endoscopy standard template.
- The debriefing may be led by any member of the theatre team but the Operator must be present.
- The debriefing may begin at any time agreed suitable by the team.
- All team members must be involved in the discussion and able to raise any concerns regarding the session’s activity.
- All issues raised at debrief must be discussed and any

suggestions for improvement, escalation or resolution recorded.

- The debriefing sheet will be returned to the department Clinical Specialist Nurse office for inclusion of any learning in the following days safety huddle.

- Within 7 days the briefing / debriefing document will be saved to the shared drive and its entry recorded in the summary sheet to enable auditing

- Completion of:

  - Safety huddle
  - Operating list briefing
  - Operating list debriefing

  Will be included in the monthly report for 5 Steps to Safer Surgery by department and specialty.

Monthly compliance reports will be reported at Specialty Business & Governance Meeting, Care Group Governance Board meeting and shared with all surgical specialties.

Compliance: 100%

Exceptions: None

References**:**

- RCHT 5 Steps to Safer Surgery
- AfPP Principles of Safe Practice in the Perioperative Environment 2016

2.13. Endoscopy Unit standard No 13 - Stocking up of procedural/clinical room

2.13.1. **Standard Statement:** All staff are responsible for ensuring that the procedural/clinical rooms are adequately stocked at all times, and ensuring correct stock rotation.

2.13.2. **Method**:

- All staff must ensure that the procedural/clinical rooms are left stocked ready for use at the end of each operating session. All areas should be checked including cupboards and shelves in preparation rooms. If this is not achievable because of pressure of work, the coordinator for the shift must be informed, so other staff can be directed to fulfil this requirement during any other quieter periods

- Staff must ensure that when placing new stock, older stock is

brought forward to ensure it is used in date order

- All expiry dates must be checked prior to the stock being placed into areas and again before use
- Each area has required stock levels for each item they hold, and these should not be exceeded
- Staff should ensure that stock items are stored neatly to reduce damage to items. If a final item is removed from a box, staff must ensure the box is disposed of and that there is a new box of the item available for use
- Any items noted to be in short supply, must be notified to the Endoscopy Unit Lead
- Regarding reduced levels, any increased usage in a particular item that will be sustained, should be notified to the Endoscopy Unit Lead
- Items that are unwanted or unused must be returned to their appropriate storage area
- Staff should only use other procedure/clinic room stock as a last resort, if the particular item required is out of stock
- Any labels on stock items must be attached to the patient notes for traceability purposes

Compliance: 100%

Exceptions: None

2.14. Endoscopy Unit standard No 14 – Values and Behaviours

2.14.1. **Standard Statement:** All staff will endeavour to maintain a professional demeanour within the department at all times, treat their colleagues with courtesy and respect, and provide the best possible care for all patients who enter the department. Fundamentally we will reflect the RCHT trust values and behaviour standards.

2.14.2. **Method:**

- All staff are expected to be changed and ready for duty at their allocated start time
- Talking outside of the clinic and procedure rooms must be kept to a minimum to avoid disruption
- Staff must familiarise themselves and comply with the Trust standard regarding the use of mobile phones
- Staff must be familiar with and adhere to the Trust Values and Behaviours

- Staff must be familiar with and adhere to the Trust Uniform Policy
- Staff must ensure that entitlement to lunch and rest breaks is not exceeded
- It is expected that when a change of team occurs, an informal handover will take place
- Smoking is not allowed on any RCHT site. Staff wishing to smoke during their allocated break times must change and leave the trust site. These staff must ensure that they do not return late from break times as this is discourteous to colleagues. Help and support is available from Occupational Health for staff members who wish to give up smoking
- Staff should address members of the team by their appropriate title unless invited to do otherwise, especially in front of patients
- Patients should be addressed by Mr or Mrs/Ms/Miss (except for paediatric patients) unless they have given prior consent to be addressed by their given name
- If it is necessary to speak to a member of the surgical team during an operative procedure, it is essential that this is initiated through the scrub person
- Staff must be familiar with the trust values and demonstrate behaviour that is consistent with these. Any member of staff demonstrating behaviour that is not consistent with these values will be challenged and action taken if behaviour is not redressed

Compliance: 100%

Exceptions: None

References:

- RCHT Values & Behaviours

2.15. Endoscopy Unit standard No 15 - Use of Mobile Phones within the department

2.15.1. **Standard Statement:**The inappropriate use of mobile phones in the Endoscopy Unit is strictly prohibited.

