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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 theatre staff must be able to demonstrate the ability to audit care and theatre 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 a high quality of care is provided to patients entering all Trust Operating Theatres.

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

   1.3.1. All staff in the division 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.

2. **Clinical Responsibilities**

   - NMC The code: Standards of conduct, performance and ethics for nurses and midwives
   - HCPC Standards of conduct, performance and ethics; Standards of proficiency - Operating department practitioners
   - Claims Management Policy Valid From: 22/05/2012 - To: 22/05/2015
   - Supporting Staff Involved In An Incident Complaint Or Claim Valid From: 20/06/2011 - To: 01/06/2014

3. **Objectives**

   - To ensure that a standard of care is delivered to each individual that is equitable and fair.
   - To identify the standards of care to be delivered to patients through all the areas within the operating theatres i.e. anaesthetic room, Operating Theatres and the Post Anaesthetic Care Unit.
   - To enable auditing of theatre practice and patient care throughout all areas.
   - To ensure all staff are aware of standards of care to be delivered to patients whilst in the Operating Department.
   - To provide information to all staff of the departments expectation of the standards of care to be delivered to all patients.

4. **Scope**

4.1. These standards of care will apply to all Operating Theatres across Royal Cornwall Hospital Trust sites.

4.2. All new members of staff will receive an electronic copy of the standards applicable to the area they will work in. All staff will be able to access the care standards via desktops in operating departments.
5. **The Guidance**

The guidance is contained in the following sections as detailed in the table of contents.

6. **Monitoring compliance and effectiveness**

6.1. Practice against the set standards will be reviewed monthly for all theatre suites and reported at the Clinical Matron meeting.

6.2. Overall performance against the standards will be included in the interdivisional Performance Assurance Framework with overview and exceptions tabled at monthly Divisional Governance Management Meeting.

<table>
<thead>
<tr>
<th>Element to be monitored</th>
<th>Practice compliance against all practice standards will be monitored</th>
</tr>
</thead>
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<tr>
<td>Lead</td>
<td>Theatre Manager / Deputy Managers</td>
</tr>
<tr>
<td>Tool</td>
<td>The revised theatre safety audit tool will be used to monitor compliance monthly. Each senior auditor will assess practice observed at each audit. Attach the tool to the policy or no one will know what you are monitoring.</td>
</tr>
<tr>
<td>Frequency</td>
<td>Each member of the theatre senior team will audit 10 observations of practice each month. The observations will be submitted to the Divisional Nurse by the 2nd of the following month for collation and reporting at Theatre Management Group. Compliance with the WHO SSC standard 16 will be reported monthly to TMG and TMCG.</td>
</tr>
<tr>
<td>Reporting arrangements</td>
<td>DGMM monthly, TMG monthly, TMCG monthly. Responses and actions agreed will be recorded in meeting minutes.</td>
</tr>
<tr>
<td>Acting on recommendations and Lead(s)</td>
<td>It will be the responsibility of the Divisional Nurse to action any recommendations from the report and report back to DGMM, TMG on outcomes.</td>
</tr>
<tr>
<td>Change in practice and lessons to be shared</td>
<td>This document consolidates and defines current practice, no changes to current practice are required. The documentation implementation will be led by the theatre managers in each area. All staff will have discussions on the local practice standards at yearly IPR. 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 theatre safety briefings and theatre managers meeting.</td>
</tr>
</tbody>
</table>

7. **Equality and Diversity**

7.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the ‘Equality, Diversity & Human Rights Policy’ or the Equality and Diversity website.

7.2. **Equality Impact Assessment**

The Initial Equality Impact Assessment Screening Form is at Appendix 2.
Section 1 - Practice

Generic Theatre Standard No 01 - Preparation of personnel within the perioperative environment.

Standard Statement: All member of staff working within the theatre environment should present a professional appearance and conduct themselves in a professional manner at all times.

- Trust Dress Code and Uniform Policy

Perioperative Uniform

1. **Theatre 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 either to change at work, or to cover their uniforms as they travel to and from workplaces.
- 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 times.

- All theatre personnel who enter the restricted/semi-restricted area of the operating department 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.
- Theatre clothes consist of a two piece trouser suit. These clothes are provided freshly laundered and should be checked that they are in good condition.
- Clean theatre clothing should be protected from contamination during transfer and storage.
- Technique to don theatre attire.
  - Remove outer clothing and jewellery.
- Wash hands.
- Place cap/hood over hair.
- Don the freshly laundered scrub suit.
- Put on clean theatre footwear

**Hands must be washed before and after donning theatre attire.**

- When in the perioperative environment, Trust ID Badges must be kept on the individual at all times. If the ID badge is held 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 must be washed regularly.
- Theatre attire must be removed when it becomes wet or soiled, and placed into containers specially designed 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.
- Theatre attire must be removed, before leaving the theatre environment, and placed into clear plastic clinical laundry bag.

**Cover gowns/laboratory coats**

- All staff must change into their outdoor clothes before leaving the theatre environment no go to the Canteen, hospital shops, Knowledge Spa or other similar public places.
- Fresh, clean attire must be donned on return to the theatre department. Used theatre attire must not be stored in lockers for further use.
- Staff are permitted to wear theatre attire in urgent and emergency situations, when required to travel between clinical operating theatre sites, providing their theatre attire is fully covered by clean cover gown/laboratory coat, fully fastened up.

**Laundering of Theatre Attire**

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

**Headwear**

- All head and facial hair should be covered completely by a head cover/cap. Disposable headwear is single-use, surgical headwear. Its function is to securely contain the hair and thereby prevent hair and skin particles from contaminating the patient.
- Can be a surgical hood, theatre cap: elastic or tied.
- Headwear should be donned prior to donning the scrub suit.
- Headwear should be changed daily, unless it becomes soiled, when it should be changed immediately.
- Headwear should always be worn in laminar flow theatres during prosthetic implant operations.
**Jewellery**
- All jewellery should be removed.
- Jewellery must be limited to a smooth wedding band only. Facial piercings are not permitted.
- No visible body jewellery to be worn. This includes ear jewellery not worn in the ear lobe, nose rings, tongue studs and other visible piercing.
- All staff must be ‘bare below the elbow’ when in the clinical environment.

**Finger Nails**
- Fingernails must be clean, short and free from nail varnish.
- False finger nails, including acrylic or gel coated or fibreglass 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 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.
- Footwear should not be left in a contaminated state or on changing room floors.

**Masks**
- Facemasks must be worn by the surgical team during sterile procedures
  - In Orthopaedic and Trauma theatres all staff within the operating theatre will wear facemasks.
- Protective face shields must be worn whenever activities place personnel at risk of splashes or aerosol contamination.
- Masks must cover the nose and mouth, fitting the contour of the face and must be tied securely. They must be changed between patients.
- The mask should not be touched once applied. A used mask must be handled by the tapes only.
- Used masks must be discarded into a yellow clinical waste bag for disposal after each case, or if soiled.
- 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 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.

2. **Patient Attire**

• Patients in preparation for surgery must wear suitable clothing

• Patients will be supplied with disposable underwear to maintain privacy and dignity

• Patient gowns should be correctly fitting to enable them to be securely closed at the rear to maintain privacy and dignity

• Patients who walk to theatre must be allowed to wear their own dressing gown over the patient gown and if they do not have their own gown they must be provided with a disposable gown to cover the patient gown during the transfer

• Patients must wear appropriate footwear during walking transfers to theatre to maintain safety.

• Patients undergoing procedures which do not require them to change out of their own clothes e.g ophthalmic procedures must have their own clothing protected during the procedure.

3. **Visitors to the perioperative environment**

All theatres must have available a copy of the RCHT Protocol: Perioperative Uniform, stating the correct preparation for staff and visitors entering and leaving all areas of the perioperative environment. Staff/visitors other healthcare professionals must be made aware of these policies and procedures.

• Relatives (in particular, parents) Relatives supporting patients in the anaesthetic rooms or recovery can enter the department without changing.

• Students (from various health professions) Must comply with trust policy on uniform in the operating department

• Visiting professionals (surgeons etc) Must comply with trust policy on uniform in the operating department

• Allied health professionals (lab technicians, maintenance workers etc) Must comply with trust policy on uniform in the operating department

• Medical device representatives. Must comply with trust policy on uniform in the operating department if entering the clinical area

• **All individuals entering the Trelawney Theatre Suite who require passage past the reception area must change into theatre attire.**

Compliance: 100%

Exceptions: Nil

**References:**

R.C.H. Uniform Policy

R.C.H. Trust Infection Control Precautions Policy

AfPP Principles of Safe Practice within the Perioperative Environment 2011
**Generic Theatre Standard No 02 - Operating Theatre Record Keeping and Documentation at RCHT**

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

**Policy On Clinical Record Keeping on document**

1. **General Considerations**
   
   - Under the Public Records Act 1958 (National Archives, 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):
     
     o **Factual, consistent and accurate**
     
     o **Recorded/written as soon as possible after the event has occurred, providing current information on the care and condition of the patient**
     
     o **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**
     
     o **Not include abbreviations, jargon, meaningless phrases, and irrelevant speculation**
     
     o **If written, recorded in black ink only so that photocopies are readable**
     
   - Records made in the operating theatre must adhere to the General Caldicott Principles (HSC, 1998) on confidentiality:
     
     o **Justify the purpose(s)**
     
     o **Don’t use patient-identifiable information unless it is absolutely necessary**
     
     o **Use the minimum necessary patient identifiable information**
     
     o **Access to patient-identifiable information should be on a strict need-to-know basis**
     
     o **Everyone with access to patient-identifiable information should be aware of his or her responsibilities.**
     
     o **Understand and comply with the law**
     
   - All entries into the health record, including amendments, should be clearly dated, timed, signed and the designation of the person making the entry should be clearly recorded.
   
   - The Theatre Manager 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.

2. **Perioperative Documentation**
   
   - The Perioperative documentation pack is a record that begins with the preoperative phase and continues into the intra and post-operative phases and provides a
comprehensive record of the patient’s time in the perioperative environment and will record:

- Patient details
- Planned procedure
- Checks prior to leaving the ward
- Checks by the receiving theatre
- Preoperative checks
- Handover from admission team to theatre team
- Blood ordering schedule
- WHO Surgical Safety Checklist
- Patient care in theatre
- Tracking Labels
- Prostheses
- Operation details
- Post-operative instructions
- Recovery handover
- Recovery details
- Handover from Recovery team to Ward Team
- Daycase discharge checklist

3. **Theatre Register**

   - The theatre register will record:
     - Procedures which were undertaken (both surgical and the type of anaesthetic)
     - The names of surgeon and anaesthetist and a list of support staff
     - The name of the scrub and circulating practitioner
     - The time each patient entered and left theatre
     - The patient’s name, date of birth, sex, NHS number, scrub and circulating practitioner, implanted materials and any untoward incidents
     - Details of any implants
     - Details of untoward events

4. **Swab Instrument and Needle Count**

   - The Swab instrument, needle and sharps count record must be made in the Theatre Register, electronically and in the patient’s record.

5. **Recording of implant/prosthesis**

   - A prosthesis used for hip of knee surgery should be recorded in accordance with the National Joint Registry (NJR) guidelines and the Consumer Protection Act (SI, 1987).

   - Information recorded will include:
     - Manufacturer
     - Product source
6. **Surgical Instruments**

   o 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.

   o 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 DATIX.

   o The instrument checklist must record the name of the scrub practitioner and the second checker and identify the patient through their NHS number only.

7. **Patient-level Resource Management (PRM)**

   o PRM is a stock control management system capturing usage and cost of consumable products at patient level. It also allows for tracking of products.

   o Members of Staff are required to record product usage against the Patients NHS number to capture the product costs against any procedure.

   o Accurate recording is essential, including serial numbers and expiry dates of any implanted products.

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

   o 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).

9. **Processing Endoscopes**

   o The following must be documented:
      
      o **Date and time the solution was activated**
      o **Solution lot number**
      o **Expiry date of the solution**
o Name of the person who activated the solution
o Age of the activated solution
o Scopes processed
o Duration of Processing Person responsible for processing
o Identity of the patient on whom the scope was used

10. **Equipment Related Records**

o Theatre practitioners will maintain records that relate to equipment used in the operating theatre. 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

o 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).

o There will be documentation to demonstrate that staff have been adequately trained and authorized in the use of equipment and medical devices.

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

o Please read Incident and Serious Incident Policy.

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

o When electrosurgical equipment is used, a record will be made in the patient’s perioperative care plan of the settings and serial number of the unit. This will safeguard the user in the situation where a patient may inadvertently experience an electrosurgical burn.

13. **Surgical Antiseptic Skin Preparation Solutions**

o The 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.

14. **Positioning of the Patient**
A record will be made of the positioning of the patient, including pressure-relieving devices in the patient’s perioperative care plan. Inadvertent nerve damage and pressure sores are a common source of litigation (AfPP, 2007).

15. **Admission and Labelling Procedure**
   - Please read RCHT Positive Identification Policy and Procedure

16. **The Procedure List**
   - The clinician undertaking the procedure must take responsibility for compilation of the procedure list in a recognised printed format; alternatively by designating a member of their team (AfPP 2006).

17. **The list should include:**

| o | Surname, forename, NHS number, date of birth of the patient |
| o | Ward |
| o | Procedure |
| o | Type of anaesthetic |
| o | Surgeon |
| o | Anaesthetist |
| o | Theatre number |
| o | Start time |

- Abbreviations must not be used. To avoid ambiguity about the digit on which the operation is to be performed, fingers should be described as: thumb, index, middle, ring and little. Toes should be described as halux (or big), second, third, fourth and fifth (or little).
**Generic Theatre Standard No 03 - Disposing of Confidential Information in the theatre department.**

**Standard Statement:** Theatre practitioners must protect and dispose of any confidential information, concerning patients that is generated for each theatre.

**Method:**

- Each operating list must be removed and disposed of in an appropriate manner. i.e. in the purpose built sealed confidential paper bin or by shredding.
- Operating lists for the following day must be left face down and placed in a discreet place.
- Notes/ X-rays remaining which pertain to patients must be removed and delivered to the appropriate area.
- Record books must be closed at the end of each shift.
- Galaxy sessions must be logged off and each computer must be closed down when the theatre is no longer in use.
- Paper containing any patient details must not be reused as scrap paper.

Compliance: 100%

Exceptions: None

**References:**

AfPP Principles of Safe Practice in the Perioperative Environment 2011

RCH Trust Policy Destruction of Confidential Waste
Generic Theatre Standard No 04 - Infection control in the Operating Department

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

Standard Precautions in the Operating Department

1. Management considerations

2. 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

3. Accidental exposure/sharps injury/conjunctiva/mucous membrane splash

4. Waste disposal

The documents below relate to the above:

Infection prevention and control - roles and responsibilities policy
Standard infection prevention and control precautions policy including Hand Hygiene and Safe Handling and Disposal of Sharps
Decontamination Policy

The Environment

Cleaning Policy

1. Theatre Traffic
   - The layout of the perioperative department is designed to minimise, restrict or contain bacteria and viral pathogens. In addition, theatre traffic should be kept to a minimum. The purpose of controlling theatre traffic (movement within theatre) is to minimise the movement of bacteria from the theatre environment itself, theatre personnel and patients.

Unrestricted areas

Traffic is not limited within the department; these areas include theatre reception areas. At all times theatre department access is restricted by swipe card. Theatre entrance doors must remain closed at all times when access / egress are not being undertaken.

Please note – all individuals unless in case of emergency who require access to Trelawney theatres beyond the reception point are required to be in full theatre attire.

Semi-restricted areas – Traffic is limited to authorised, correctly attired personnel and patients
Restricted areas – Traffic is very limited and personnel must be correctly attired. This includes the operating theatre

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

- There should be a restriction on movement and talking within the operating theatre.

- All doors to the operating theatre must remain closed to ensure effective ventilation of the area. As far as possible all potential equipment and supplies for the proposed clinical procedure and/or list should be available in theatre prior to a clinical procedure commencing. This will then reduce the traffic in and out of theatre and therefore maximise the efficiency of the ventilation system.

2. Environment cleaning

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

- The Theatre Manager should maintain records of cleaning schedules, daily weekly monthly and 6 monthly deep cleans, which detail the standards of cleanliness required in each part of the theatre premises including items and equipment, and that a schedule of cleaning frequency is available on request. Work schedules must be displayed in particular work areas.

- Example of Environmental Theatre Cleaning schedule (further guidance from the Revised Healthcare Cleaning Manual (2009) on setting up schedules etc.):
<table>
<thead>
<tr>
<th>Example of Environmental Theatre Cleaning Schedule</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Anaesthetic rooms</strong></td>
</tr>
<tr>
<td>Clean and restock shelves, drawers and cupboards, check all product expiry dates</td>
</tr>
<tr>
<td>Clean and restock drug cupboards, check all expiry dates</td>
</tr>
<tr>
<td>Clean and check Anaesthetic machines and monitoring equipment</td>
</tr>
<tr>
<td>Clean and restock airway management and regional anaesthesia trolleys</td>
</tr>
<tr>
<td>Clean and check hot lines</td>
</tr>
<tr>
<td>Clean and check Bair huggers</td>
</tr>
<tr>
<td>Defrost drug fridge monthly</td>
</tr>
<tr>
<td>Clean and check operating table and all table attachments</td>
</tr>
<tr>
<td><strong>Theatres</strong></td>
</tr>
<tr>
<td>Clean and restock shelves and cupboards in Prep rooms</td>
</tr>
<tr>
<td>Clean and restock fluid warming cabinet</td>
</tr>
<tr>
<td>Check expiry dates of trays and separately wrapped items in each prep room</td>
</tr>
<tr>
<td>Check soft packed items for sterility and expiry dates</td>
</tr>
<tr>
<td>Clean and restock sluice cupboards and shelves</td>
</tr>
<tr>
<td>Clean and restock Theatre Gratnell trolley</td>
</tr>
<tr>
<td>Clean and restock theatre scrub areas</td>
</tr>
<tr>
<td>Clean soap dispensers</td>
</tr>
<tr>
<td><strong>Other</strong></td>
</tr>
<tr>
<td>Clean and check difficult intubation trolley</td>
</tr>
<tr>
<td>Clean and check trauma table attachments</td>
</tr>
<tr>
<td>Clean and check lead protection gowns</td>
</tr>
<tr>
<td>Clean and restock plaster trolley</td>
</tr>
<tr>
<td>Check trauma implants for sterility and expiry dates</td>
</tr>
<tr>
<td>Clean and check stacking systems</td>
</tr>
<tr>
<td>Clean and check other ENT &amp; General electric/ power equipment</td>
</tr>
</tbody>
</table>
The Theatre Manager 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 they are responsible for is conducted according to the recommendations in the Revised Healthcare Cleaning Manual (NPSA, 2009).
- Must agree with the Estates Department that ensures regular programme of maintenance to the Theatre Environment.
- Ensure that the Estates department responds to requests for repair to the structure of the theatres in a timely manner and/or pursue where response has been overlooked.
- Maintain a transparent process for theatre 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 perioperative 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 team leader, deputy or theatre manager must undertake a visual audit of the environment for cleanliness before the commencement of the operating list and take action where appropriate. Results of this audit must be kept and available for audit.