2.15.2. **Method:**

- Staff must be familiar with the trust policy regarding the use of mobile phones in the hospital
- The use of RCHT mobile phones is restricted for essential and appropriate clinical communication only

- Personal phones must not be used except in exceptional circumstances
- Staff may use their personal mobile phones in the coffee room whilst on their designated breaks. Medical staff may use their personal telephones for essential Trust business use but taking of images is strictly forbidden with personal devices
- Mobile phones must be switched off or on silent mode in the procedure rooms. procedure rooms and consultation rooms
- Sending text messages and receiving calls whilst in the procedure rooms is strictly prohibited unless considered essential / critical to the current patient being operated on or if the surgeon is on call and unable to divert emergency calls whist operating
- Sending text messages and receiving calls whilst in clinical areas must be clinically indicated and for trust business and communications only
- The Trust accepts no responsibility for loss, damage to, or breakage of personal mobile phones.
- The use of picture phones, by any staff member or visitor, is strictly prohibited in clinical areas.

Compliance: 100%

Exceptions: None

2.16. Endoscopy Unit standard No 16 - Consent and refusal of consent

2.16.1. **Standard statement:** All staff should be familiar with the RCHT policy for consent to examination and treatment.

Any patient refusing or expressing concerns after giving consent must be allowed time to discuss the concerns fully before submitting to treatment. Concerns regarding consent must be brought to the attention of the senior doctor immediately.

Refer to:

- RCHT Consent to Examination or Treatment Policy

2.16.2. **Children and Consent**

Refer to:

- RCHT Consent to Examination or Treatment Policy

2.16.3. **Consent to photography and recording**

- Staff will ensure that prior to any photographs being taken or video equipment is used, the appropriate consent has been obtained from the patient

- Patients have the right to refuse permission for any photographs to be taken, or any video equipment to be used during their surgery

- It is essential that anyone wishing to use photographic, or video equipment has obtained the necessary permission from the patient prior to their use

- Any photographs taken of patients are the copyright of the Secretary of State for Health and may only be used subsequently if further permission is gained from the patient

- When outside agencies have been given permission to film or photograph within the operating department, staff should be reminded of their role in patient advocacy and standards of professional conduct

- Media personnel should not be permitted into the Perioperative Environment without the Trust Executive permission

- The use of personal devices for recording patient images is strictly forbidden

Compliance: 100%

Exceptions: Non

References:

- RCHT Recordings and Photography Policy
- RCHT Consent to Examination or Treatment Policy

2.17. Endoscopy Unit standard No 17 - Managing Accidents & Incidents

2.17.1. **Standard Statement:** All staff members are responsible for the identification and documentation of accidents and incidents within the department.
All staff will refer to the following RCHT policies on the reporting and management of incidents:

- Incident Reporting and Management Policy and Procedure

- Reporting of Injuries, Diseases and Dangerous Occurrences (RIDDOR) Policy

- Serious Incident management Policy and Procedure

- A Policy and Procedure for Being Open

2.17.1. **Method:**

All staff will receive training on the responsibilities of the employer and the employee in relation to health and safety, and be familiar with the following policies:

- Health and Safety and Environmental Policy (Introduction & Responsibilities for Health & Safety)
- Policy for Risk & Incident Management
- Serious Adverse Incident Policy & Procedure

2.17.2. All accidents to, or all incidents involving staff/and or equipment/ adverse incidents/breaches of protocol or any issues pertaining to patient care and the running of the theatre lists must be reported to the co-ordinator and a report completed via the trust incident reporting system

Compliance: 100%

Exceptions: None

References:

- RCHT Incident Reporting Policy

2.18. Endoscopy Unit standards No 18 – Visitors to the Endoscopy Unit

2.18.1. **Statement:** Staff will ensure that only visitors, who have obtained the relevant permission for definitive supportive and / or educational purposes, are present in the clinical area or procedure rooms.

2.18.2. **Method:**

- Patients have the right to confidentiality unless they have consented to have information divulged. Patients have the right to refuse the presence of visitors during their appointment
- The number of visitors permitted in the perioperative environment must be kept to a minimum
- All visitors must have gained appropriate consent prior to arrival
- All visitors must be provided with the appropriate apparel and instruction given as to their use
- All visitors must be clearly identified and wear an identity badge

- All visitors must be made aware that all procedures carried out within the perioperative environment are confidential in nature, and that any information, discussions, technical data, or documentation must be treated in confidence

- All visitors must be made aware of unit etiquette, and they should be introduced to all staff working in the area they will be attending

- It is essential that visitors be chaperoned at all times during their visit

- Visitors must be made aware of the procedure should they feel faint or unwell during their stay

- All medical, nursing, and technical personnel who are not employees of the trust but intend to participate in patient care during their visit, must have their professional qualifications verified prior to admission to the department

Compliance: 100%

Exceptions: None

2.19. Endoscopy Unit standard No 19 - Mandatory training

2.19.1. **Standard statement:** All staff to attend and take responsibility for their individual mandatory training needs.

2.19.2. **Method:**

Staff to take individual responsibility for keeping up to date with mandatory requirements.

Evidence can be provided for all training compliance in the following areas:

- COSHH
- FIRE
- BLS/ILS/PBLS
- Manual handling
- Infection control
- Health and safety
- Risk management
- Conflict resolution
- Information Governance

- Child Safeguarding (Level 1,2 and 3)
- WHO
- Human Factors

2.19.3. **Performance and Development Reviews**

All staff will have an annual Individual performance Appraisal (PDR) with their line manager where they will be able to identify individual learning and development needs.

The Endoscopy Unit Lead will collate data to inform the department annual training needs analysis, in order to support allocation of funding and planning of staff development.

Compliance: 100%

Exceptions: None

References:

- RCHT Mandatory Training Policy

2.20. Endoscopy Unit Standards No 20 - Expectant Mothers (Staff) Working in the Endoscopy Unit

2.20.1. **Standard Statement:** Expectant Mothers (Staff) Working in the Endoscopy Unit

2.20.2. **Duty of Employee:**

The Employee who is an expectant mother: as soon as is reasonably practicable, the employee has a duty to inform her line manager and the occupational health department. This must be confirmed in writing so that the line manager can make provision for maternity leave and arrange for a risk assessment to take place.

2.20.3. **Duty of employer:**

- The Endoscopy Unit Lead has a responsibility to ensure that potential hazards are assessed by a risk assessment for nursing staff and the Specialty Service Manager for Medical staff
- Ensure that all members of their staff have received information, instruction, and training appropriate to their job responsibilities
- Health and Safety Services: To provide advice and guidance to managers and individual employees on the health and safety aspects of hazards and risks associated with pregnancy and breastfeeding

- To liaise with managers across departmental boundaries in the provision of advice and guidance that may facilitate the resolution of any outstanding hazards/risks identified

- To monitor and audit the effectiveness of the policy and risk assessment system

- Occupational Health Department: To provide advice and guidance to employees on occupational health issues that they may encounter at work when a new, expectant or breast-feeding mother

2.20.4. **Management of Risk**

- Potential hazards for the expectant mother in the clinical environment must be assessed by a risk assessment. Once the risks are identified, a plan of action must be formulated to ensure that the expectant mother is not exposed to any unnecessary risks within the workplace. The action plan must be reviewed at regular intervals to ensure that the working environment is safe. This is a legal requirement (HMSO, 1994)

- If this is beyond the remit or authority of their managers/supervisors, they are to undertake the management of the task of risk elimination or reduction themselves or pass it onto an appropriate level of authority for implementation

- Up to date written records of all the risk assessments, action plans and reviews must be kept for the expectant mother

- All significant risks must be recorded onto the appropriate Risk Register, and this is kept up to date

- The risk assessment must be specific to the workplace environment where the expectant mother is required to work

- The risk assessment must identify any concerns about potential hazards to which the expectant mother may be exposed

- Advice should be obtained from the local Control of Substances Hazardous to Health (COSHH) advisor as this person will have a record of manufacturing safety data sheets