- Disposable gloves must be worn for all cleaning tasks.
- Cleaning of the perioperative clinical environment (anaesthetic room, prep room, scrub up and theatre) must take place via a ‘top to bottom’, ‘out to in’ method.
- Damp Cleaning of the perioperative ledges and shelves (anaesthetic room, prep room, scrub up and theatre) will take place prior to every surgical session, if the theatre has remained dormant for longer than 4 hours.
- 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.

3. **Between case cleaning procedures**

- Surfaces that receive direct patient contact e.g. operating tables, other furniture and instruments must be cleaned in accordance with the RCHT Decontamination policy.
- Clinical waste, laundry and instruments must be disposed of according to the RCHT Generic Waste Management Policy.
• Mattresses that are torn or damaged in any way must be repaired immediately (not taped) in order to prevent contamination with blood or other body fluids and potential pathogens. If this is not practical the mattress should be decommissioned, removed from circulation and disposed of in accordance with the RCHT Generic Waste Management Policy

4. Terminal Daily Cleaning Procedures

• All equipment should be cleaned and all portable equipment removed from the theatre following cleaning.

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

• Scrub sinks in scrub areas 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.

• Suture storage boxes should be wiped with detergent and water and dried before being replaced on the shelves.

5. 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 (ie: upward facing surfaces, including windowsill which must be kept free from clutter).

• Walls must not be allowed to become visibly dirty, and washing at least every 6 months is recommended by the Hospital Infection Society (2002).

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

• For other surfaces, normal housekeeping methods are adequate (eg: daily damp cleaning of ledges and shelves)

• Floors of the operating room should be disinfected at the end of each session and be scrubbed daily. 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.

• Before equipment is brought into the operating theatre, it must be inspected for dust and cleaned in accordance with 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 perioperative environment must be monitored and maintained at 20°C - 22°C and humidity between 50% - 60% to help suppress bacterial growth.
• Only the number of personnel required to manage the proposed clinical procedure safely should be present in the operating theatre.

• There should be a restriction on movement and talking within the operating theatre.

• All doors to the operating theatre must remain closed to ensure effective ventilation of the area. As far as possible all potential equipment and supplies for the proposed clinical procedure and/or list should be available in theatre prior to a clinical procedure commencing. This will then reduce the traffic in and out of theatre and therefore maximise the efficiency of the ventilation system.

• Problems with the structure of the theatre environment e.g. areas of wall with peeling paint, must be reported to the theatre manager for repair.

• Storage of cardboard boxes in the prep room/anaesthetic room must be discouraged as cardboard cannot be cleaned effectively.

• Open containers used to keep items tidy e.g. suture boxes (when not containing sutures), Lin Bins, plastic trays, boxes etc. must be recorded on the cleaning schedule and emptied of contents, cleaned and replaced, monthly.

• Where items are stored in plastic boxes drawers etc. routinely, in anaesthetic room, scrub up, prep room, 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. Gratnell, must be cleaned, including removing the contents from the drawers/Lin Bins.

• The Team Leader should undertake a visual audit of the environment for cleanliness before the commencement of the operating list and action taken where appropriate.

6. **Cleaning Equipment and Materials**

• Before equipment is brought into the operating theatre it should be inspected for dust and cleaned.

6.1. **Floor scrubbing machines**

• Cleaning machines should be decontaminated and stored according to [RCHT Decontamination Policy](#).

• Floor-scrubbing machines have detergent reservoirs that should be cleaned regularly. The brushes and pads of scrubbing machines are detachable and should be removed and thoroughly washed and dried after each use.

• Brushes and pads used in the operating theatres should be autoclaved at least weekly. It is preferable if each theatre has its own brushes and pads.

6.2. **Mops**

• A clean mop must be used in each theatre every day.

• Mops should be washed in detergent after each use during the day.
- Mop heads should be laundered daily in accordance with the RCHT Decontamination Policy
- Mop buckets for spillage should be emptied, washed and dried and stored inverted after each use and kept dry until the next occasion when they are required.
- Storage and transportation of used mop heads must be undertaken in accordance with the RCHT Decontamination Policy.

6.3. 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.

7. Spillage of Blood & Body Fluids extracted from the RCHT Decontamination Policy

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>The spill should be dealt with as soon as possible.</td>
</tr>
<tr>
<td>b.</td>
<td>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.</td>
</tr>
<tr>
<td>c.</td>
<td>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.</td>
</tr>
<tr>
<td>d.</td>
<td>Where the spillage may contain sharp material, forceps should be used to remove the sharp material, placing it immediately in a sharps bin.</td>
</tr>
<tr>
<td>e.</td>
<td>If the spillage is large, soak up the excess fluid using paper towels and carefully place these in a clinical waste bag.</td>
</tr>
<tr>
<td>f.</td>
<td>Clean surface with warm water and detergent using a disposable cloth or mop.</td>
</tr>
<tr>
<td>g.</td>
<td>If the spill is on a carpeted area this should be disinfected following cleaning using a steam cleaner or wet extract carpet shampooer.</td>
</tr>
<tr>
<td>h.</td>
<td>Curtains or loose fabric covers should be laundered or dry cleaned.</td>
</tr>
</tbody>
</table>
Generic Theatre Standard No 05 - Aseptic Technique (ANTT) - Aseptic Technique in the Operating Department

Standard Statement: All Theatre 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.

5.1. General considerations
- Perioperative staff with infected lesions of the skin or bacterial infections of the upper respiratory system should not participate in any aseptic technique.
- Staff must be aware of differences between sterile items and non-sterile items and share responsibility for monitoring aseptic practice.
- 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 operating theatre environment are expected to act as role models, demonstrating positive behaviours that actively promote best practice for infection prevention and control procedures in the operating theatre environment.
- A ‘zero’ tolerance for breaches to practice for infection prevention and control procedures in the operating theatre environment must be fostered.

5.2. 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 non sterile areas. Once placed, drapes must not be repositioned to avoid contamination of the sterile field.

5.3. Scrubbed personnel
- Staff participating in an aseptic technique should present themselves as recommended in GTS 01 Perioperative Uniform and 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 operating theatre 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 operative 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.

5.4. Special Considerations

• Dressings must be removed carefully from the wound to prevent scattering of microorganisms into the air. It is recommended that this is carried out by an assistant wearing gloves rather than a scrubbed member of the surgical team. Used and soiled dressings should be discarded immediately and in accordance with RCHT Generic Waste Management Policy.

• To reduce the risk of airborne cross infection, talking, movement, opening and closing doors, exposure of wounds, disturbance of clothing and linen, and number of personnel in the theatre must be kept to a minimum. Special consideration must be taken to maintain the integrity of the sterile field at all times.

• The sterile field should be constantly monitored and maintained, as sterility cannot be assured without direct observation of the sterile field. Any break in sterility must be reported and acted on to ensure patient safety.

• Laying up of instruments in a theatre with an ultra-clean ventilation system should be done entirely under the canopy wherever possible.

5.5. Trolley

• Scrubbed personnel must move draped sterile trolleys by placing hands on the horizontal surfaces only.

• 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 items must be presented to the scrubbed person or placed securely on a specific area of the sterile field identified and managed by the scrubbed person. Items must not be tossed on to the sterile field as they may roll off or cause other items to be displaced.

• Sharps and heavy items must be presented to the scrubbed person to avoid penetration of the sterile field.

• When dispensing solutions, the solution vessel must be placed near the trolley edge or held by the scrubbed person. The solution must be poured slowly to avoid splashing which could cause strike-through and compromise the sterile field.
- 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.
- Preparation of sterile trolleys in advance is not recommended, 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.

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 surgery
  - 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
RCH Trust Decontamination Policy
RCHT Cleaning Policy
Generic theatre Standard 01
Generic Theatre Standard No 06 - Management of Patients with known Infections or carriers of Infectious Agents

Standard Statement: All Theatre staff will have knowledge of the requirements for caring for patients with known Infections or carriers of Infectious Agents in the operating department to protect self, colleagues and patients from the risk of health care acquired infection.

General considerations

- **Training** all staff involved in the care of the patient must be aware of the specific precautions and have received adequate training.

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

- **Communication** is absolutely essential prior to handover, so the next healthcare team have the ability to instigate isolation procedures, as necessary.

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

- **In order to limit accidental exposure** good theatre 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 surgery taking place in the theatre. Standard precautions must be adhered to. The theatre 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.

- **Recovery PACU** Known infectious patients do not always need to be recovered in theatre. Safety gel, granules/sachets to be used when transporting possibly infected fluids, e.g. urine from the bay to the sluice. Appropriate communication with the recovery team must occur to ensure that they are informed of the patient’s status. The recovery bay and all equipment must be cleaned following transfer to the ward. Recovery staff must ensure that the receiving ward is fully aware of infectious status, in a timely manner to allow the receiving ward to make any necessary arrangements.

- **Waste** Contaminated PPE and clinical waste disposed 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.

Please see individual standards for or specific guidance on

- Staff risk
- Patient position on list schedule
- Hand Hygiene
- Personal Protective Equipment (PPE)
- Environment/equipment cleaning
- Recovery PACU instructions

Quick-view chart on list position and recovery placement for each infectious agent can be seen below.

Compliance: 100%
Exceptions: None
### Quick-view chart on list position and recovery placement for each infectious agent

<table>
<thead>
<tr>
<th>Infection</th>
<th>Place on List</th>
<th>Recovery</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Clostridium difficile C. diff. and GDH</strong></td>
<td>Symptom free in last 72 hours&lt;br&gt;DO NOT NEED to be last on list</td>
<td>Symptom free in last 72 hours&lt;br&gt;DO NOT NEED to be recovered in theatre</td>
</tr>
<tr>
<td></td>
<td>Symptoms present in last 72 hours&lt;br&gt;Consider either allowing sufficient time between patients to clean AND recover OR placing patient&lt;br&gt;LAST ON LIST</td>
<td>Symptoms present in last 72 hours&lt;br&gt;SHOULD BE recovered in theatre</td>
</tr>
<tr>
<td><strong>Creutzfelt-Jacob Disease (CJD)</strong></td>
<td>SHOULD BE placed at the end of the list where possible</td>
<td>DO NOT NEED to be recovered in theatre</td>
</tr>
<tr>
<td><strong>Extended-spectrum beta-lactamases (ESBLs) and Amp C</strong></td>
<td>Diarrhoea symptom free in last 72 hours&lt;br&gt;DO NOT NEED to be last on list</td>
<td>Symptom free in last 72 hours&lt;br&gt;DO NOT NEED to be recovered in theatre</td>
</tr>
<tr>
<td></td>
<td>Symptoms present in last 72 hours&lt;br&gt;Consider either allowing sufficient time between patients to clean AND recover OR placing patient&lt;br&gt;LAST ON LIST</td>
<td>Known ESBL patients SHOULD NOT BE RECOVERED NEXT TO a patient at high risk of contracting ESBL (for definitions please see the RCHT ESBL Policy).</td>
</tr>
<tr>
<td><strong>Glycopeptide Resistant Enterococci (GRE)</strong></td>
<td>Diarrhoea symptom free in last 72 hours&lt;br&gt;DO NOT NEED to be last on list</td>
<td>Symptom free in last 72 hours&lt;br&gt;DO NOT NEED to be recovered in theatre</td>
</tr>
<tr>
<td></td>
<td>Symptoms present in last 72 hours&lt;br&gt;Consider either allowing sufficient time between patients to clean AND recover OR placing patient&lt;br&gt;LAST ON LIST</td>
<td>Known GRE patients SHOULD NOT BE RECOVERED NEXT TO a patient at high risk of contracting GRE (for definitions please see the RCHT GRE Policy).</td>
</tr>
<tr>
<td><strong>MRSA</strong></td>
<td>DO NOT NEED to be last on list</td>
<td>DO NOT NEED to be recovered in theatre</td>
</tr>
<tr>
<td><strong>Norovirus</strong></td>
<td>SHOULD BE placed at the end of the list where possible</td>
<td>SHOULD BE recovered in theatre</td>
</tr>
<tr>
<td><strong>TB</strong></td>
<td>DO NOT NEED to be last on list</td>
<td>DO NOT NEED to be recovered in theatre</td>
</tr>
<tr>
<td><strong>Patients with Diarrhoea</strong></td>
<td></td>
<td>If infection is suspected, these patients SHOULD BE recovered in theatre</td>
</tr>
</tbody>
</table>
**Generic Theatre Standard No 06A - Management of Patients with Known Clostridium difficile and GDH in the Operating Department**

**Standard Statement:** All Theatre staff will have knowledge of the requirements for caring for patients with Clostridium difficile in the operating department to protect self, colleagues and patients from the risk of health care acquired infection.

The bacterium produces two potent toxins that cause mucosal damage and inflammation of the large bowel. Although in most cases it causes a relatively mild illness, occasionally, particularly elderly patients may develop a severe form of the disease called ‘pseudomembranous colitis’. This condition is characterised by significant damage to the large bowel, and may lead to gross dilation with possible rupture or perforation of the bowel.

*C.difficile* infection is often acquired in hospital, and almost all patients who develop *C.difficile* diarrhoea are taking, or have recently been given antibiotic therapy. Nearly all antibiotics have been causally associated with *C.difficile* however, some such as cephalosporins, (particularly oral cephalosporins) and antibiotic combinations such as cefuroxime and clarithromycin are more strongly associated whereas gentamicin, vancomycin, and trimethoprim are much less often associated.

It has been firmly established that person to person transmission can occur in the hospital setting and indeed major outbreaks have resulted. Staff hands are the most important mode of transmission, but studies have also demonstrated that *C.difficile*, as a spore forming organism, can survive for long periods of time in the environment and on contaminated equipment.

The sensible use of antibiotics is the key to the prevention of *C.difficile* infection. Unnecessary use of antibiotics must be avoided. Where possible, short courses of narrow-spectrum antibiotics, of only three to five days, are preferred to longer courses. All antibiotic prescriptions should be kept under review.

Trust antimicrobial prescribing guidance must be followed. Antimicrobial prescribing audits will be conducted regularly.

**General Considerations**

**RCHT C.Diff Prevention and management of Clostridium difficile infection policy**

**RCHT Generic Theatre Standards 4: Infection Control in the Operating Theatre**

- **Staff** very rarely suffer from symptoms related to *C.difficile*. However, should staff be receiving antibiotics then they may be at some risk of infection, and therefore should avoid contact with known cases of *C.difficile* infection.

- **Position on list** Symptom free in last 72 hours: DO NOT NEED to be last on list. Symptoms present in last 72 hour: Consider either allowing sufficient time between patients to allow staff to robustly clean, without pressure, using Actichlor Plus AND recover OR placing patient LAST ON LIST

- **Hand Hygiene** Staff hands are the most important mode of transmission from patient to patient. Soap and water must be used for hand hygiene rather than alcohol rub - soap and water is far more effective. Decontaminate hands following Ayliffe’s seven step technique (*RCHT ANTT Policy*). Patients must also be encouraged to wash their hands. If the patient is bed bound, patient wet wipes should be offered for hand hygiene as an alternative to soap and water.

- **PPE** Gloves and aprons must be worn for direct patient contact with symptomatic patients or when cleaning. Hands must be washed with soap and water following removal of protective clothing. If aprons have not been worn, theatre attire (tops and trousers) should be changed after all direct patient contact has been completed, also after ‘cleaning’.
• **Environment/equipment cleaning** for surfaces that receive direct patient contact e.g. operating tables, other furniture and instruments please follow decontamination and disinfection instructions follow Appendix 1 & 2 of RCHT IPAC Decontamination Policy. A chlorine based disinfectant must be used for daily routine cleaning of the environment.

• **Recovery/PACU** Symptom free in last 72 hours DO NOT NEED to be recovered in theatre. Symptoms present in last 72 hours SHOULD BE recovered in theatre.

Compliance: 100%
Exceptions: None

References:
AfPP Principles of Safe Practice in the Perioperative Environment 2011
RCHT ANTT Policy
RCHT IPAC Decontamination Policy
RCHT Prevention and management of Clostridium difficile infection policy
RCHT Generic Theatre Standards 4: Infection Control in the Operating Theatre
Generic Theatre Standard No 06B - Management of Patients with CJD in the Operating Department

Standard Statement: All Theatre staff will have knowledge of the requirements for caring for patients with Transmissible Spongiform Encephalopathy (TSE) Agents, Transmissible Creutzfeldt-Jacob Disease (CJD) in the operating department to protect self, colleagues and patients from the risk of health care acquired infection: Safety and Infection Prevention

The prevention of transmission of infection and the provision of safe instruments are fundamental for patient care. Incorrect procedures for the handling or processing of instruments used on patients infected with any form of Transmissible Spongiform Encephalopathy (TSE), namely Creutzfeldt-Jakob Disease (CJD) or Variant Creutzfeldt-Jakob Disease (vCJD) can present an infection risk to patients on whom instruments are subsequently used.

General Considerations

Please see: Policy for the Management of Patients who are symptomatic or at increased risk of Transmissible Creutzfelt-Jakob disease (CJD)

Generic Theatre Standard 04 - Infection control in the Operating Department

- **Staff** Available epidemiological evidence indicates that normal, social or routine clinical contact with a patient suffering from any type of CJD, including vCJD, does not present a risk to other patients, healthcare workers, relatives and the community. Although cases of CJD/vCJD have been reported in healthcare workers, there have been no confirmed cases linked to occupational exposure. The highest potential risk in the context of occupational exposure is from exposure to highly infective tissues through direct inoculation (e.g.: as a result of a sharps injuries, puncture wounds or contamination off broken skin) and exposure of the mucous membranes should also be avoided. Compliance with standard infection prevention and control precautions will minimise risks from occupational exposure. Though the risk remains low, where correction can be achieved by other means transfusion of blood and blood products should be avoided. Healthcare workers, who work with symptomatic patients with definite, probable or possible CJD or vCJD or with potentially infected tissues, should be appropriately informed about the nature of the risk and relevant safety procedures.
  - Employers are required to keep a list of employees exposed to the agent of CJD of any type when there is a deliberate intention to work with the agent or, in cases if inoculation injury, if a risk assessment shows there is a significant risk. It is important to emphasise that a list is required where there is a likelihood of exposure, not simply when there has been a known incident or accident. This may include the scrub team in theatres. The lists will be kept by Occupational Health for 40 years after the last exposure. Some staff may need to be listed as being potentially exposed to CJD for example, neurosurgeons, laboratory and mortuary staff.
  - Inform the Infection Prevention and Control team, theatre co-ordinator, Sterile Services Manager and appropriate laboratories.

- **Position on List**, It is the responsibility of the patient’s Consultant to undertake a patient assessment and determine the patients risk group. The operative procedure should only be undertaken if there is no reasonable alternative. This is especially important where flexible endoscopes are involved, as there is no way of re-processing such equipment. However patients must not be denied treatment on the basis of their CJD/vCJD risk. The patient SHOULD BE placed at the end of the list where possible.
• **Hand hygiene**, decontaminate hands following Ayliffe’s seven step technique (RCHT ANTT Policy) or use antiseptic hand rub, or surgical hand antisepsis.

• **Protective Clothing**, the principles for reducing the risks from percutaneous exposure to blood borne viruses apply equally to CJD. Standard infection control precautions should be followed for any spillages which should be cleared up using disposable items as quickly as possible, keeping contamination to a minimum. Disposable gloves and apron should be worn when removing such spillages. All surfaces contaminated with high-risk material e.g.: blood, CSF or brain tissue, should be cleaned with sodium hypochlorite 10,000 ppm using standard disinfection processes. Destroy all used instruments and protective clothing by incineration.

• **Environmental/equipment cleaning**
  - Compliance with standard infection prevention and control precautions will minimise risks from occupational exposure.
  - Decontamination of instruments used in invasive procedures cannot be achieved by autoclaving as this does not inactivate TSE agents. Thorough cleaning and physical removal of organic matter from instruments is essential. Washer disinfectors must conform to and be validated against CFPP 01-01.
  - Special procedures must be followed for instruments that have or may have been used on patients with confirmed or suspected TSE, or who are in an at risk category. See relevant section **Policy for the Management of Patients who are symptomatic or at increased risk of Transmissible Creutzfelt-Jakob disease (CJD)**.

• **Recovery/PACU** Patients DO NOT NEED be recovered in theatre.

• **Other**
  - For endoscopes check **Policy for the Management of Patients who are symptomatic or at increased risk of Transmissible Creutzfelt-Jakob disease (CJD)**.
  - For all symptomatic patients (i.e. Those who fulfil the criteria for definite, probable or possible CJD or vCJD) the following precautions should be taken: Inform the Infection Prevention and Control team, theatre co-ordinator, Sterile Services Manager and appropriate laboratories. Keep traffic in theatre to a minimum.
  - Keep equipment to a minimum. The following single use protective clothing should be worn:
    - Liquid repellent operation gown, over a plastic apron
    - Sterile surgical gloves
    - Mask
    - Goggles or visor
  - Identify specimens as “high risk”.
  - Standard infection control precautions should be followed for any spillages which should be cleared up using disposable items as quickly as possible, keeping contamination to a minimum. Disposable gloves and apron should be worn when removing such spillages. All surfaces contaminated with high-risk material e.g.: blood, CSF or brain tissue, should be cleaned with sodium hypochlorite 10,000 ppm using standard disinfection processes.
  - For asymptomatic patients at risk from familial or iatrogenic CJD, the same precautions apply.
- **Surgical Instruments**
  o Use single-use disposable instruments and equipment where possible.
  o If single use items are not available, the instruments and equipment should NOT be re-used under any circumstances. For asymptomatic patients at risk from familial or iatrogenic CJD, the same precautions apply.
  o A tracking system should be in place that will trace instruments back to all patients who have undergone a surgical procedure, including flexible endoscopes and associated equipment.
  o In order to facilitate tracking and removing the instrument set from circulation, it is imperative to contact SSD so that the staff can instigate ‘quarantine’ procedures for the instrument set, isolation transport from the theatres to SSD and perform either adequate decontamination process or destruction of the set.
  o See relevant section Policy for the Management of Patients who are symptomatic or at increased risk of Transmissible Creutzfeld-Jakob disease (CJD).

Compliance: 100%
Exceptions: None

**References:**
AfPP Principles of Safe Practice in the Perioperative Environment 2011
RCH Trust Policy Policy for the Management of Patients who are symptomatic or at increased risk of Transmissible Creutzfeld-Jakob disease (CJD)
RCHT Decontamination Policy RCHT IPAC Decontamination Policy
Generic Theatre Standard No 06C Management of Patients with Extended-spectrum beta-lactamases (ESBLs) and Amp C in the Operating Theatre Department

Standard Statement: All Theatre staff will have knowledge of the requirements for caring for patients with ESBLs into operating department to protect self, colleagues and patients from the risk of health care acquired infection.

Extended-spectrum beta-lactamases (ESBLs)

- Bacteria that produce enzymes called extended-spectrum beta-lactamases (ESBLs) are resistant to many penicillin and cephalosporin antibiotics and often to other types of antibiotic.
- The 2 main bacteria that produce ESBLs are Escherichia coli (E. coli) and Klebsiella species. The ESBLs that E. coli most often produce are called CTX-M enzymes.
- E. coli with ESBLs may cause urinary tract infections (UTIs) that can sometimes progress to more serious infections like blood poisoning, which can be life threatening. Resistance makes these infections more difficult to treat. (Public Health England, 2014)

General Considerations

RCHT ESBL Policy on precautions to be observed when caring for patients colonised or infected with extended Spectrum Beta - Lactamase producing organisms

Generic Theatre Standard 04 - Infection control in the Operating Department

Generic Theatre Standard 06 - Management of Patients with MRSA

- **Staff risk** Transmission of ESBL producing organisms occurs due to poor hand hygiene and the use of contaminated items in the clinical setting.
- **Patient position on list schedule** DO NOT NEED to be last on list, however, to ensure robust cleaning, adequate, non-pressured time be allowed to the staff to clean effectively.
- **Hand Hygiene** is of paramount importance and alcohol hand gel is very effective against ESBLs.
- **Personal Protective Equipment (PPE)** Disposable Gloves and aprons must be worn for direct contact with the patient and their surrounding environment and when dealing with urine and faeces. All staff must change their theatre attire before following decontamination and cleaning and/or before treating the next patient.
- **Environment/equipment cleaning** All surfaces cleaned with Actichlor Plus following surgery. Adequate time for cleaning of the theatre and equipment must be allowed between patients
- **Recovery PACU instructions** Known ESBLs patients DO NOT NEED to be recovered in theatre. Known ESBL patients should not be recovered next to a patient at high risk of contracting ESBL (for definition, please see the RCHT ESBL Policy). The recovery bay and all equipment must be cleaned following transfer to the ward. Recovery staff must ensure that the receiving ward is fully aware of ESBLs status.
- **Other** All linen must be treated as infected and handled accordingly.

Compliance: 100%

Exceptions: None

References:

AfPP Principles of Safe Practic e in the Perioperative Environment 2011
RCH Trust Policy
Policy on precautions to be observed when caring for patients colonised or infected with extended Spectrum Beta - Lactamase producing organisms
RCHT Decontamination Policy
RCHT IPAC Decontamination Policy
Generic Theatre Standard No 06D Management of Patients with Glycopeptide Resistant Enterococci (GRE) in the Operating Theatre Department

**Standard Statement:** All Theatre staff will have knowledge of the requirements for caring for patients with GRE into operating department to protect self, colleagues and patients from the risk of health care acquired infection.

Enterococci are Gram positive bacteria that are commonly found in the bowel of humans and animals. They rarely cause infection. They are occasionally responsible for urinary tract infections (UTIs), often related to the use of indwelling catheters, and more rarely cholangitis, endocarditis and gut-related sepsis. Two main types are associated with human diseases: Enterococcus faecalis and Enterococcus faecium. Enterococcus faecium is more common to cause bacteremic infections.

Glycopeptide resistant enterococci (GRE) are resistant to vancomycin, usually teicoplanin and often other antibiotics. During mid 1980s enterococci resistant to vancomycin emerged and therefore often termed as Vancomycin Resistant Enterococci (VRE). GRE usually tend to cause colonisation rather than infection but when they cause serious infection, they are difficult to treat because of less therapeutic option.

Hospital outbreaks of GRE have been reported mainly from renal dialysis, transplant, haematology and intensive care units. Risk factors for colonisation and infection with GRE include previous antibiotic therapy (especially with glycopeptides, cephalosporins, or carbapenems), immunosuppression, prolonged hospital stay, and admission to intensive care, renal, haematology or liver units. Once gut colonisation has occurred, carriage can be prolonged and there is no effective means of eradication.

**General Considerations**

Please see the Glycopeptide Resistant Enterococci (GRE) Policy

Generic Theatre Standard 04 - Infection control in the Operating Department

- **Staff risk** Effective hand decontamination is the most important measure to prevent and control the spread of GRE. Portering staff do not need to wear protective clothing whilst transporting patients. They only need to wear protective clothing if there is any possibility of having close contact with the patient and they must decontaminate their hands after removal.

- **Patient position on list schedule** DO NOT NEED to be last on list, however, to ensure robust cleaning, adequate, non-pressured time be allowed to the staff to clean effectively.

- **Hand Hygiene** Effective hand decontamination is the most important measure to prevent and control the spread of GRE. Alcohol gel is effective on GRE, so should be used in all potential situations as recommended in the Standard Precautions policy. Hands must be decontaminated between each patient contact whether or not the patient is known to be colonised with GRE.

- **Personal Protective Equipment (PPE)** Staff should use standard precautions after contact with urine or faeces to prevent spread. Staff must put on gloves when entering the theatre and wear a plastic apron if substantial contact with the patient or environmental surfaces is anticipated. PPE must be removed followed by hand washing before coming out of the patient zone.

- **Environment/equipment cleaning** During the care of a patient with GRE, the clinical environment may become heavily contaminated and can persists for months if not properly cleaned and decontaminated. The environment and equipment used on patients must be cleaned after use with Hypochlorite based cleaning products. GRE can survive for long time on phones, pagers, stethoscopes, BP cuffs, key boards and other high touch surfaces and special care should be taken to clean and decontaminate all items while caring a GRE positive patient. After the GRE positive patient has left theatre it must be thoroughly cleaned (top to bottom), in an attempt to reduce environmental contamination.
• **Recovery PACU instructions** Known GRE patients DO NOT NEED to be recovered in theatre. Known GRE patients should not be recovered next to a patient at high risk of contracting GRE (for definition please see the RCHT GRE Policy). The recovery bay and all equipment must be cleaned following transfer to the ward. Recovery staff must ensure that the receiving ward is fully aware of GRE status.

• **Disposal of linen and waste:** Appropriate personal protective equipment must be used and hand decontamination must always be performed after disposal of waste and removal of gloves Care must be taken not to shake linen or hold it close to uniform. All used linen must be placed in a hot water soluble bag (refer to linen policy) All waste must be disposed of appropriately as clinical waste.

Compliance: 100%
Exceptions: None

**References:**

AfPP Principles of Safe Practice in the Perioperative Environment 2011
RCH Trust Policy Glycopeptide Resistant Enterococci (GRE) Policy
RCHT Decontamination Policy RCHT IPAC Decontamination Policy
Generic Theatre Standard No 06E Management of Patients with MRSA in the Operating Theatre Department

Standard Statement: All Theatre staff will have knowledge of the requirements for caring for patients with MRSA into operating department to protect self, colleagues and patients from the risk of health care acquired infection.

General Considerations

RCHT MRSA Policy MRSA - Meticillin Resistant Staphylococcus Aureus Policy

Generic Theatre Standard 04 - Infection control in the Operating Department

- **Staff risk** the most effective method of preventing and controlling the spread of MRSA is by the effective decontamination of hands after every patient episode or contact. Personnel and movement in theatre should be kept to a minimum as MRSA may be released into the atmosphere on the skin squames, fibres from clothing or carried as dust particles. There is no reason to exclude pregnant staff from caring for patients with MRSA.

- **Patient position on list schedule** DO NOT NEED to be last on list

- **Hand Hygiene** High standards of hand decontamination are required to minimise the risk of cross infection. Hands should be adequately decontaminated before and after patient contact and on leaving an isolation facility/ward. Hand decontamination should be by thorough washing with soap and water, or the application of a 70% alcohol hand rub. Bacterial counts increase when the skin is damaged therefore care must be taken to maintain skin integrity. It is important that a good quality Trust approved hand cream is applied regularly throughout the shift e.g. beginning and end and when a break is taken.

- **Personal Protective Equipment (PPE)** If there is a risk of exposure to blood or body fluids then all staff handling the patient or having contact with their immediate environment should wear disposable aprons. If aprons have not been used theatre attire (tops, trousers and hats) must be changed as soon as is reasonably practicable or if contamination has occurred. Gloves – gloves do not obviate the need for hand decontamination and should only be worn when there is contact with body fluids.

- **Environment/equipment cleaning** All surfaces cleaned with Actichlor Plus following surgery. Adequate time for cleaning of the theatre and equipment must be allowed between patients. All surfaces that have been in contact with the patient should be cleaned as per the manufacturers’ guidelines.

- **Recovery PACU instructions** Known MRSA patients DO NOT NEED to recovered in theatre. Appropriate communication with the recovery team must occur to ensure that they are informed of the patient’s status. PPE (gloves and apron) should be worn during the transfer. The recovery bay and all equipment must be cleaned following transfer to the ward. Recovery staff must ensure that the receiving ward is fully aware of MRSA status and the patient transferred to a side room.

Compliance: 100%
Exceptions: None

References:

AfPP Principles of Safe Practice in the Perioperative Environment 2011
RCH Trust Policy MRSA MRSA - Meticillin Resistant Staphylococcus Aureus Policy
RCHT Decontamination Policy RCHT IPAC Decontamination Policy
Generic Theatre Standard No 06F - Management of Patients with suspected/confirmed Norovirus in the Operating Theatre Department

Standard Statement: All Theatre staff will have knowledge of the requirements for caring for patients with Norovirus in the operating department to protect self, colleagues and patients from the risk of health care acquired infection.

Norovirus is a major cause of acute gastroenteritis and diarrhoea in children and adults. The cause of illness, Norovirus (previously known as Norwalk-like or Small Round Structured Virus) was described in 1968 in samples from an elementary school in Norwalk, Ohio. The disease is often termed Winter Vomiting Disease because of the increased prevalence in the winter months; however it can be detected throughout the year.

Norovirus is the most common cause of outbreaks of gastro-enteritis in hospitals and can also cause outbreaks in other settings such as schools, nursing homes and cruise ships. Hospital outbreaks often cause major disruption in hospital activity resulting ward closures, cancelled admissions and delayed discharges which can significantly reduce clinical activity for the duration of the outbreak. Failure to observe and comply with Infection Control guidelines/policy can lead to further spread of infection and a delay in the hospital returning to normal activity. Outbreaks can affect both patients and staff, sometimes with attack rates in excess of 50%. For this reason, staff shortages can be severe, particularly if several wards are involved at the same time. It is therefore essential that cases are detected early and isolated appropriately to prevent spread and major outbreaks.

General Considerations

Please see Policy for the Management of outbreaks of suspected / confirmed Norovirus

Generic Theatre Standard 04 - Infection control in the Operating Department

- **Staff risk** Noroviruses are highly contagious. Noroviruses are transmitted primarily through the faecal – oral route either by person to person spread or via contaminated food or water. In addition Noroviruses can be spread via aerosol dissemination of infected particles following vomiting. Transmission can also occur through hand transfer of the virus to the oral mucosa following contact with environmental surfaces, fomites and equipment which have been contaminated with either faeces or vomit. Norovirus can survive for up to 12 days on some surfaces.

- **Patient position on list schedule** Preferably at the end of the list

- **Hand Hygiene** the hands of healthcare staff can provide the vehicle for the transmission of norovirus. It is essential that all staff wash their hands when required using the correct washing technique to help reduce the risk of transmission. Alcohol gel IS NOT effective against these viruses and therefore hands must be washed with soap and water before and after every patient contact and contact with potentially infectious equipment, furnishings or other fomites. Gloves do not obviate the need to wash hands.

- **Personal Protective Equipment (PPE)** aprons and gloves must be used appropriately (single use items) and for each episode of care/treatment/examination on all patients by all staff. These must be changed for each episode of care. There is currently no evidence to support the wearing of face masks for either patients or staff.
• **Environment/equipment cleaning** All equipment that the patient has come in contact with must be cleaned with a chlorine based disinfectant e.g. Actichlor plus, after the patient has left the theatre.

• **Recovery PACU instructions** These patients SHOULD BE recovered in theatre.

• **Other.** Patients must be provided with the opportunity to wash their hands or use hand wipes after each toileting episode and also before each meal

Compliance: 100%
Exceptions: None

**References:**

AfPP Principles of Safe Practice in the Perioperative Environment 2011
RCH Trust Policy Policy for the Management of outbreaks of suspected/confirmed Norovirus
RCHT Decontamination Policy RCHT IPAC Decontamination Policy
Generic Theatre Standard No 06G - Management of Patients with suspected/confirmed TB in the Operating Theatre Department

Standard Statement: All Theatre staff will have knowledge of the requirements for caring for patients with TB in the operating department to protect self, colleagues and patients from the risk of health care acquired infection.

Tuberculosis (TB) is an infectious disease caused by the organism Mycobacterium Tuberculosis. It usually presents as a respiratory disease affecting lungs, larynx, pleura or mediastinal lymph nodes. It can also affect bones and joints, the gastrointestinal and renal tracts, the central nervous system or be disseminated through the blood stream. TB can present a health risk to staff if they become infected from patients; staff can also infect patients.

Resistance to TB drug treatment can develop, and in some cases multi-drug resistance (MDR TB) develops if patients are not compliant with medication. All patients with TB should have risk assessments for drug resistance and all patients should be tested for HIV (NICE 2011).

Tuberculosis is a notifiable disease. The medical staff attending the patient have a legal responsibility to notify a case of TB as soon as the diagnosis is made and a decision to commence full treatment is taken.