2.20.5. **Risk Assessment Guidance**

Explanations (Hazards)	Consider The Risk	Risk Avoidance
Violence & Aggression	Could the individual be exposed to clients/patients, even visitors that could cause physical harm to an expectant mother	Review/exposure working with violent & aggressive client groups. Consider work areas with alternative client groups.
Shocks, Vibration & Movement	Regular shocks, low frequency vibration or movement pose a risk of miscarriage.	Avoid whole body vibration work, or where the stomach is exposed to jolts.
Manual Handling (Where loads risk injury)	Hormonal changes make pregnant workers susceptible to injury and obviously as pregnancy progresses Posture/spaces/manoeuvrability become issues	Apply normal manual handling rules. Avoid lifting / mechanise / use handling aids. Assessment / Risk reduction / training. Reduce the amount of physical work and ensure it is within their capabilities
Driving	Arrest by seat belt/collision whilst driving a vehicle may cause injury to mother and unborn child.	Any concerns about the ability to drive, consult GP/Occupational Health
Noise	No specific risk - loud noise over prolonged periods may raise blood pressure.	Adhere with current legislation concerning noise.
Strong Smells	Nausea/discomfort	Report any unusual odours. Identify and remove if possible. Avoid exposure.
Ionising Radiation X-Ray Gamma Rays Alpha & Beta Particles	Large doses are harmful. Exposure limits set for course of pregnancy. Exposure risk/radioactive liquids/dusts for nursing mothers (especially skin Ingestion/inhalation risk to unborn child).	Comply with statute exposure rates for pregnant women. Avoid employment of nursing mothers in areas of high radioactive contamination. Safe systems of work to avoid
Non-Ionising Radiation Ultraviolet Infra-red	At no more risk than other workers. (N.B. Extreme overexposure to radio frequency radiation could raise body temperature).	Ensure exposure to electric and magnetic fields is within exposure limit.

Compliance: 100%

Expectations: None

References:

- RCHT Risk Management Policy

2.21. Endoscopy Unit Standard No 21 - Human Resource Management

Refer to:

- RCHT Disclosure and Barring Checks Policy
- RCHT Management of Corporate and Local Induction Policy
- RCHT Core Training Policy

2.21.2. Disclosure and Barring Service Checks

- All new Endoscopy Unit staff are required to have a current enhanced DBS check before commencing employment
- Staff transferring to new roles within the trust will also require enhanced DBS checks before commencing in post
- Staff are required to inform their line manager at the earliest opportunity of any cautions / convictions received during their employment. Each case will be considered individually and will not necessarily impact on any aspects of employment with the trust
- Registered staff are also required to inform their professional body

2.21.3. Grievance Procedures

- All staff have the right to raise any issue that they believe has adversely affected them and have it investigated
- Staff should speak to their line manage in the first instance or if this is not possible the Clinical Matron, Head of Nursing or HR team
- The trust has a number of Independent Listeners (freedom-to-speak-up Guardians) available who will support any member of staff contactable via switchboard
- RCHT Grievance and Disputes Policy and Procedure

2.21.4. Nurses and Registered Staff Responsibility

- All registered staff are responsible for maintaining their own professional registration.

- Registered nursing staff are required to revalidate every 3 years. Staff who allow their professional registration to expire will not be allowed to work in a registered capacity until proof of registration is received. Salary will be adjusted for the time they have been unregistered.

- RCHT Professional Registration Policy

2.21.5. **Whistle Blowing**

RCHT Raising Concerns In The Public Interest (Whistleblowing) Policy

2.21.6. **Complaints**

- RCHT Compliments, comments, concerns, and complaints (the 4C's) policy & related procedures

- All staff are encouraged to foster an open and honest culture and addressing where possible, any informal concerns and complaints at the earliest opportunity in order to avoid formal complaints

- All staff are responsible for seeking service user / patient feedback – this is obtained with the encouragement of Friends and family feedback and Care opinion

2.21.7. **Harassment and Bullying**

Dignity at Work Policy Procedure and Guidance

2.21.8. **Educational Support:**

Refer to:

- Management of Corporate and Local Induction Policy
- Core Training Policy
- Medical Devices Training Policy
- Preceptorship guidance and framework policy
- Induction All Staff: All newly appointed staff will receive a local induction / orientation program that facilitates their integration into the Endoscopy Unit Lead

- Induction Non-Substantive Staff: The Trust Policy: 'A policy for the induction of temporary workers' must be adhered to when new agency, bank or otherwise non substantive staff are employed by the Endoscopy Unit Lead and the supervising clinician

- The Endoscopy Unit Lead must ensure the allocation of staff to clinical duties must reflect a risk- managed mix of substantive (or familiar and experienced staff) and non-substantive staff

2.21.9. **Staff Competence in the Endoscopy Unit at RCHT**

- All staff in the Endoscopy Unit will be required to complete and maintain the relevant skills to their banding and clinical role.

- Individuals who have completed the relevant skills and competence to perform a task or role will be supported to do this following formal agreement and sign off by the Endoscopy Unit Lead. This will be in line with the registered/ unregistered banding framework.