General considerations

Please see RCHT TB Policy Infection prevention and control policy on the management of patients with tuberculosis

Generic Theatre Standard 04 - Infection control in the Operating Department

- Staff risk People who have active infectious (open) pulmonary TB expel small respiratory droplets when coughing and sneezing. These small droplet nuclei, carried by air currents can be inhaled by exposed people and cause infection.
  - Pregnant staff should avoid contact with confirmed/suspected TB cases.
  - It is the responsibility of the Theatre manager manager to maintain an accurate record of staff (including locum and agency staff) who have had significant exposure (more than 8 hours) to any suspected or confirmed case of pulmonary TB. This list will be required in the event of contact tracing and should be forwarded to the Occupational Health Department on the advice of the Infection Prevention and Control Team.
  - The significance and degree of infectious risks to staff should be discussed at the incident meeting which should be attended by an Occupational Health Representative.
  - If a member of staff reports suspicious symptoms, the individual must be referred to the Occupational Health Department as soon as possible. The Occupational health Practitioner, after taking a full clinical history, will take appropriate action including any necessary investigations.
  - The decision on the staff member’s fitness for work, or advice on restricted duties, will be a clinical one based on the clinical findings and the areas where he/she works. Should the clinical findings and/or investigation indicate or confirm TB infection then referral to the Lead Clinician for TB will be arranged for follow up and management.
  - A decision on when the individual is fit to return to work with patients will be made in conjunction with the Lead Clinician for TB.
  - The member of staff’s General Practitioner will be kept informed of the outcome.
If a member of staff is confirmed to have contracted TB and incident meeting should be convened to determine further actions required.

- **Patient position on list schedule** DO NOT NEED to be last on list. Anaesthetic staff should ensure both the anaesthetic circuit and filters are changed prior to anaesthetising the next patient.

- **Hand Hygiene** perform hand hygiene using alcohol gel on entry and exit from the isolation area and following patient contact. If hands come into contact with sputum or other body fluids and contaminated items wash the hands. (See Standard Precautions Policy for further details).

- **Personal Protective Equipment (PPE)** Wear non-sterile gloves and aprons only when touching blood or body fluids or sputum contaminated items and specimens. Put on clean gloves just before touching mucous membranes or non-intact skin. Care should be taken when cleaning up sputum or exudates from wounds. Change gloves between procedures on the same patient after contact with material that may contain high numbers of Bacilli. Remove gloves (single use item) promptly after use and wash hands. Gloves should be disposed of as clinical waste. (see Standard Precautions Policy) Only wear a disposable plastic apron for procedures where there is a risk of contamination of clothing from splashing or aerosolisation. Remove the apron on completion of tasks and dispose of after use as clinical waste. Gloves and aprons must be worn when handling used linen, which must be disposed of as infected linen in heat soluble bags in red bags for infected laundering.

- Masks are not routinely recommended for casual short contact with TB cases (NICE 2006). Masks should only be worn based on the infection risks to staff or other patients. For example in sputum inducing aerosol generating procedures like intubation/extubation and using suction in the upper respiratory tract.

- Wear EN 149 FFP3 respirator if there is a risk that the patient has MDR TB and for confirmed cases. Ensure that masks are well fitted. Remove masks carefully avoiding contamination of the hands and wash the hands using soap and water.

- Do not re-use masks. Dispose of them as clinical waste, inside the isolation area.

- **Environment/equipment cleaning** All equipment that the patient has come in contact with must be cleaned with a chlorine based disinfectant e.g. Actichlor plus, after the patient has left the theatre.

- **Recovery PACU instructions** DO NOT NEED to recovered in theatre, unless IPAC staff indicate otherwise.

- **Other** Patients should be encouraged to cover the mouth and turn away from others when coughing. The patient must wear a mask e.g. oxygen mask when leaving the isolation area, if they have a productive cough and respiratory TB.

Compliance: 100%
Exceptions: None

**References:**

AfPP Principles of Safe Practice in the Perioperative Environment 2011
RCH Trust Policy Infection prevention and control policy on the management of patients with tuberculosis
RCHT Decontamination Policy RCHT IPAC Decontamination Policy
**Generic Theatre Standard No 06H - Management of Patients and staff with diarrhoea in the Operating Theatre Department**

**Standard Statement:** All Theatre staff will have knowledge of the requirements for caring for patients with diarrhoea in the operating department to protect self, colleagues and patients from the risk of health care acquired infection.

In the UK, gastroenteritis causes a huge burden of disease in the community and is responsible for much time missed from work. A large number of patients with gastroenteritis are admitted to hospital each year usually because they are frail and elderly. Patients and/or staff with gastroenteritis can infect other patients leading to healthcare associated outbreaks of diarrhoea and vomiting. Strict infection prevention and control precautions are therefore necessary for patients with symptoms suggestive of gastroenteritis.

Organisms that cause infectious diarrhoea are spread by the faecal/oral route. For an individual to become infected the organism must be ingested and most commonly this will result from unwashed and contaminated hands coming in contact with the mouth. It may also occur via ingesting contaminated food.

**General Considerations**

Please read **Policy for the management of patients and staff with Diarrhoea**

**Generic Theatre Standard 04 - Infection control in the Operating Department**

- **Definition of acute v chronic diarrhoea:** It can be difficult to determine what actually constitutes a “normal” bowel action as this can vary greatly between individuals, but true diarrhoea consists entirely of liquid/water (type 6/7 Bristol Stool Chart).

- **Acute diarrhoea** has a sudden onset and typically lasts between 1 – 4 days. Chronic diarrhoea persists longer than 4 weeks and usually due to an underlying cause. Diarrhoea is considered significant when a patient has more than 3 episodes in 24 hours. However, any case of diarrhoea, which may or may not be accompanied by vomiting, amongst patients or staff should be regarded as potentially infectious and treated as such unless an infectious cause can be confidently excluded.

- **Common infectious cause of diarrhoea**
  - Norovirus – abrupt explosive onset of profuse watery diarrhoea which may be accompanied by projectile or violent vomiting. Several cases may occur on the ward within hours.
  - Clostridium difficile – watery diarrhoea with a characteristic farmyard/manure type smell, and is associated with current or recent antibiotic administration. Refer to the Policy for the Management of Clostridium difficile

- **Examples of other causes:**
  - Rotavirus
  - Salmonella
  - Shigella
  - Campylobacter - common causes of bacterial food poisoning
  - Enteropathogenic *E.coli* - associated with travel
  - Amoebic dysentery
  - *Giardia lamblia*
  - *Verotoxin producing E. coli*
  - *Cryptosporidium*
• If a patient, who has not been diagnosed with an infectious agent, has an episode of diarrhoea in the operating theatre department, communication is absolutely essential prior to handover so the next team have the ability to instigate isolation procedures, as necessary e.g. the patient should be isolated in the existing bed space within the ward/bay.

• **Strict hand washing** with soap and water is essential by all staff attending the patient. Alcohol hand gel should not be used as this is not effective against norovirus and clostridium difficile.

• **Personal Protective equipment** i.e. gloves and aprons should be used for all patient contact.

• **A Bristol Stool Chart** must be commenced if not already in place.

• The Infection Prevention and Control Team must be informed and a Datix form completed.

• **Environmental cleaning** of the area with a chlorine based disinfectant e.g. Actichlor plus.

• **Communication** is absolutely essential prior to handover, so the next healthcare team have the ability to instigate isolation procedures, as necessary.

• **Recovery PACU instructions** If infection is suspected, these patients SHOULD BE recovered in theatre.

**Management of staff with diarrhoea**

• Any member of staff who experiences a sudden onset of diarrhoea and/or vomiting must not present for work. If they are at work when this happens they should report their symptoms to their line manager and leave work immediately. If possible the toilet which the member of staff used should be closed until ‘terminal cleaning’ has been undertaken.

• They must not return to work until they have been asymptomatic for 48 hours and have passed a normal stool.

• Staff may be required to submit a sample of faeces to assist with outbreak investigation.

Compliance: 100%

Exceptions: None

**References:**

AfPP Principles of Safe Practice in the Perioperative Environment 2011

RCH Trust Policy Policy for the management of patients and staff with Diarrhoea

RCHT Decontamination Policy RCHT IPAC Decontamination Policy
**Generic Theatre Standard No 07 - Decontamination**

7.1 **Decontamination Life Cycle**
- Decontamination Policy

7.2 **Decontamination Policy**
- Decontamination Policy

7.3 **Risk Management (decontamination & equipment)**
- Medical Device and Equipment Management Policy

7.4 **Single Use Medical Devices**
- Under no circumstances should single use medical devices be reused
- Staff must ensure that they are aware of medical device single use status
- Single use items must be disposed of after use in line with Trust waste policy for clinical waste or equipment
- Single use items used during surgery must be disposed of in theatre and not returned to SSD on the instrument tray
- Decontamination Policy

7.5 **Decontamination Training**
- Decontamination Policy

7.6 **Acquisition of surgical equipment**
- Procurement Policy
- Medical Device and Equipment Management Policy

7.7 **Loan Surgical Instruments & Equipment**
- All loan equipment must be agreed by the theatre manager and SSD manager before use.
- Electrical equipment must be tested by the trust medical physics department for electrical safety before use.
- All surgical instruments must be sterilised via the Trust SSD department before use
- Confirmation must be gained from SSD before ordering loan equipment that the SSD department has the appropriate capacity and instructions on decontamination before placing the order.
- On receipt of loan equipment the supply inventory must be fully checked and signed to confirm all items required are present before forwarding to SSD
- Decontamination Policy

7.8 **Cleaning**
Guidance on automated cleaning washers/disinfectors and manual cleaning can be found in the following RCHT documents:
- Decontamination Policy
- Medical Device & Equipment Management Policy
- Cleaning Policy
7.9 Packaging
- Decontamination Policy

7.10 Sterilisation
- Porous load sterilisers
- Benchtop sterilisers
- Decontamination Policy

7.11 Transport
- Decontamination Policy

7.12 Traceability
- Decontamination Policy

Compliance: 100%
Exceptions: None

References:
AfPP Principles of Safe Practice in the Perioperative Environment 2011
RCH Trust Policy Decontamination
**Generic Theatre Standard No 08 - Catheterisation of Female Patients**

**Standard Statement:** To ensure safe and hygienic insertion of urinary catheter in female patients undergoing surgical procedure.

**Method:**

- All staff will be familiar with the hospital policy regarding female catheterisation. Theatre staff will maintain patient dignity and minimise risk of infection to the patient.
- All staff will receive the appropriate training and have been assessed as competent prior to performing this procedure.
- Theatre staff will place patient with hip flexed and knees bent, feet should be resting about 60cm apart.
- Theatre personnel must ensure that the patient’s privacy and dignity are maintained at all times. Excess staff/visitors must be asked to leave the theatre.
- Staff must ensure that the patient remains covered until theatre staff are ready to perform the procedure.
- Good visibility must be ensured by use of theatre lighting.
- Staff must wash their hands using bactericidal soap or bactericidal alcohol hand rub.
- Staff must don sterile gloves and an apron.
- A member of staff is to open the outer catheter pack; the nurse performing the procedure can then proceed to open supplementary packs maintaining an aseptic technique.
- Place a sterile sheet across the patient’s thighs.
- Separate the labia minora so that the urethral meatus is seen. Using swabs provided on the pack, one hand should be used to maintain labial separation until catheterisation is complete. This provides better access to the urethral orifice and helps prevent labial contamination of the catheter.
- The urethral orifice will be cleaned using 0.9% NaCl solution, single downward strokes will be used. This minimises the risk of cross-infection.
- The urethral orifice or catheter should be lubricated using sterile aqueous lubricating jelly, or sodium chloride solution.
- The catheter, of appropriate size as assessed by the theatre practitioner or surgeon, is placed in the receiver between the patient’s legs, this provides a temporary container as the urine drains.
- The tip of the catheter is introduced into the urethral orifice and the catheter advanced 6 – 8 cm, to prevent the balloon from being trapped in the urethra.
- The balloon is inflated with the appropriate quantity of sterile water as dictated by the manufacturers instructions, having ensured that the catheter is draining adequately i.e. having visualised urine flowing.
- The catheter bag is attached to the catheter, using hourly drainage measuring devices when appropriate to the surgery.
- Ensure that the catheter lumen is not occluded and that the patient is not lying on the catheter.
- Staff must ensure that the patient is dry to prevent secondary infection and skin irritation.
- Used equipment is disposed of into the yellow contaminated waste bag.

**Compliance:** 100%

**Exceptions:** None

**References:**
- RCHT Adult Urinary Catheterisation Policy
Generic Theatre Standard No 09 - Care of the Deceased In the Operating Department


Care of the Deceased Patient in RCHT Operating Theatre

Contacts in the Event of a Patient Death in the Perioperative Environment

- Bereavement Office staff can be contacted on 01872 252713
- The Bereavement Office is operated by 4 members of staff and open Monday to Friday – 9.00am to 5.00pm
- The mortuary staff have key liaison with the Bereavement Support Service staff, coordinating on issues such as viewings and specialised services.
- The mortuary staff work 9.00am to 5.00pm and ‘on-call’
- The Department of Histopathology, staff are based at Royal Cornwall Hospital where mortuary and post mortem facilities are available.
- For further information/advice:
  - Bereavement Office ext 2713
  - RCH Mortuary ext 2555
  - Histopathology Department x2550

Following the death of the patient in the perioperative environment

- The requirements of different faiths and religions must be taken into consideration.
- **Daytime:** The Bereavement Office must be telephoned to be informed.
- **Night Time:** The Bereavement Office will communicate with the mortuary to determine any new admissions to the mortuary out of hours. A message can also be left on the answer phone so Bereavement Staff can pick up once they are in.
- A member of the Bereavement Office staff will then:
  - Go to the ward to collect any property left behind
  - Contact a doctor to complete the death certificate
- Visiting the deceased is coordinated by the Bereavement Office; they will also coordinate and have links with all funeral directors.
- The Bereavement Officer will consult the mortuary register and liaise with ward staff and the chaplain regarding post mortems, funeral requirements and consent, advising the mortuary technicians of requirements
- The mortuary staff will ensure the Pathology Directorate mortuary card is completed and placed in the correct file.

Signatures

- All entries into the health record, including amendments, should be clearly dated, timed, signed and the designation of the person making the entry should be clearly recorded.

Donor Transplant Coordinators

- Are responsible for the care of a patient who has died, speaking to the family and organising the organ donation procedure.
- The Theatre Manager will retain copies of signatures of all healthcare professionals who make entries on healthcare records, together with the professional’s registration number (NMC or HPC). The register of signatures will be reviewed and updated annually.
In the Event of an Unexpected Death Occurring in Theatre

- If an unexpected death occurs within the perioperative environment the person in charge must ensure that the following personnel are informed immediately, in order to comply with the requirements:
  - Theatre Manager
  - Ward and/or intensive care staff
  - It is the responsibility of the medical staff to inform their senior colleagues
  - The surgeon must inform the Coroner’s Office. A medical certificate will not be issued.
  - It is the surgeon's decision to decide whether to continue with the operating session or to cancel the remainder of the operating for that session.
  - Sudden unexpected death will result in a coroner’s post mortem as a legal requirement.
  - Post mortem examination can provide information about the illness or other cause of death. Without a post mortem, the cause of death can be wrong in up to 30% of cases
  - By law a coroner can order a post mortem examination to be done. There are three main reasons why a death is referred to the coroner:
    - Death has been sudden and unexpected.
    - A person has been ill but the doctor confirming the death is not certain why it happened at that particular time.
    - A death has been the result of an accident or unusual circumstances (including deaths following a medical procedure such as surgery).
  - If a member of theatre staff is approached by a relative, or other responsible person, about post mortem arrangements for adults, the request should be referred directly to a member of the medical team responsible for the deceased or the Bereavement office, as appropriate.

Organ Donation

- If the patient had previously agreed/consented to organ donation, immediate advice must be sought from the coroner, via the consultant in charge, or from the coroner's office. The coroner must be told and must agree before organs can be removed. In some cases, organ donation may not be possible for medical reasons.

In The Event of an Unexpected Death Occurring in St Michael's Hospital Theatres (in addition to the above guidelines)

- The body will be removed by the coroner and medical certificate issued after post mortem and inquest.
- The Coroner will arrange for the body to be collected.
- If there is gross contamination by body fluids, the deceased patient should be washed.
- The deceased patient should be straightened and placed into a body bag to await collection.

In The Event of an Unexpected Death Occurring in West Cornwall Hospital (in addition to the above guidelines)

- There is an unmanned mortuary on site
- The portering staff must be contacted regarding the death of a patient and the need to remove the deceased patient to the on-site mortuary
- If there is gross contamination by body fluids, the deceased patient should be washed.
- The deceased patient should be straightened and placed into a body bag to await collection.

Outline Procedure for ‘Last Offices
- Last Offices should be carried out within 2 – 4 hours of death.
- All drains must be left in position.
- Catheters or cannula should be closed with a spigot.
- Endotracheal or tracheostomy tubes should remain in situ.
- Wounds should be covered by a dressing.
- Document all tubes/equipment remaining, e.g. tunnelled skin catheters, pacemaker.
- Apply petroleum jelly to lips and peri-oral area. Suction oropharynx if patient previously intubated/had a tracheostomy.
- A cadaver bag/zip-up bag should be used; absorbent sheets may be placed on either side of the head.
- It is advisable to ascertain from the anaesthetist in advance that permission is granted to remove either the endotracheal tube or tracheotomy tube if the family wishes to view the body.
- Staff should ensure that all documents are complete at the time of death.
- It is essential that infection control and good hygiene of practice throughout all stages in this care, including transfer to the mortuary.
- As a mark of respect, it is appropriate for a registered practitioner to escort the deceased to the theatre suite exit.
- The relatives should be given the opportunity to pay their last respects, if this is their preference. The provision of a private waiting area for relatives in the vicinity of the operating department is recommended.
- A quiet area: the Anaesthetic Room, Recovery if there are no other patients or the theatre itself, should be made available to allow them to be alone with the deceased.
- It is essential that operating department staff are given appropriate support following the death of a patient in the area. A Confidential Counselling Service is available for all staff: 01872 252770.
1. Detailed guidelines including list of equipment required for Last Offices: Preparing the Body (These should be laminated and placed in the Last Offices Box)

**Equipment List:**

- Personal Protective Equipment (disposable gloves, aprons, goggles relative to the risk of body fluid exposure.)
- Bowl of warm water, soap, disposable wash cloths and two towels.
- Disposable razor, comb and equipment for nail care.
- Equipment for mouth care including equipment for cleaning dentures.
- Identification labels x 2.
- Documents required:
  - Mortuary Card (A5 yellow)
  - Notification of Death for Bereavement Office (A4 White)
- Shroud or patient’s personal clothing if previously requested by patient, or clothes that comply with family or cultural wishes.
- Body bag and labels for the body bag including labels that identify any known infection/disease.

- Gauze, waterproof tape, dressings and bandages if wounds or intravenous arterial lines and cannula are present.
- Receiver for collecting urine if appropriate.
- Plastic bags for clinical (yellow), household waste (black), laundry (red).
- Sharps bin.
- Clean sheet.
- Record book for property and valuables.
- Bags for the patient’s personal possessions.

2. Detailed Procedure of ‘Last Offices’ for a Perioperative Patient

1. Ascertain if the family has any preferences or knowledge of the preferences that the patient, in life, may have requested that will influence last offices practice.

2. Collect all equipment necessary.

3. Ensure the area where the procedure is to be performed is private and as free from interruptions as possible.

4. Remove all but one pillow. Support the jaw by placing a pillow or rolled up towel on the chest or underneath the patient’s jaw.

5. Do not bind the patient’s jaw with bandages as this can leave pressure marks on the face which can be difficult to remove.

6. Remove any mechanical aids such as syringe drivers, heel pads etc. Apply gauze and tape to syringe driver sites and document disposal of medication.

7. Straighten patient’s limbs.

8. If lines are to remain, cut and cap/spigot off any large-bore tubes and cover with gauze and adhesive dressing. Ensure that documentation alerts mortuary staff to their presence. Do not remove any invasive lines.

9. Attempt to close the patient’s eyes by using gentle pressure to the eyelids for 30 seconds, using a small piece of clinical tape if required.

10. Apply gentle pressure over the bladder area, if the patient is not catheterised, allowing the bladder to drain. This will minimise the risk of post-mortem leakage.

11. Leakages from the oral cavity, vagina and bowel can be contained by using suction, drainage and using incontinence pads. Do not attempt to pack these orifices. The body bag will prevent any leakage escaping further.
12 Exuding wounds, surgical incisions should be covered with a clean dry dressing and absorbent pads as necessary.

13 Stitches and clips should be left intact. Stomas should be covered with a stoma bag.

14 Wash the patient, unless requested not to do so for religious/cultural reasons or carer’s preference.

15 Attend to hygiene needs, paying particular attention to hair, nail care and oral hygiene.

16 Male patients should be shaved, unless they chose to wear a beard in life. If shaving a man apply a water-based emollient cream to the face.

17 Clean the patient’s mouth using a foam stick to remove debris and secretions. Apply petroleum jelly to lips and perioral area.

18 If the patient had dentures with them these can be cleaned and replaced into the mouth if possible. If this cannot be done send them to the mortuary with the patient and document this.

19 Remove jewellery and any personal items, unless requested or advised otherwise. Ensure that appropriate records are made of any personal items left on the body or otherwise. (Follow RCHT Guidance on Patient’s Property).

20 Ensure identification labels/wrist bands are in place in accordance with RCHT Guidance on Positive Patient Identification.

21 All deceased patients must be properly identified with two identification bracelets, one on the wrist and one on the ankle. They must show the patient’s name, hospital/NHS number, date of birth, and religion if known. In the event of the patient’s name being unknown the HIN system is used and the identification bracelet must state UNKNOWN MALE / FEMALE.

22 Dress the patient in a gown/shroud or own clothes, as required.

23 Place an incontinence pad underneath the buttocks to contain any soiling.

24 Enclose the body in a sheet, securing it with adhesive tape, ensure the face and feet are covered and that all limbs are held securely in position.

25 Place the body in the bag, completing: Notification of death - one copy of the notification of death slip must be taped securely to the shroud, one copy must be taped securely to the outside of the sheet or cadaver bag, and one copy in the patient notes of the deceased.

26 Ensure documentation is complete
   - Notice of death (A5 yellow card); Mortuary card
   - Notification of Death for Bereavement Office (A4 White)

27 Document last offices practice, including property and any specific requirements for mortuary care.

28 Dispose of clinical waste

29 Arrange for transfer of the body, communicating any specific requirements to portering/mortuary staff

30 Transfer property, patient records and any additional items to the general office/bereavement office

3. Special Guidelines for Different Religious Faiths
   - Buddhism
- A request may be made for a Buddhist priest to be informed as soon as possible after the patient’s death. This may be done by relatives.
- A Buddhist may refuse analgesia due to the belief that it could cloud his/her thoughts and stop meditation prior to death.
- The body should not be moved for at least one hour as it is likely prayers will be said.
- There are no customary rituals for laying out the body so normal last offices are appropriate.
- **Christianity**
  - Last Offices may be requested. Further advice may be sought from the family priest or the hospital chaplain. There may be a request for a rosary or crucifix to be placed appropriately on the body.
- **Chinese**
  - It is essential that perioperative staff contact the family as soon as possible after death in order to ensure any specific requests or wishes of the deceased and/or family are adhered to if practical.
- **Hinduism**
  - It is important that the body of a Hindu patient is always covered following death.
  - The family usually remain with the deceased and the eldest son should be present. Relatives, of the same sex as the deceased, wash the body. Nursing staff may do this if the family requests.
  - Post mortems are considered disrespectful to the deceased and the family may need support in coming to terms with the legality of this issue.
- **Islam (Muslim)**
  - Death is considered inevitable and relatives may take comfort from praying and reciting the Qur’an. When obvious that the patient is dying, they should be supported to lay on their right side in order to face Kaaba or Mecca, for direction of prayer. If this is not possible, every effort should be made to place the patient on their back with their feet facing towards Kaaba, with head slightly raised. The body must remain covered at all times.
- **Jehovah’s Witnesses**
  - It is essential that perioperative staff contact the family as soon as possible after death in order to ensure any specific requests or wishes of the deceased and/or family are adhered to if practical.
- **Judaism**
  - Perioperative staff must contact the family Rabbi/local Hebrew burial society, as soon as possible after death in order to ensure any specific requests or wishes of the deceased and/or family are adhered to if practical. Perioperative staff must not wash the body of the deceased as this is part of the rites performed. Staff may close the eyes and mouth, straighten the body and bandage the jaw. A plain white sheet may be placed over the body.
  - The body must not be moved at Sabbath (Friday sunset – Saturday sunset) or on festivals including: Rosh Hashanah, Yom Kippur, Succoth or Shavuot.
- **Mormonism**
  - It is essential that perioperative staff contact the family as soon as possible after death in order to ensure any specific requests or wishes of the deceased and/or family are adhered to if practical.
There are no customary rituals for laying out the body so normal last offices are appropriate.

**Rastafarian**
- It is essential that perioperative staff contact the family as soon as possible after death in order to ensure any specific requests or wishes of the deceased and/or family are adhered to if practical.
- There are no customary rituals for laying out the body so normal last offices are appropriate.

**Sikhism**
- Family and friends are normally present.
- The family may request that the perioperative staff carries out last offices. If requested close the eyes, straighten the body and wrap in a plain sheet.
- When laying out the body it is important to adhere to the five Ks, which are as follows:
  - Kesh: Do not cut the hair or beard or remove the turban
  - Kanga: This is a semi-circular comb which fixes the uncut hair, and this should be left in situ at all times.
  - Kara: This is the bracelet that is worn on the wrist of the patient; this should be left in situ at all times.
  - Kaccha: These are the short trousers or breeches which are worn as underwear; this should be left in place after death.
  - Kirpan: This is a ceremonial sword, usually very small, that will be worn by the person at all times. Again this should be left undisturbed during last offices.
### 4. Helpful Contacts

<table>
<thead>
<tr>
<th>Faith</th>
<th>Contact</th>
<th>Address</th>
<th>Telephone No</th>
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<tbody>
<tr>
<td><strong>Trust Chaplains</strong></td>
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<tr>
<td>Kathy Smith</td>
<td></td>
<td>Longreach House, CRCH, Redruth</td>
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<tr>
<td>Christopher Newell</td>
<td></td>
<td>Bodmin Hospital, Bodmin</td>
<td>Contact through Bodmin Hospital</td>
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<tr>
<td>Elke Deeley</td>
<td></td>
<td></td>
<td>switch board 01208 251300</td>
</tr>
<tr>
<td><strong>Apostolic Church Assembly of God</strong></td>
<td>Mr G Glanville</td>
<td>Kobenhavn Lanjeth St Austell</td>
<td>01726 61746</td>
</tr>
<tr>
<td><strong>Bahai</strong></td>
<td>Diane Profaska</td>
<td>Kuffi Wheal Friendly St Agnes</td>
<td>01872 553184</td>
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<td>TR5 0SR</td>
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<tr>
<td></td>
<td>Mrs B Goode</td>
<td>Carrick Assembly Chy-os-Noweth</td>
<td>01872 864117</td>
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<td></td>
<td>Staggy Downs Carnon Downs Truro</td>
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<tr>
<td><strong>Buddhist</strong></td>
<td>Mr Richard Rowlett</td>
<td>Barquientine Porkellis Wendron</td>
<td>01326 341104</td>
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<tr>
<td>(Ananda)</td>
<td></td>
<td>Helston TR13 0JS</td>
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<td></td>
<td>Don Deacon Pollie Haarrington (Soto Zen)</td>
<td></td>
<td>01637 877501</td>
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<tr>
<td><strong>Christian Scientist</strong></td>
<td>Mr J R Gribble</td>
<td>Concord Mount Carbis Redruth</td>
<td>01209 216186</td>
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<tr>
<td><strong>Christian Spiritualist</strong></td>
<td>Mr D Webb</td>
<td>Flat 2 67 Causewayhead Penzance</td>
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<tr>
<td><strong>Community Church</strong></td>
<td>Mrs H Willis (Elder)</td>
<td>Christian Community Church</td>
<td>01872 275020</td>
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<td>15 Carey Park Truro</td>
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<tr>
<td><strong>Greek Orthodox</strong></td>
<td>Father Nikitas Lantsbery</td>
<td>15 Bronescombe Close Penryn</td>
<td>01326 372900</td>
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<td>TR10 8LE</td>
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<tr>
<td><strong>Humanist</strong></td>
<td>Mr J Lanford</td>
<td>Truro</td>
<td>01872 8638285 01736 754895</td>
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<tr>
<td><strong>Islam (Muslim)</strong></td>
<td>Rashid Ahmad</td>
<td>7 Trevose Avenue Newquay TR 7 1NJ</td>
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<tr>
<td><strong>Jehovah Witness</strong></td>
<td>Mr P Morris</td>
<td>General Visiting</td>
<td>01872 272692</td>
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<td><strong>Jewish</strong></td>
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<td></td>
<td>David Hampshire</td>
<td>Visitation Committee 18 Mill Road</td>
<td>01872 273059</td>
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<td>Penponds Camborne</td>
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<td>Harvey Kirzfield</td>
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<tr>
<td><strong>Church of the Latter Day of Saints (Mormon)</strong></td>
<td>Bishop P D West</td>
<td>11 Dozmere Feock Truro</td>
<td>01872 862713</td>
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<tr>
<td>National Federation of Spiritual Healers (01932 783164)</td>
<td>Anne Fowles (evenings)</td>
<td>A fee required by donation</td>
<td>01736 363114</td>
</tr>
<tr>
<td></td>
<td>Rita Jefferies</td>
<td>12 Carne Road Newlyn</td>
<td>01736 350629</td>
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<tr>
<td>Pagan</td>
<td>Cassandra Latham</td>
<td>The Dolls House Churchtown</td>
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<td>St Buryan Penzance</td>
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<tr>
<td>Quaker</td>
<td>Pat Griffith</td>
<td>1 The Leas Uplands Park</td>
<td>01872 276510</td>
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<td>Truro</td>
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<tr>
<td>Salvation Army</td>
<td>David L Wing</td>
<td>111 Cornish Crescent</td>
<td>01872 274023</td>
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<tr>
<td>Sikh</td>
<td>Sing Sabh Gurd Wara</td>
<td>Rangaratha Temple Bristol</td>
<td>0117 9554929</td>
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<td>0117 9511609</td>
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<td>0117 9559333</td>
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<tr>
<td>Spiritual Healing</td>
<td>Mrs J Flanders</td>
<td>The Court House Stapledon Lane</td>
<td>1362 99</td>
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<td>Ashburton Devon</td>
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Generic Theatre Standard No 10 - Fire Prevention

Fire Prevention in the Operating Theatre Environment

- Fire Precautions

Fire Safety Policy

- Potential fire hazards
  - Alcohol skin prep
  - Monopolar Surgery
  - Head and Neck Procedures
  - Laser Safety
  - Management of Airway Fire
  - Fibreoptic light cables or sources

- 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. If drapes are applied before the preparation has dried the vapour can accumulate.

  Alcohol flames are difficult to see under the operating 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 electrosurgery is planned.

- Monopolar electrosurgery
  - In monopolar electrosurgery, the active electrode is in the surgical site. The patient return electrode is somewhere else on the patient’s body. The current passes through the patient as it completes the circuit from the active electrode to the patient return electrode.
  - Electrosurgery units use a high frequency alternating electrical current for cutting and coagulation. They are the main potential ignition source for a fire
  - Electrosurgery can produce a high temperature electrical arc if carbonized tissue is allowed to build up on the tip of the electrosurgery device. It is essential that an electrocautery tip cleaner be applied to remove the build-up of carbonised tissue.
  - The power setting for the electrosurgery 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.

The active electrode should not be used in the presence of intestinal gases, as these contain hydrogen and methane, which are highly flammable.

**Head and Neck (H&N) Procedures**

- During H&N procedures a careful risk assessment must be performed to assess the proximity of the surgical field and combustible airway devices/anaesthetic gases. Where a risk is identified, measures must be taken to reduce this risk.
- In order to avoid any risk of ignition by skin prep, only aqueous antiseptic skin prep solution may be used.
- Careful consideration must be given to the potential accumulation of anaesthetic gases and in particular oxygen under drapes e.g. patients undergoing procedures under local with oxygen supplementation. Particular attention must be given to prepping, draping and positioning the patient to reduce this risk.
- Where there is a potential risk of airway fires, the use of N\textsuperscript{2}O is not recommended as this gas supports combustion.
- Where possible, in situations where an airway fire is a risk, closed/semi closed anaesthetic breathing systems and cuffed endo-tracheal tubes should be used. The Mistral jet ventilation system can be useful as it can provide variable FIO\textsubscript{2} from 21-100\%. However, it must not be used by anyone untrained in it's use and if required, attempts should be made to find a clinician able to use it safely.
- If the risk assessment determines the anaesthetic/surgical procedure: a potentially high risk for igniting, then high oxygen concentrations must be avoided.
- The use of diathermy is contraindicated whilst the patient is receiving 100\% oxygen.
- Draping and positioning the patient should be performed in a manner that does not allow pooling of oxygen under the drapes.
- If facial hair is exposed, coat the hair with a water-soluble surgical lubricating jelly to make it non-flammable.
- Additionally, moisten sponges, gauze and pledgets (and their strings) to render them ignition resistant.
- Theatre staff should be made aware that an airway fire may occur during tracheostomy. It is recommended that a bowl of saline is available on the surgical instrument trolley at all times.

**Laser safety**

- There is no UK legislation specific to non-ionising radiation protection. Therefore, the following legislation is most relevant: the Health and Safety at Work etc Act 1974; the Management of Health and Safety at Work Regulations 1999 and the Health and Safety (Safety Signs and Signals) Regulations 1996.
- In the United Kingdom, the Radiation Protection Division of the Health Protection Agency (HPARPD) (formerly the National Radiological Protection Board) advises the government providing guidance and recommendations on protection from both ionising and non-ionising radiation.
- Please read RCHT Non-Ionising (Laser and Optical) Radiation Safety Policy

*Each clinical area that possesses a laser will have easily accessible ‘Local Rules’, appropriate to the particular type of laser, the intended application, the hazards, associated risks and local circumstances. The laser must only be used in accordance with these Local Rules.*
• **Management of Airway Fire**

  o Stop ventilation
  o Disconnect oxygen source & flood the airway with water or saline
  o Consider flushing saline down the tracheal tube to extinguish an intraluminal fire
  o Remove the burned endotracheal tube (ETT) & examine the airway
  o Mask ventilate the patient & re-intubate
  o Survey the extent of injury with flexible bronchoscope
  o Monitor the patient for 24 hours
  o Administer steroid to reduce inflammation & oedema
  o Provide antibiotics & ventilator support if indicated

• **Fibreoptic light sources or cables**

  o Light sources can generate sufficient energy to melt, scorch or become an ignition source, especially when placed on patient drapes. Surgical drapes and swabs will burn. Fire retardants are used in some of these materials but do not remove the risk of ignition.
  o The light cable must be contained securely, away from the patient’s drapes whenever reasonably practicable.
  o The light source must be placed on ‘standby’ mode when not in use.

• **Staff responsibilities**

  o All staff must be aware of the trust fire evacuation policy
  o All staff must have attended mandatory yearly updates
  o All staff must be aware of location of fire escape routes and fire fighting equipment in all areas of work
  o A local fire coordinator 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 operating department
  o All staff have a responsibility not to block fire exists or escape corridors with equipment
  o Each clinical area should be checked each day to ensure that fire exist 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.
**Generic Theatre Standard No 11 - Dealing with Hazardous/Non Hazardous Spillages**

**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.

**Method:**

- **Hazardous Spillages**
  - 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 Operating Theatres 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 a minimum.
  - Any untoward occurrences involving hazardous substances must be reported, with referral to the Occupational Health Department as necessary.

- **Non Hazardous Spillages**

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

**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:**

RCH Trust Infection Control Precautions Policy, Disposal of Waste
AfPP Principles of Safe Practice in the Perioperative Environment 2011
**Generic Theatre Standard No 12 - Management of Clinical Waste**

Please see:
- **Generic Waste Management Policy**
- **Standard infection prevention and control precautions policy including Hand Hygiene and Safe Handling and Disposal of Sharps**

**Sensitive Disposal at RCHT**
- Pregnancy losses before 24 weeks are termed pre-viable and therefore do not need to be registered or certified. The parent(s) should be given the same choice on the disposal of foetal remains as for a stillborn child.
- The parents should be clearly and sensitively informed on the options available to them both verbally and in writing by trained health professionals.
- The RCN have further guidance: **Sensitive Disposal of all Foetal remains: Guidance for Nurses and Midwives.**
- Ensure the suction canister is not absorbent pre-gelled, nor add absorbent gel/granules to contents.
- The canister will be and contents will be identified with the patient's NHS number and sent to Histopathology, for storage before being taken to the crematorium or cemetery.
**Generic Theatre Standard No 13 - Management of Clinical Specimens**

**Standard:** Collection of specimens and transportation to the laboratory.

**Standard Statement:** In the operating theatre, 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.

**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 post mortems
  - 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 ‘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.
  - The Theatre Manager will retain copies of signatures of all healthcare professionals who make entries on healthcare records, together with the professional's registration number (NMC or HPC). The register of signatures will be reviewed and updated annually.
  - It is the responsibility of the requester to ensure that specimens and forms are correctly labelled.
  - It is the responsibility of the person sending the specimen to ensure that samples and forms are correctly labelled to the agreed standards.
  - 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, but on occasion may be another medical practitioner such as the anaesthetist. Whoever provides the detail must supply all information, including clear identification of who they are, their grade, and their contact details.
  - The theatre assistant responsible for the transport of the specimen to the laboratory must be aware of their responsibilities, in particular the delivery point in each laboratory.
It is the responsibility of the medical staff to notify the histology department of specimens requiring frozen section and complete the investigation request form prior to starting the operation. The surgical team must check that this has happened before the surgery starts.