- Achieving competence in a skill at a higher level will not guarantee a higher banded role. This can only be considered when suitable vacancy exists, and a fair and equitable recruitment process is followed.

- Any concerns regarding individual's competence will be addressed informally with the individual in the first instance. Appropriate training and development programs will be agreed and supported.

2.21.10. **Staff Responsibility:**

- The nurse must comply with the NMC Code

- Professional standards of practice and behaviour for nurses and midwives Preserve Safety: 13 Recognise and work within the limits of your competence

- The HCA must comply with the Skills for Health: Code of Conduct for Healthcare Support Workers and Adult Social Care Workers in England: 1. Be accountable by making sure you can answer for your actions or omissions

2.21.11. **RCHT Capability Policy and Procedure**

- It is not assumed that experienced staff have the skills or knowledge required when transferring to a new area of care. Careful assessment of basic skills and a period of orientation are essential before competence can be achieved

- Experienced staff (registered for more than one year) should be expected to undertake relevant and recognised courses on teaching and assessing in the clinical areas that will meet the needs of all learners in that area

- Assessors and candidates must be aware of the requirements of an individual assessment before it is undertaken. Reference

should be made to the assessment systems of individual courses

2.21.12. **Professional Development**

- All members of the workforce must receive regular updates and continuous the Endoscopy Unit Lead is responsible for ensuring staff have specific time rostered for regular updates and CPD activity, as identified through their clinical need/activity and yearly appraisal

- Staff are responsible for identifying gaps in their knowledge and skills, bringing this to the attention of the Endoscopy Unit Lead and working with them to seek a reasonable resolution

- Requests for supported development i.e., funding or time out of the clinical area must be supported by the individuals line manager and be in line with service need

- Requests must then be submitted to the Clinical Matron and then the HON for review and allocation of funding / time if deemed appropriate

- Time out of the clinical areas for learning will be allocated by the line managers and will support service need requirements, individuals should be aware that time out of the clinical areas cannot be guaranteed in all cases and may be cancelled at short notice to support service need and patient safety

- Degree courses are routinely supported 50/50 – 50% in employees time and 50% at trust time

- Individuals are encouraged to seek alternative routes for development i.e., secondment to other areas /shadowing. All requests should be made to the line manager who will endeavour to facilitate these requests whenever possible

Compliance: 100%

Exceptions: None

3. Monitoring compliance and effectiveness

Information Category	Detail of process and methodology for monitoring compliance
Element to be monitored	Practice compliance against all Procedure room practice standards will be monitored
Lead	Endoscopy Unit Lead
Tool	The revised Endoscopy Unit safety audit tool will be used to monitor compliance monthly. Each senior auditor will assess practice observed at each audit.
Frequency	The Endoscopy management team will audit 10 WHO observations of practice each month. The observations will be submitted to the Governance Lead for Specialist Services and Surgery by the 2nd of the following month for collation and reporting at the Care Group Huddle. Compliance with the Endoscopy WHO SSC will be reported monthly to the management team.
Reporting arrangements	At monthly governance meetings. Responses and actions agreed will be recorded in meeting minutes.
Acting on recommendations and Lead(s)	It will be the responsibility of the Head of Nursing to action any recommendations from the report and report back to General Manager.
Change in practice and lessons to be shared	This document consolidates and defines current practice, no changes to current practice are required. The documentation implementation will be led by the Endoscopy Unit Lead. All staff will have discussions on the local practice standards at yearly PDR and will complete yearly online WHO training. Any shortfalls by individuals identified will be dealt with by the appropriate manager in line with trust policy. Lessons learned will be shared with all stakeholders at Unit safety briefings and Specialist Services and Surgery meetings.

4. Equality and Diversity

4.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the 'Equality, Inclusion and Human Rights Policy' or the Equality and Diversity website.

4.2. Equality Impact Assessment

The Initial Equality Impact Assessment Screening Form is at Appendix 2.