**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 practitioner 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 practitioner must check 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 practitioner must relay this information to the circulating practitioner who will assist in the specimen collection process.

**Specimen Labelling**

- After checking with the patient’s notes, 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.
  - Consultant’s 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.
  - Contact details for the medical practitioner.
  - 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 recorded in the patient’s notes. This may be achieved by showing the scrub practitioner the notes, consent form or operating list. The documentation used must previously have been checked for accuracy of the details.
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 operating theatre. The specimen must be accompanied by the documentation.

The security and labelling of any operative specimen is 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 theatre 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 practitioner 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 operating theatre before the next scheduled patient arrives.

Specimens for frozen section are placed in dry containers, labelled as stated and must be dispatched immediately to the appropriate department (Royal College of Pathologists 2005).

Results of frozen sections must be received and a written record made by a member of medical staff.

Foreign Bodies

Foreign bodies must be clearly labelled and retained for inspection.

Forensic specimens must be saved in accordance with local policy ensuring that there is a total traceability of the specimen at all times until it reaches its destination.

Some forensic samples will not necessarily be body tissue eg: a bullet or shot removed during surgery from firearm wounds.
When orthopaedic implants or other mechanical devices (e.g., ventricular assist devices) are to be removed, the following must be ascertained:

- Whether the implant is to be sent for bacterial, pathological, metallurgical or mechanical examination.
- The legal ownership of the implant before any destructive testing is carried out.

- **Foetal Tissue**
  - It is imperative that personal wishes are respected in relation to a foetus or foetal tissue, and the guidelines followed in the:
    - Policy on Procedure for the sensitive disposal of pre-24 week foetal tissue.
  - Laboratory staff need to be informed of any personal wishes expressed if a foetus or foetal tissue needs to be sent for pathological examination.
  - Foetal tissue must be treated in accordance with Health Service Guidelines HSG 1991/19 (NHS Management Executive 1991).

- **Temporal Artery Biopsy**
  - Temporal Artery Biopsy or Specimens of Similar Size
    - For Temporal Artery Biopsy or similar size specimens a ‘cellsafe’ biopsy capsule must be used to reduce the risk of the specimen migrating and become ‘missing’.

- **Traceability**
  - There must be a central point for specimens and specimen forms to be taken to following an operation. A specimen folder will hold tracking forms that require 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 form 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 cool box/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 please it must be placed in a large bag with the form and put on the floor.
  - The cool box/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 cool box/collecting box after that time will stay at the central point until the first collection of the next day.
  - If the surgeon has asked for a histology specimen to go to the histology laboratory for frozen section, the tracking form must be completed and both the specimen and specimen form (in a bag) must be passed to a porter to take to the lab immediately.
  - It is the individual responsibility of each person who takes the specimens to the central place to ensure that all details are correct prior putting them in the box.

- **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 nurse 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 log book 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: See addenda’s for frozen sections, ENT specimens and breast specimens.

References:
AfPP Principles of Safe Practice in the Perioperative Environment 2011

Addenda to Collection of Specimens Standard
No 14a Localised Excision of Breast Lesion:
This applies to patients who have a specimen taken with a wire in situ.
- The specimen must be placed in a clear plastic bag.
- The relevant specimen form and X-ray request must be completed by the surgeon prior to the case commencing.
• Staff must ensure that the relevant forms accompany the specimen i.e. the specimen form and the X-ray form. The telephone extension number of the theatre in which the operation is being performed must be marked on the specimen form.

• The patient’s existing X-rays must also accompany the specimen.

• Theatre staff will provide a labelled specimen pot large enough for the specimen to be placed in following X-ray. Formalin must be added to the pot prior to it leaving the department. X-Ray will place the specimen in the pot following their handling of it.

• The patient’s details must be placed in the specimen logbook and the name of the orderly transporting the specimen obtained by theatre staff. Specimens must be taken directly to the Breast Unit.

• Theatre staff will inform the breast unit that the specimen is en-route to them.

• The Breast Unit will contact the relevant theatres to inform surgeon if the excised margins of the specimen are adequate.

No.14b Other Breast Specimens:

• Breast specimens must have a red dot affixed to the specimen form to denote their priority status to the laboratory. A red dot needs only to be applied to the form and not the receptacle.

No 14c Frozen Sections:

• It is the responsibility of the medical staff to give notification to the histology department of specimens requiring frozen section. They are responsible for completing the relevant specimen forms prior to the case starting. Theatre staff must check that this has been completed.

• Theatre staff must check that, included on the specimen form, is the extension of the theatre where the surgery is taking place.

• Specimens going for frozen section must be placed in dry containers only.

• Specimens must be despatched immediately to the laboratory.

• Theatre staffs are to call the laboratory when the specimen has been despatched to warn them of its arrival.

• Theatre staff must enter the details of the patient into the specimen log book.

• Theatre staff must obtain the name of the orderly delivering the specimen to the laboratory.

• Only the surgeon or a member of the medical team may take the results from the laboratory.

No 14d E.N.T. Specimens:

• All E.N.T Specimens are labelled for E.N.T. On the specimen form where the request for the patient’s location is made.

• Some E.N.T. specimens require a pin-board. Theatre staff must obtain this from the Pathology department; they will also provide the container and pins.

• It is the responsibility of the surgeon to pin the specimen out as required.

• Theatre staff must label the container with the patient’s details. This label can be placed on the lid of the container.

• These pinned specimens are always sent dry, and must therefore be sent directly to the laboratory as soon as possible.

• The details of these specimens must be recorded in the theatre logbook as normal.
Generic Theatre Standard No 14 - Management of Latex Allergy Patients in the Operating Department

Latex and the Perioperative Environment

This standard is to be read in conjunction with

- Guidelines for the Anaesthetic Management of Patients with Latex Allergy.

1. General Guidance

- The RCHT Theatres and Anaesthetics Division have reduced or removed the Natural Rubber Latex (NRL) products in the operating theatres as far as is reasonably practicable. Creating an NRL free environment, will therefore be possible when required

- A list of all hospital items identifying if they do or do not contain NRL: is contained in the Guidelines for the Anaesthetic Management of Patients with Latex Allergy.

2. Education

- 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.

3. Communication Processes

- Please refer to the 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.

4. Pre-admission assessment

- All patients admitted for planned surgical procedures should have had their allergy status assessed and recorded as part of the preoperative assessment process.
- It is important that information on patient allergies is communicated to the theatre 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 transferred to theatre while the appropriate actions are taken.

5. Pre-anaesthesia

- The anaesthetist responsible should try to distinguish type 1 hypersensitivity from type 4 hypersensitivity as this will influence the level of precautions taken.
- See Guidelines for the Anaesthetic Management of Patients with Latex Allergy

6. Induction of anaesthesia

- See Guidelines for the Anaesthetic Management of Patients with Latex Allergy
7. **Intraoperatively**

- The key is to avoid contact with latex on the skin, intravenously, by inhalation and particularly by contact with mucous membranes, peritoneum and serosal surfaces.
- All staff must be aware of the need to maintain a latex free environment on the ward, in transit, in theatre and recovery. For type 1 hypersensitivity consider recovery in theatre.
- The single most important precaution is to avoid any member of staff wearing latex containing gloves.

8. **Recovery**

- For patients with known type 1 hypersensitivity consider recovery in the operating theatre to mitigate the risk of exposure in other areas.
- For all other patients there is no requirement to bypass the recovery area.

9. **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 operating department are latex free, 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.
**Generic Theatre Standard 15 – 5 Steps to Safer Surgery including WHO Surgical Safety Checklist**

Standard: Application of the 5 Steps to Safer Surgery including WHO Surgical Safety Checklist (SSC) in all operating departments.

Standard Statement: All operative procedures performed in trust operating theatres will have the correct and full application of the WHO SSC process completed and documented by the theatre 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.

Method:

1. **List Briefing**
   - Prior to the commencement of the operating list – participation by the full theatre team allocated to the operating list
   - The list briefing will be documented on the standard template and all issues covered, if any points are not relevant they should be marked as such.
   - Staff must introduce themselves to each other by name and role. This information will be recorded on a visible wipe clean board.
   - The theatre nurse / practitioner designated “in charge” of the list must be clearly identified.
   - Any changes to the published Galaxy list must be discussed and understood by all members of the theatre team. If changes include laterality of change of procedure the list should be changed and reprinted.
   - Any issues related to the organization of the list must be discussed e.g. staffing, wards, recovery, beds, radiology.

2. **WHO Surgical Safety Checklist Theatre and all other General Anaesthetic activity (See Appendix 4)**
   - Every Patient should have a completed Pre-Op Assessment and Pre-Op Checklist as part of the perioperative document prior to transfer to theatre, cataract patients will utilise the cataract perioperative pathway document.
   - Every Patient will have a copy of the WHO Surgical Safety Checklist
   - 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 practitioner in charge of the operating theatre to ensure that the WHO SSC process is completed accurately and diligently.

3. **Sign In – Before Induction of Anaesthesia**

- If the senior surgeon has not seen the patient on the ward they must be present at ‘Sign In’. If the senior surgeon has seen the patient it is up to their discretion as to whether they are present for ‘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.

- The registered practitioner/delegated person will clearly mark the checklist in the appropriate place to confirm the check has taken place.

- On completion the registered practitioner will clearly print their name and Sign to confirm completion of the sign in check.

- The registered practitioner/delegated person will confirm that the correct patient details are completed on the WHO Surgical Safety Checklist (a patient identity label may be used).

4. **Time Out – Before start of surgical intervention including skin preparation**

- To be completed by the whole operative team including surgeon(s) and anaesthetist(s) – the senior operating surgeon retains the accountability to ensure that this check is fully completed.

- 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 surgery 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 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.

• For Gynaecology procedures only – Before each stage of a multi-stage operation and before vital organs are removed the consent form must be re-checked.

5. **Sign-out - after completion of the final swab and instrument count and prior to any staff member leaving the operating theatre**

• To be completed by the whole operative team including surgeon(s) and anaesthetist(s)

• 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 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 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 WHO Surgical safety Checklist must be signed by the team member leading the check and the senior operating surgeon.

6. **List Debriefing**

• The whole theatre team including surgeon(s) and anaesthetist(s) debrief at a suitable interval to review the procedures undertaken on the operating schedule

• 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:
  o What went well?
  o Any challenges or concerns about the list
  o Communication, skill-mix, issues outside theatre, timing issues
  o Any specific equipment issues that needed to be addressed before the next list
  o Anything that could have been done to make the list safer
  o Anything that could have been done to make the list more productive

• Any issues should be reported to the Theatre Manager and a Datix report raised if necessary.

• Any issues of shared learning must be included for the following days departmental “safety huddle”

Maternity Theatres
1. List Briefing

  o Prior to the commencement of the operating list – the theatre team will meet at
  o 08.30 to review the unit status board.
  o Staff must introduce themselves to each other by name and role. This information will be recorded on a visible wipe clean board.
  o Any changes to the planned list and possible cases requiring theatre must be discussed.
  o Any issues related to the organization of the list must be discussed e.g. staffing, recovery, beds.
  o The staff must discuss special surgical requirements, equipment, instruments, blood transfusion requirements, including cell salvage, allergies and antibiotic prophylaxis requirements.

2. WHO Surgical Safety Checklist - Maternity (See Appendix 5)

  o Every Patient should have a Pre-Op Assessment and Pre-Op Checklist completed prior to surgery
  o Every Patient will have a WHO Surgical Safety Checklist
  o All steps to be read out loud though steps relating to airway/aspiration risk 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.

3. **Sign In – Before Induction of anaesthesia**

- It is up to the discretion of the senior surgeon in theatre as to whether he/she is present at ‘Sign In’, providing the surgeon has seen the patient on the ward.
- If the senior surgeon has not seen the patient on the ward they 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.
- The registered anaesthetic practitioner (ODP/RN) will instigate the ‘Sign In’ and clearly mark the checklist in the appropriate place to confirm the check has taken place.
- On completion the registered practitioner will clearly print their name and sign to confirm completion of the sign in check.

**Time Out – Before start of surgical intervention for example skin preparation**

- The whole theatre team including surgeon(s) and anaesthetist(s) – the operating surgeon retains the accountability to ensure that this check is fully completed.
- The second Midwife will instigate the ‘Time Out’, confirm all team members are present and initiate the checklist by reading out loud all points contained in the timeout section of the checklist.
- 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/problems/issues raised during the checking procedure should be documented and reported to the relevant Department Manager/Coordinator.
- Any concerns or queries raised by any team member must be resolved before surgery commences.
- The Midwife will clearly mark the checklist in the appropriate place to indicate the point has been discussed and must print name and sign to confirm the time out check is complete.
4. **Sign-out - after completion of the final swab and instrument count and prior to any staff member leaving the operating theatre**

- The whole theatre team including surgeon(s) and anaesthetist(s)
- The surgeon or registered anaesthetic practitioner 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 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/problems/issues raised during the checking procedure should be documented and passed to the relevant Department Manager/Coordinator.
- Any concerns or issues that have arisen during the procedure must be logged. If necessary, a Datix must be completed.
- The team formally acknowledges any concerns for recovery and postoperative management of the patient.
- The WHO Surgical Safety Checklist must be signed by the registered practitioner and the senior operating surgeon then filed in the patient medical record.

5. **List Debriefing**

- The whole theatre team including surgeon(s) and anaesthetist(s) debrief at a suitable interval to review the procedures undertaken on the operating schedule.
- The whole team acknowledges:
  - What went well?
  - Were the any challenges or concerns about the list?
  - Communication, skill-mix, issues outside theatre, timing issues
  - Were there any specific equipment issues that needed to be addresses before the next list?
  - Is there anything that could have been done to make the list safer?
  - Is there anything that could have been done to make the list more productive?
o Any issues should be reported to the Senior Midwife, or a Datix raised if necessary.

6. **Trial of Instrumental Delivery in Theatre**

   o The ‘Sign In’ and ‘Time Out’ processes should happen before the start of the assisted delivery process as per the process described above. The Midwife will instigate the check procedure.

   o The possibility of progression to caesarean section should be discussed in the Time Out checklist.

   o At the end of the delivery irrespective of the route of delivery the full team will complete the ‘Sign Out’ as per the process described above.

   o **Treatment room, endoscopy and non theatre areas only**

   o List Briefing

   o List briefing should take place prior to the commencement of the operating list participation of the whole team is required.

   o Staff must introduce themselves to each other by name and role. This information will be recorded on a visible wipe clean board.

   o Any changes to the planned list and possible cases must be discussed.

   o Any issues related to the organization of the list must be discussed e.g. staffing, recovery, equipment, beds.

   o The staff must discuss special surgical/procedural requirements, equipment, instruments, allergies and antibiotic prophylaxis requirements.

   o Registered Practitioners will maintain overall responsibility for completion of the WHO Surgical Safety Checklist but may choose to delegate any part of the tasks related to its application to non-registered staff other than the required registered practitioner’s signature.

   o The registered practitioner retains professional accountability for the appropriateness of the delegation of that task.

   o Every patient having an interventional surgical procedure (including in endoscopy, Catheter Labs, St Michaels Treatment Room - this list is not exhaustive) will have a Treatment room, endoscopy and non theatre area WHO Surgical Safety Checklist.

   o All steps will be read out loud though steps relating to blood loss and renal failure may be treated with discretion.

   o ‘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 checklist process.
**Sign In – Before injection of Local Anaesthetic or commencement of the procedure**

- The Senior Surgeon/Operating Clinician must be present.

- A delegated team member will instigate the ‘Sign In’ and clearly mark the checklist in the appropriate space to confirm the checks have taken place.

- If at any point during completion of ‘Sign In’ a member of the team is required to leave the peri-operative environment, the checklist should be suspended and recommenced when all are present.

- If at any point during ‘Sign In’ 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.

**Sign Out - after completion of the final swab and instrument count (if applicable) and prior to any staff member leaving the perioperative environment**

- The whole team, including the Surgeon/Operating Clinician, will be present.

- The Surgeon/Operating Clinician will confirm all the team members are present and initiate the checklist by reading out loud all points in the ‘Sign Out’ section.

- If at any point during completion of ‘Sign Out’ a member of the team is required to leave the peri-operative environment, the checklist should be suspended and recommenced when all are present.

- If at any point during ‘Sign Out’ 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/problems/issues raised during ‘Sign Out’ should be documented and passed to the relevant department manager.

- Any concerns or issues that have arisen during the procedure must be logged and reported on Datix if necessary.

- The team should acknowledge formally any concerns for recovery and/or post-operative management of the patient.

- Patient details must be entered into the relevant area. These may be handwritten or a patient label may be used.

**List Debriefing**

- The whole team including surgeon(s) and anaesthetist(s) debrief at a suitable interval to review the procedures undertaken on the operating schedule.

- The whole team acknowledges:
- What went well?
- Were the any challenges or concerns about the list?
  - Communication, skill-mix, issues outside theatre, timing issues
  - Were there any specific equipment issues that needed to be addressed before the next list?
  - Is there anything that could have been done to make the list safer?
  - Is there anything that could have been done to make the list more productive?
- Any issues should be reported to the Departmental Manager, or a Datix raised if necessary.

**Radiological procedures performed outside of a theatre suite**

Radiological procedures performed outside of a theatre suite may use the National Patient Safety Agency agreed WHO Surgical Safety Checklist for Radiology Interventions ONLY. However the list briefing, sign in, time out (if required), sign out and list debriefing processes in this policy
Generic Theatre Standard 15 a – Audit of 5 Steps to Safer Surgery including WHO Surgical Safety Checklist

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.

Standard: Application of the 5 Steps to Safer Surgery including WHO Surgical Safety Checklist (SSC) in all operating departments will be audited to assure compliance.

Standard Statement: All operative procedures performed in trust operating theatres will have the correct and full application of the WHO SSC process completed and documented by the theatre team.

Method:

Audit of Compliance with 5 Steps to Safer Surgery, including 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 theatre departments and incorporates the principles of Team review.
- All staff on-duty are expected to attend – the practitioner leading the huddle is expected to ensure that all are present.
- The safety huddle discussion will be documented on the standard template provided and will include any issues identified for learning from the previous days operating.
- The practitioner leading the safety huddle will ensure that all theatres are represented and 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 office.
- The completed record will within 7 days be saved to the shared governance file for audit monthly.

Theatre List Briefing – step 1 of 5 steps to safer surgery

- Each theatre list will have a theatre list briefing before the start of the operating session.
- The theatre list briefing will be structured following the standard template
- The theatre list briefing may be led by any member of the theatre team but the operating surgeon and anaesthetist if allocated 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 theatre for the briefing of staff joining the team, new information may be added during the session.
WHO Surgical Safety Checklist – steps 2, 3 & 4 of 5 steps to safer surgery

- Every patient undergoing a surgical procedure will have a fully completed WHO SSC
- The WHO SSC is retained in the perioperative document and forms part of the medical record
- Completion of each phase of the WHO SSC (see practice standard) will be recorded in the Galaxy electronic theatre record system
- Each individual patient record of WHO SSC will be reviewed in recovery for completion
- Incomplete WHO SSC will be returned to the relevant theatre for completion before the patient leaves the operating department
- On discharging the patient from the operating department the galaxy electronic theatre record will be updated to show completion of the WHO SSC
- For patients returning to admission units directly from theatre and not recovery the WHO SSC completion will be made in the galaxy theatre screen
- The theatre electronic record will be checked daily and all department managers notified of negative entries. These individual cases must be investigated and ratified within 48 hours to confirm completion of the WHO SSC or the rationale for non-completion.

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

Audit of Quality

- The above process quantitatively records the WHO SSC for each patient it does not measure the quality of completion of the process.
- The process for completion of the WHO SSC is detailed in Theatre Practice Standard 15
- 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 theatre 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 Theatre Managers
- Theatre Managers will not assess their own departments and will be supported by assessment completed by the anaesthetic and recovery services managers (5 direct observations each per month).
- 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, theatre and specialty. Individual reports related to clinicians can be provided.

Theatre List Debriefing - step 5 of 5 steps to safer surgery

- Each theatre list will have a theatre list debriefing at the end of the theatre session and before team members leave.
- The theatre list debriefing will be structured following the standard template
- The theatre list debriefing may be led by any member of the theatre team but the operating surgeon and anaesthetist if allocated must be present.
- The theatre list debriefing may begin at any time agreed suitable by the team towards completion of the final case.
- 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 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 governance file and its entry recorded in the summary sheet to enable audit by the divisional governance team.
- Completion of:
  - Safety huddle
  - Theatre list briefing
  - Theatre 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 Divisional Governance Board meeting and shared with all surgical specialties.**

References: AAGBI

AfPP Principles of Safe Practice in the Perioperative Environment 2016
**Generic Theatre Standard No 16 - Stocking up of Theatres.**

**Standard Statement:** All staff are responsible for ensuring that the operating theatres are adequately stocked at all times, and ensuring correct stock rotation.

**Method:**

- All staff must ensure that the theatres 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 and fluid warming cabinets as well as the trolleys in theatres. 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 into theatres, 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 theatres and again before use.

- Each theatre 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 Stores person on duty Bleep7215 or extension 5756. Also noted on the white board outside the main storeroom.

- The stores team monitor the stores levels on a daily basis, but welcome any information regarding reduced levels, any increased usage in a particular item that will be sustained, should be notified to the Stores person so that stock levels can be increased accordingly.

- Items that are unwanted or unused must be returned to their appropriate storage area.

- Items should not be removed from the main storage area as this is a receiving and distribution area only and items may not have been processed completely.

- Staff should only use other theatres 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. Any prostheses or implants used should also have labels attached to the reorder sheets in each theatre and patient’s operation note.

- Ordering of non-stock items can only be authorised by the Divisional Management Team.

**Compliance:** 100%

**Exceptions:** None

**References:**

See other Theatre Standards:

Pharmacy Delivery and Stock Rotation
**Generic Theatre Standard No 17 - Theatre Etiquette**

**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.

**Method:**
- All staff are expected to be changed and ready for duty at their allocated start time.
- Talking outside of the anaesthetic rooms and theatres must be kept to a minimum to avoid disruption.
- The use of mobile phones is restricted – staff must familiarise themselves and comply with the theatre standard regarding the use of mobile phones in the department.
- Staff must be familiar with and adhere to the existing Operating Theatre Standards.
- Staff must be familiar with and adhere to the Operating Theatre Philosophy.
- Staff must be familiar with and adhere to the dress policy as outlined in the Preparation of Personnel Operating Theatre Standard.
- Staff must ensure that entitlement to lunch and breaks is not exceeded. The morning coffee break will be granted by the team leader and is for fifteen minutes. Lunch breaks are not to exceed 30 minutes unless permitted by the team leader in mitigating circumstances. The afternoon tea break is discretionary and will be granted, when possible, by the theatre team leader.
- 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.
- To prevent disruption of air flows and minimise the risk of cross infection staff must restrict their movement in and out of each theatre environment.
- Staff should address members of the theatre team by their appropriate title unless invited to do otherwise, especially in front of awake patients.
- Patients should be addressed by Mr or Mrs/Ms/Miss (except for paediatric patients) unless they have given prior consent to be address by their given name. Details of preferred form of address should be indicated on the theatre check list.
- 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
- Preparation of Personnel
- Use of Mobile Phones in Theatre
- Operating Theatre Philosophy
- Preparation of theatre staff
Generic Theatre Standard No 18 - Use of Mobile Phones in the Operating Theatres

Standard Statement: The inappropriate use of mobile phones in the operating theatre department is strictly prohibited.

Method:

- Staff must be familiar with the trust policy regarding the use of mobile phones in the hospital.
- Staff are only to use their mobile phones in the coffee room whilst on their designated breaks, or for essential Trust business use.
- Mobile phones must be switched off or on silent mode in the restricted areas i.e. Prep room, Anaesthetic room, Operating Theatre and Sluice.
- Sending text messages and receiving calls whilst in the theatre is strictly prohibited when patients are present.
- The Trust accepts no responsibility for loss, damage to, or breakage of staff member’s mobile phones.
- The use of picture phones, by any staff member or visitor, is strictly prohibited in theatre.

Compliance: 100%

Exceptions: On call Surgeons and anaesthetists who are unable to divert emergency calls whilst operating.
Section 2 – Theatre Management / Coordination

Generic Theatre Standard No 19 - Consent and Refusal of Consent

All theatre staff should be familiar with the trust 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 operating surgeon immediately.

Policy for Consent [Error! Bookmark not defined. to Examination or Treatment on document library]

Children and Consent

Policy for Consent to Examination or Treatment on document library

Consent to Photography and Recording

Policy for Recordings and Photography on document library
Generic Theatre Standard No 20 - Managing Conscientious Objection

Theatre Staff Objection to Termination of Pregnancy at RCHT

General Considerations

- RCHT facilitates the procedure for surgical Termination of Pregnancy (sTOP), and recognises there is the potential for staff to action their right of conscientious objection.

- Where practitioners from other specialties are required to provide treatment or assist, it is the responsibility of the perioperative team lead, for theatre staff, surgeon for clinician colleagues or anaesthetist for anaesthetic colleagues, to ensure that those called in are aware of the fact that treatment is of a patient undergoing termination of pregnancy, and to ensure that such practitioners do not have conscientious objections.

- If a member of staff has expressed a conscientious objection, they will be expected to participate in all aspects of care for the patient at all times with the exception of assisting in the technological procedures.

- The member of staff will be allowed to withdraw, just prior to and during the technological aspect of the patient’s treatment.

- The member of staff will be expected to return to caring for the patient, once the technological part of the procedure has been completed.

- If a patient undergoing termination of pregnancy requires immediate care and treatment to prevent serious injury or death, then that care and treatment must be provided by a practitioner to the best of their ability, even if they have previously made known a conscientious objection.

- Staff should make their line manager, aware as soon as possible, that they have a conscientious objection, in writing, and that they intend to action on it.

- Example of written conscientious objection:

  I register a conscientious objection to Termination of Pregnancy. I understand RCHT will not expect me to assist with the technological aspect of the termination of pregnancy procedure. I will provide, to the best of my ability, any treatment that is required to prevent serious injury or death of a patient undergoing termination of pregnancy.

  Name, Post Held, Signature, Date

- This written confirmation will be kept in the staff member’s Personnel file.

- Where members of staff have expressed a conscientious objection and non-urgent treatment is required for a patient undergoing termination of pregnancy:

  - The perioperative team lead, for theatre staff, surgeon for clinician colleagues or anaesthetist for anaesthetic colleagues, should ensure alternative staff are available to care for the patient during the technological phase of the termination of pregnancy procedure.

  - It is unacceptable for staff members who action their right to conscientious objection to endure any discrimination from other members of staff. There is a ‘no tolerance’ stance by RCHT regarding discrimination.

  - Managers and staff should read The Dignity at Work Policy, Procedure and Guidance (Valid From: 27/06/2012 - To: 12/06/2015) carefully to ensure that they maintain the standards required and understand the procedures to be adopted when problems arise.
Generic Theatre Standard No 21 - Organ Donation Procedures for RCHT Theatres

Short notice theatre space for organ procurement

The DCD programme has been developed nationally to improve the potential for organ donation in the face of a national shortage of available organs. If each acute hospital in the UK could facilitate just one additional donor we could see up to 1000 extra transplants.

- More than 10,500 people need an organ transplant in the UK. In 2008-09 a record 3,513 people’s lives were transformed by a transplant. Transplants are now so successful that many more patients can be considered for treatment in this way.

- Advances in surgical skills and better drugs mean that a year after surgery: 96% of kidneys in living donor transplants, 93% of kidneys from people who have died, 90% of liver transplants, 81% of heart transplants, 77% of lung transplants are still functioning well.

- Approximately 1,000 people die every year (3 a day) in the UK while waiting for an organ transplant or because they become too ill to survive an operation and are removed from the list.

- We have an excellent record in this Trust, but we need to make sure the processes are in place to continue to support the program.

- The number of cases for RCHT is small, 6-12 per year, and the majority of cases will occur out of hours when theatre availability is not an issue. However there is always the possibility that a theatre may need to be made available during operating hours. In such circumstances it would be necessary to hold a theatre available for at least 2 hours.

The Guidance

SCENARIO A

- If the retrieval is likely to occur during normal operating hours a theatre and staff will have to be identified.

- Is one of theatre 7 -9 empty? -Use that theatre.

- If not, is there a list that could be moved to another theatre?- If possible proceed to move that list.

- If not, plan to interrupt the CEPOD or trauma list. Inform theatre staff, surgeons and ward as soon as possible.

- A log of cancelled lists will be kept by the Theatre Manager to ensure to ensure a fair and equitable impact on different speciality lists.

- No Triage category A patients will be delayed.

- Staff.

An anaesthetic and circulating practitioner are necessary. Ideally they should be provided from on duty staff where possible, however a list of staff agreeable to being on-call for organ retrieval will be available. The theatre co-ordinator will be responsible for identifying and allocating staff to support the procedure.

Short Notice Theatre Space For Organ Donation

Last Offices
See generic theatre standard 10 – Care of the deceased in the operating department.
**Generic Theatre Standard No 22 - Management of Operating Lists including Out of Hours**

Within the remit of the Theatres and Anaesthetics Division, we have 20 theatres over 3 sites which incorporate Royal Cornwall Hospital, St Michael's Hospital and West Cornwall Hospital. The primary use for these theatres are:

**Royal Cornwall Hospital** – Comprises of three suites
- **Tower Theatres:** ‘Cold Hub’ Elective and Day surgery, Urology, Lower GI,
  - Theatre 1
  - Theatre 2
  - Theatre 3
  - Theatre 4
  - Theatre 5
  - Theatre 6
- **Trelawny Theatres:** ‘Hot Hub’ including 24 hour theatres for Trauma and CEPOD. Orthopaedic elective. Upper GI Surgery.
  - Theatre 7
  - Theatre 8
  - Theatre 9
  - Theatre 10
  - Theatre 11
- **Newlyn Theatres:**
  - Theatre 12
  - Theatre 13
  - Theatre 14

**St Michael’s Hospital**
- Theatre 1
- Theatre 2
- Theatre 3
- Theatre 4

**West Cornwall Hospital**
- Theatre 1
- Theatre 2

There are three recovery areas for Royal Cornwall Hospital site one in Tower suite one in Trelawny suite which is adjacent to the Critical Care Unit and one in Newlyn suite.

**Management of Operating Sessions at RCHT**

**Theatre Scheduling**

All theatre lists are managed and compiled in conjunction with the Trust’s Theatre Scheduling Policy.

As per the Trust policy for Theatre Scheduling, the responsible Consultant Surgeon for the list will after appropriate involvement of other clinical disciplines such as anaesthesia, radiology and other relevant healthcare professionals and where practicable, confirm the list order 5 working days prior to the day of surgery after taking into account: urgency, extremes of age, allergies and any medical conditions that make early or predictable start times desirable, e.g. diabetes or sleep apnoea.
Any list changes that have been made after the 5 working days must follow the Trust's Theatre Scheduling policy with all relevant personnel made aware and be discussed in the list’s briefing prior to the first patient arriving in theatre.

The final version of the session list will be available in the relevant theatre and also via the Nurse in Charge.

The Booking Administrators will plan the list in order to make maximum use of the resources and time available.

Operating lists must be compiled taking into account the following:
- Operating time available
- Key safety steps including and not limited to briefing, WHO checklist and debriefing.
- GA or LA Session
- Expected duration of surgical procedure including anaesthetic time
- Case mix
- Grade of operating Surgeon / Anaesthetist
- Equipment preparation time including any special equipment / implants / additional resources
- Whether a patient requires an assessment to meet their individual needs that may require theatres to make some reasonable adjustment to the list.
- Bed availability, for in-patients, day cases and in particular ITU / HDU

The information that accompanies the scheduling of a procedure should include when relevant and is not limited to:
- Patient name
- NHS number and hospital number
- Date of birth
- Gender
- Planned procedure (the use of abbreviations should be avoided or limited to the list of Trust approved abbreviations which can be seen in appendix ??)
- Site and side of procedure if relevant (laterality must always be written in full i.e. ‘left’ or ‘right’)
- Source of patient, e.g. ward or admissions lounge

Further information that can be provided when relevant may include:
- Significant comorbidities
- Allergies, e.g. to latex or iodine
- Infection risk
- Any non-standard equipment requirements or non-stock prostheses
- Body mass index
- Planned post-procedural admission to high dependency or intensive care facility

The list plan takes into account the time required to set up, calibrate and perform safety checks on specialist equipment and for staff to participate in briefing, debrief and other key safety steps identified.

Shift patterns commence at 08:00 with operation sessions starting at 08:30 allowing for the necessary safety checks outlined above with the operation session closing at 17:30 with staff rostered until 18:00 allowing for appropriate safety checks as outlined above.

Theatre Managers have a responsibility to ensure that any theatre lists which start outside of normal operating session times are staff accordingly and take into account the time required to setup up, calibrate and perform safety checks on specialist equipment, and for staff to participate in briefing, debriefing and other key safety steps.
1. Cancellation of elective / scheduled patients

- Cancellation on the day of elective / scheduled patients is to be avoided if at all possible due to the distress caused to patients

- In situations where it is possible an elective patient may be cancelled after admission to hospital for reasons other than that they are unfit for anaesthesia or surgery the guideline below should be followed for assessment and notification

- The Theatre Manager / coordinator is responsible for ensuring that the guideline is followed and that the appropriate notification is made.

- While all attempts will be made to secure a theatre team to accommodate over runs and mitigate cancellation it is not appropriate for any member of staff to face undue pressure to stay beyond their planned finish time.

- Any list over run must have the support of a full theatre team for patient safety.
2. **Guidance on avoiding cancellations of elective procedures**

This guidance recommends the process that Divisions must follow to manage potential cancellations of surgery on the day of operation. This applies to all patients scheduled for an elective procedure and is effective from 1st January 2014.

The Specialty Service Manager must always be informed immediately if there is a potential cancellation. Patients must not be cancelled unless the process detailed below is adhered to. This will be audited on a weekly basis through performance review, via the List Broker.

Below are detailed some trouble shooting actions, which may be helpful when facing a potential cancellation.

1. If the theatre runs out of time and cannot be extended, can the patient be put on an alternative list without being discharged e.g. remain in hospital overnight and be added to a list the following day/overnight stay?

2. If bed difficulties, can the patient be transferred to another area or facility? Have you notified the Site Manager for help- consider WCH or SMH?

3. Doctors available – can the operation be undertaken by alternative Doctor, done out of hours or transferred to alternative list?

4. Emergency took priority; can the operation be undertaken on another list?

If potential cancellation arises

Theatre Manager or Ward Manager notifies

Service Lead of Specialty concerned

Resolved

Not resolved

Divisional Manager of Specialty informed

If theatre issue

Divisional Theatre Manager

Resolved

If bed issue

Site Manager

Not resolved

Chief Operating Officer Informed

Root Cause Analysis completed by Relevant Divisional General Manager
3. Planned over-running sessions

- Planned operating list extensions are requested and agreed in advance by the DGM.
- Notification of agreed list extensions will be made as soon as possible to the theatre managers / coordinators to enable staffing to be planned within the normal off-duty system.
- Short notice requests for operating list extensions will be considered by the theatre manager / coordinator and a theatre team sought to support the list with appropriate skill and knowledge. If this is not possible the theatre manager will notify the relevant Service Lead and Divisional Management Team at the earliest opportunity to enable further planning and list adjustment.
- If a theatre team cannot be identified in advance it is not appropriate to assume that the allocated team will support the planned over run and the operating list will need to be adjusted accordingly.
- Service Leads are advised to maintain communication with the relevant theatre manager to ensure that any distress and patient cancellation is mitigated.
- While all attempts will be made to secure a theatre team to accommodate list extensions and mitigate cancellation it is not appropriate for any member of staff to face undue pressure to stay beyond their planned finish time.

4. Ensuring an effective response to emergency situations

- Operating at night policy
- Approved document for safer staffing levels for Obstetric anaesthetist and obstetric operating department practitioners
- Short Notice Theatre Space For Organ Donation
- Guidelines for Management of Emergency Theatres (Trauma)
- Theatres provide two 24/7 operating theatres supporting emergency trauma and multi-speciality surgical activity (CEPOD).
- These theatre have “ring fenced” staffing allocations which should not be diverted to support elective activity unless in agreement with consultant surgeons on call that day.
- The theatre manager / coordinator is responsible for ensuring that an adequate skill mix is maintained in all theatres to support the activity planned.
- Where access to a theatre is required at short notice for emergency surgery and both emergency theatres are in use the theatre manager / coordinator will in collaboration with the on call consultant determine the elective list most appropriate to be halted in order to facilitate emergency surgery. This decision will be based on list progression, clinical priority and staff skill mix required.