Appendix 1. Governance Information

Information Category	Detailed Information
Document Title:	Endoscopy Unit Practice Standards Clinical Guideline V1.0
This document replaces (exact title of previous version):	New Document
Date Issued/Approved:	September 2022
Date Valid From:	November 2022
Date Valid To:	November 2025
Directorate / Department responsible (author/owner):	Chris Mitchell – Clinical Matron Specialist Services and Surgery
Contact details:	01872 253416
Brief summary of contents:	Defined standards expected within the Endoscopy Unit.
Suggested Keywords:	procedure rooms, surgical equipment, standards, clinical standards, clinical practice, unit, dermatology, clinic rooms, endoscopy
Target Audience:	RCHT: Yes CFT: No CIOS ICB: No
Executive Director responsible for Policy:	Chief Medical Officer
Approval route for consultation and ratification:	Care Group Governance Meeting, Medicine Practice Committee, Information Governance Group
General Manager confirming approval processes:	Roz Davies, General Manager for SS&S
Name of Governance Lead confirming approval by specialty and care group management meetings:	Maria Lane
Links to key external standards:	None required.
Related Documents:	None
Training Need Identified?	Yes – WHO training

Information Category	Detailed Information
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet and Intranet
Document Library Folder/Sub Folder:	Clinical Guideline

Version Control Table

Date	Version Number	Summary of Changes	Changes Made by
September 2022	V1.0	Initial issue	Chris Mitchell, Clinical Matron

All or part of this document can be released under the Freedom of Information Act 2000

This document is to be retained for 10 years from the date of expiry.
This document is only valid on the day of printing

Controlled Document

This document has been created following the Royal Cornwall Hospitals NHS Trust Policy for the Development and Management of Knowledge, Procedural and Web Documents (The Policy on Policies). It should not be altered in any way without the express permission of the author or their Line Manager.

Appendix 2. Equality Impact Assessment

Section 1: Equality Impact Assessment (EIA) Form

The EIA process allows the Trust to identify where a policy or service may have a negative impact on an individual or particular group of people.

For guidance please refer to the Equality Impact Assessment Policy (available from the document library) or contact the Equality, Diversity and Inclusion Team RCHT.inclusion@nhs.net

Information Category	Detailed Information
Name of the strategy / policy / proposal / service function to be assessed:	Endoscopy Unit Practice Standards Clinical Guideline V1.0
Directorate and service area:	Specialist Services and Surgery
Is this a new or existing Policy?	New
Name of individual completing EIA (Should be completed by an individual with a good understanding of the Service/Policy):	Chris Mitchell
Contact details:	01872 253416

Information Category	Detailed Information
1. Policy Aim - Who is the Policy aimed at? (The Policy is the Strategy, Policy, Proposal or Service Change to be assessed)	The aim of this policy is to outline the standards of care that must be delivered while caring for patients and managing the staff in the Endoscopy Unit.
2. Policy Objectives	To standardise care and practice To standardise expectations
3. Policy Intended Outcomes	Standardisation of care and practice Standardise expectations
4. How will you measure each outcome?	WHO audit Spot checking
5. Who is intended to benefit from the policy?	Patients and staff

Information Category	Detailed Information
6a. Who did you consult with? (Please select Yes or No for each category)	• Workforce: Yes • Patients/ visitors: No • Local groups/ system partners: No • External organisations: No • Other: No
6b. Please list the individuals/groups who have been consulted about this policy.	**Please record specific names of individuals/ groups:** Gastroenterology Team Hepatology Team
6c. What was the outcome of the consultation?	Approved
6d. Have you used any of the following to assist your assessment?	**National or local statistics, audits, activity reports, process maps, complaints, staff or patient surveys:** No

7. The Impact

Following consultation with key groups, has a negative impact been identified for any protected characteristic? Please note that a rationale is required for each one.

Where a negative impact is identified without rationale, the key groups will need to be consulted again.

Protected Characteristic	(Yes or No)	Rationale
Age	No	
Sex (male or female)	No	
Gender reassignment (Transgender, non-binary, gender fluid etc.)	No	
Race	No	
Disability (e.g. physical or cognitive impairment, mental health, long term conditions etc.)	No	
Religion or belief	No	
Marriage and civil partnership	No	

Protected Characteristic	(Yes or No)	Rationale
Pregnancy and maternity	No	
Sexual orientation (e.g., gay, straight, bisexual, lesbian etc.)	No	

A robust rationale must be in place for all protected characteristics. If a negative impact has been identified, please complete section 2. If no negative impact has been identified and if this is not a major service change, you can end the assessment here.

I am confident that section 2 of this EIA does not need completing as there are no highlighted risks of negative impact occurring because of this policy.

Name of person confirming result of initial impact assessment: Chris Mitchell, Clinical Matron

If a negative impact has been identified above OR this is a major service change, you will need to complete section 2 of the EIA form available here:
Section 2. Full Equality Analysis