5. Cancellations/changes to the operating list

- Planned operating lists will be printed off from galaxy prior to the start of the list
- Best practice suggests that operating lists should not be changed once published
- It is accepted that at times it will be necessary to alter the order of the operating list due to clinical priority / patient need, this should be discussed with all team members at the pre-list briefing to ensure that all staff are aware of changes planned.
- The theatre coordinator must be informed of all list changes agreed by the theatre teams at the earliest opportunity.
- It is the responsibility of the operating surgeon / practitioner in charge to ensure that all copies of the operating list are changed and that all team members are aware.

6. Staffing of theatre operating sessions including emergency lists.

- Electronic Management and Production of Staff Rosters Policy
• All planned operating sessions are staffed on nationally recommended AfPP staffing guidelines to ensure minimum safe staffing levels at all times with the required qualification or equivalent level of experience. Availability of an appropriate workforce for each operating theatre should be confirmed by the Theatre Manager prior to the start to any list or session. If at any time, a member of the procedural team is concerned about whether the assigned workforce is sufficient in number or skill-mix for the safe conduct of the proposed clinical activity, they should bring this to the attention of the Theatre Manager or equivalent individual for the procedural area. The Theatre Manager or equivalent should respond to such concerns and assess the situation and should only advise that the procedure be performed if he or she is satisfied that the workforce is appropriate to support safe patient care.

• At times when due to short notice absence staffing levels fall short of the recommended minimum safe staffing requirement the Theatre Manager / Clinical matron will review all areas and redeploy staff as appropriate to maintain service and patient safety.

• A risk assessment approach will be utilised to mitigate any shortfall in numbers or skill mix.

• Staff may be requested to move to work in an alternative area to that allocated at short notice to respond to staff number or skill mix shortfalls. This is a reasonable management request and staff are expected to comply.

• Where staff are requested to travel between trust sites for this reason, allowance will be made for the travelling time and all costs will be reimbursed through the trust travel claim system in line with the Trust Travel Subsistence Policy.

• Where staff have no means of personal travel a taxi will be provided at a cost to the trust.

• Following a risk assessment and agreement with the Divisional Management Team the Theatre Manager may feel it is appropriate to reduce the skill mix of a lower acuity list to mitigate against patient cancellation.

• It is acknowledged from time to time members of the clinical team may be required to leave or join part way through an activity (where possible this should be avoided).
  o If this is a planned step it must be discussed at briefing, to make all team members aware of this anticipated activity
  o For member responsible for the swab count accuracy, who need to leave the operating table, please refer to Operating Theatre Standard No 9 – Swab and Instrument Counts.
  o If there is an unplanned occasion when a crucial member of the clinical team needs to leave or join the clinical team part way through an activity the Consultant Surgeon and / or Consultant Anaesthetist plus the Scrub Practitioner and the Team Lead must be informed, so they can take any necessary steps to ensure patient safety.
  o When there is a change in the clinical team, either during or between procedures, the outgoing and incoming team members must ensure that they hand over all relevant information, including any issues arising from the team brief, sign in and time out, and they should inform the rest of the team about the change. If the handover takes place during a procedure, relevant patient and procedure information must also be exchanged. Where the change involves the change of the operator during the procedure, the number and location of any swabs or other foreign objects in body cavities at the point of handover must be verified by the scrub practitioner.

• Should it be necessary to perform an emergency procedure with a workforce that does not comply with nationally recommended AfPP staffing guidelines, or where concerns have been raised, it should be reported as a safety incident through the Trust’s incident reporting system Datix.

• It is acknowledged occasionally member of the workforce may have clinical responsibilities outside of the procedural area; therefore, the potential for competing and irreconcilable clinical demands must be addressed.
o We identify this could be a possible issue outside of normal working emergency theatres also covering the obstetric theatre or cardiac arrest teams or medical staff covering both theatres and emergency departments or wards.

o In these situations the theatre manager and anaesthetic services manager should risk assess and monitor the incidences of competing priorities to provide assurance that appropriate workforce levels are maintained.

- Where a change of venue is required during a procedure, for instance when a pregnant woman is transferred from a delivery room to an operating theatre for an instrumental or operative delivery. Such a transfer should be treated as a handover of care and there must be effective communication about changes in team members during the process and any instruments, swabs or packs transferred between venues either with or inside the patient.

7. Sending For Patients

- Elective operating lists will be compiled in advance by the appropriate booking coordinator, in consultation with senior members of the theatre staff wherever possible.

- Elective lists should be available the day prior to surgery, to allow theatre staff to plan instrumentation, prostheses and staffing appropriately.

- Specific instrument or prosthetic requirements that need to be arranged in advance, must be notified to the Senior Theatre Practitioner responsible for that specialty as far in advance.

- On the morning of surgery, theatre reception will phone to ensure that bed space is available for all patients, confirm ward allocation and inform the relevant theatre of any problems.

- The first patient of each operating session will be sent for automatically according to the planned start time for each list. Should there be any delay to the projected start time for afternoon sessions, theatre staff will inform reception to prevent the patient being sent for inappropriately.

- Subsequent patients are requested as required, via theatre reception.

- Emergency patients are done in order of clinical priority and are sent for directly by the Emergency Theatre Coordinator, who will phone the ward in advance to ensure that each patient is ready for collection.

- Cases must not be sent for after 3pm without the prior consent of the Theatre Coordinator.

- The Theatre coordinator must be informed of any additions to scheduled operating lists, and of any other problems arising.

- Only the Theatre Coordinator has the authority to cancel patients due to lack of operating time.

- Cancellations due to lack of theatre time must be escalated in line with section 1.

8. Fasting

- The Policy for Fasting Patients Who Require Anaesthesia or Intravenous Sedation provides information on fasting times.

- Theatre staff have a responsibility to ensure patients are not deprived of oral nutrition or hydration for unnecessarily long periods due to delays or list changes.

- Where patients have been fasted for fluid for longer than 6 hours theatre staff should work with ward staff to identify potential or real delays and discuss the patients fasting plan, alerting the anaesthetist to ask whether it would be acceptable for the patient to have a drink of still water. Where it is not possible for the patient to have a drink consideration should be given to starting maintenance intravenous fluids.
Generic Theatre Standard No 23 - Booking Emergency Theatre Cases

Standard Statement: All cases booked for the Emergency theatre will be dealt with in order of clinical priority as determined by the responsible surgeon and anaesthetist.

Method:

• All cases requiring emergency surgery must be listed via the emergency theatre coordinator on bleep ****

• All cases booked, that require anaesthetic intervention, must be referred to the on call anaesthetist on bleep. ****, by the booking surgeon.

• Details including the patient’s name, hospital registration number, date of birth, ward or location, surgery required, booking doctors’ name and bleep number, the name of the surgeon expected to perform the surgery and contact details, consultant whose care the patient is under, time and date of booking, and the theatre practitioner who accepts the booking, must be recorded on the emergency theatre list.

• The doctor booking the case must identify the clinical priority of the surgery according to agreed guidelines. (Details available in Theatre*)

• The theatre coordinator must be notified of any cancellations as soon as possible, and the reason for the cancellation must be identified. The name of the person cancelling the case must be recorded on the emergency theatre list.

Compliance: 100%

Exceptions: NCEPOD Category 1 patients who require immediate lifesaving surgery, and whose details may not be complete.

Reference:

Theatre booking guidelines

NCEPOD Guidelines
**Generic Theatre Standard No 24 - Incident Reporting**

**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 trust 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**

**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**

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 - Datix.

Compliance: 100%

Exceptions: None

**References:**

Generic Theatre Standard No 25 - Controlled Drugs in the Operating Department

Standard: All aspects of management of controlled drugs within operating department areas will be in concordance with Trust and National Policy.

Please see:

- A policy for the Rules relating to all Activities Involving Controlled Drugs
- The Medicines Policy Chapter 3 - Ordering and Stock control
- The Medicines Policy Chapter 4 – Standards of Practice – Custody and Storage
- The Medicines policy Chapter 5 – Preparation and Administration

Controlled drugs keys will be held only by Registered Nurses and Registered ODP’s.

Regular controlled drugs checks will be carried out and recorded in a daily logbook held in each controlled drug cupboard.

Method:

- Under the Misuse of Drugs Act (1971), the accountability for safe custody and issue of controlled drugs lies with the Registered Practitioner within the operating theatre.
- Responsibility for the issue of controlled drugs and for holding the keys may be delegated by the Registered Nurse or Registered ODP within the theatre but they will retain accountability for the drug stock.
- Agency nurses and ODPs whose registration has been confirmed with the N.M.C. may be delegated to hold the keys and issue controlled drugs.
- Controlled drugs keys will be kept centrally in a locked cupboard until they are required.
- Controlled drugs checks will be carried out prior to commencement of each days operating list and at each changeover of staff. The controlled drugs will again be checked at the end of the days operating session before the keys are returned to the central holding cupboard.
- Two members of staff of which one must be a registered nurse / ODP must carry out each drug check. The other member of staff may be any member of the theatre team who has received the appropriate training and has been assessed as competent in this skill.
- Each check must be recorded in the stock control logbook kept in each anaesthetic room. Both parties who carry out the drugs check must sign the logbook.
- Controlled drugs must be issued in accordance with the Misuse of Drugs Act 1971. All drugs must be signed for in the controlled drug register by the person issuing or checking the drug and by the person administering the drug.
- Ordering of controlled drugs may only be undertaken by registered nurses /ODPs, whose signature is held on file in the pharmacy department.
- Controlled drugs must be received from pharmacy in a sealed transfer bag. These drugs must only be entered into the register and put into the controlled drug cupboard by a registered nurse / ODP.
- If a controlled drug is found to be missing, all efforts must be made to locate it. If it is not possible to discover where the discrepancy has occurred, the Theatre Coordinator and pharmacy must be informed and a datix report completed.

Compliance: 100%
Exceptions: None

References:

Misuse of Drugs Act 1971
RCHT Medicines Policy
RCHT A Policy for the rules relating to all activities involving controlled drugs
Generic Theatre Standard No 26 - Pharmacy delivery and stock rotation

Standard Statement: All staff are responsible for putting Pharmacy items away and ensuring correct stock rotation.

Please see:
- The Medicines Policy Chapter 3 - Ordering and Stock control
- The Medicines Policy Chapter 4 – Standards of Practice – Custody and Storage

Method:
- All staff will receive training on how to put Pharmacy away correctly, it is imperative that pharmacy items are stored correctly to maintain effectiveness and access in emergency situations.
- Staff must ensure that they are familiar with the location of all drugs in case of an emergency.
- Every item of Pharmacy delivered to the departments, must be checked confirmed on the order list provided and retained as proof of delivery.
- All items must be stock rotated, i.e. new stock placed at the back and older stock brought forward to ensure items are used in date order, to prevent drugs passing their expiry date and wastage of resources.
- Once emptied, the Pharmacy boxes should be returned to Theatre Reception.
- General pharmacy requirements are fulfilled twice a week by pharmacy technicians on a top up basis.
- Controlled Drugs are ordered by Registered Nurses / ODPs as required by each individual theatre.
- Special one off items may be ordered as required using the request system to pharmacy, specific patient details may be required.

Compliance: 100%
Exceptions: None
**Generic Theatre Standard No 27 - Photography and Video**

**Standard Statement:** Staff will ensure that prior to any photographs are taken or video equipment is used, the appropriate consent has been obtained.

**Please refer to:**
- **Policy for Recordings and Photography**

**Method:**

- 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: None

**Reference:**

AfPP Principles of Safe Practice in the Perioperative Environment 2011
**Generic Theatre Standard No 28 - Radiation Protection**

**Standard Statement:** All staff members have a responsibility to protect the patient, themselves and others. They will ensure that they do not knowingly expose themselves or others to more radiation than is necessary.

**Please refer to:**

- Ionising Radiation Safety Policy
- RCHT Non-Ionising Radiation Safety Policy

**Method:**

- Only authorised personnel who are trained and assessed may use X-Ray equipment.
- Patients undergoing procedures where X-Ray is deemed necessary should be protected wherever possible. Radiation doses and exposure should be kept to a minimum.
- Only essential staff should remain in the theatre whilst X-Ray is in use. All staff remaining in the immediate vicinity must be protected with appropriate lead garments.
- Protective lead garments must be safeguarded from damage, cleaned after use and examined frequently. They must be stored hanging freely on the provided racking system.
- Light weight lead gowns should be available for staff with known back injury who are required as part of the normal role to support x-ray procedures.
- Any member of staff known to be pregnant should not be present in theatres when X-Ray is being deployed.
- When X-Ray is in use it is essential that access to the area is restricted in order to prevent accidental exposure, with notices being displayed wherever possible.
- Details of any radio-opaque contrast used must be recorded in the perioperative documentation. Radio-opaque contrast must be used with extreme caution in any patient with known iodine allergy.

**Compliance:** 100%

**Exceptions:** None

**Reference:**

AfPP Principles of Safe Practice in the Perioperative Environment 2011

R.C.H. Trust Radiation Safety Policy
Generic Theatre Standard No 29 - Visitors to the Operating Theatre

Standard Statement: Staff will ensure that only visitors who have obtained the relevant permission for definitive supportive and / or educational purposes, are present in the operating theatre whilst the patient is undergoing surgery.

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 perioperative phase.
- 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, report to Theatre reception to sign in and be identified to the Theatre Coordinator.
- 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 theatre 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 stay in theatres.
- 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

Reference:
AfPP Principles of Safe Practice within the Perioperative Environment 2011
Section 3 – Human Resources

Generic Theatre Standard No 30 - Mandatory training responsibilities

Please see:

- Trust Core Training Policy

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

Method:

- Staff to take individual responsibility for keeping up to date with mandatory requirements
- Staff and management produce evidence that all statutory training requirements have been met in the following areas:
  - COSHH
  - FIRE
  - BLS/ILS/PBLS
  - Manual handling
  - Infection control
  - Health and safety
  - Risk management
  - Conflict resolution
  - Information Governance
  - Child Safeguarding
- All staff will have an annual Individual performance Appraisal with their line manager where they will be able to identify individual requests for training and development.
- Theatre managers will collate information to provide the department annual trading needs analysis to support allocation of funding for staff development

Compliance 100%
Exceptions None

Reference:
RCHT Mandatory Training Policy & Procedure
Generic Theatre Standard No 31 - The Management of Staff who are expectant and new mothers

Standard Statement: Expectant Mothers (Staff) Working in the Perioperative Environment

1. Duty of the 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. Duty of the Employer

- **Theatre Manager** has a responsibility to ensure that potential hazards are assessed by a risk assessment.
- Ensure that all members of their staff have received information, instruction and training appropriate to their job responsibilities.
- To ensure a planned service routine takes place for anaesthetic vaporizers and documentation to prove this is available.
- Potential pollution from waste anaesthetic gases must be regularly monitored and documentation on results must be available.
- **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.

3. Anaesthetic Gasses

- The highest levels of pollution in paediatric anaesthesia can occur at induction and on recovery but, with good air conditioning, the occupational exposure limit levels quickly return to normal.
- Using a laryngeal mask airway in-patients undergoing ventilation is not necessarily associated with high concentrations of waste gases, providing the air conditioning is running at 20 air changes per hour
- The Department of Health (NHS Executive 1996) published advice on the exposure standards for anaesthetic agents. In certain clinical settings (e.g. paediatric, ear, nose and throat procedures), and for the recovery practitioner working close to the patient, exposure levels will be higher. A risk assessment must be undertaken and may require that the expectant mother is removed from the clinical area, particularly in the first 12 weeks of pregnancy.
- The risks of leaks of anaesthetic agents must be minimised:
  - Anaesthetic equipment should fit the patient correctly (e.g. face masks for children).
  - Gases should only flow during anaesthesia, turned on at induction and turned off on completion of anaesthetic.
  - The scavenging system should be checked for correct connection prior to anaesthetic administration.
- Making sure that waste gas disposal lines are connected
- Avoiding turning on nitrous oxide or vapouriser until the circuit is connected to the patient
- Switching of the nitrous oxide and vapouriser when not in use
- Maintaining oxygen flow until scavenging system is flushed.

- Anaesthetic gases are exhaled by patients in the recovery area. The gases are virtually unchanged and initially are at very high levels. Recovery staff work in close proximity to the patients' head and gas concentrations can exceed those found in the scavenged theatre areas.

- Staff must be aware of:
  - The importance of the ventilation systems being in good working order.
  - The need to perform air sampling accurately, during an operating list and review regularly.
  - The sampling methodology, to ensure that waste anaesthetic gas levels are measured accurately at the point representing the breathing zone of the carer.
  - The use of personal monitoring devices.
  - Staff rotation methods.

- All theatres have local scavenging systems to recover anaesthetic agents, and ventilation systems. These must be turned on to prevent atmospheric pollution, when anaesthetic gasses are being used.

- The management of waste anaesthetic gases and exposure to personnel comes under the remit of the Control of Substances Hazardous to Health Regulations (COSHH) (HMSO 2002b/2004) which clearly state that employers have a legal obligation to monitor the exposure of employees to substances hazardous to health.

4. Management of Risk

- Potential hazards for the expectant mother in the perioperative 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 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 for anaesthetic agents used within the clinical area which are known to be of risk to expectant mothers.
5. Risk Assessment Guidance

<table>
<thead>
<tr>
<th>Explanations (Hazards)</th>
<th>Consider The Risk</th>
<th>Risk Avoidance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Violence &amp; Aggression</strong></td>
<td>Could the individual be exposed to clients/patients, even visitors that could cause physical harm to an expectant mother</td>
<td>Review/exposure working with violent &amp; aggressive client groups. Consider work areas with alternative client groups.</td>
</tr>
<tr>
<td><strong>Shocks, Vibration &amp; Movement</strong></td>
<td>Regular shocks, low frequency vibration or movement pose a risk of miscarriage.</td>
<td>Avoid whole body vibration work, or where the stomach is exposed to jolts.</td>
</tr>
<tr>
<td><strong>Manual Handling (Where loads risk injury)</strong></td>
<td>Hormonal changes make pregnant workers susceptible to injury and obviously as pregnancy progresses posture/spaces/manoeuvrability become issues.</td>
<td>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.</td>
</tr>
<tr>
<td><strong>Driving</strong></td>
<td>Arrest by seat belt/collision whilst driving a vehicle may cause injury to mother and unborn child.</td>
<td>Any concerns about the ability to drive, consult GP/Occupational Health.</td>
</tr>
<tr>
<td><strong>Noise</strong></td>
<td>No specific risk – loud noise over prolonged periods may raise blood pressure.</td>
<td>Adhere with current legislation concerning noise.</td>
</tr>
<tr>
<td><strong>Strong Smells</strong></td>
<td>Nausea/discomfort</td>
<td>Report any unusual odours. Identify and remove if possible. Avoid exposure.</td>
</tr>
<tr>
<td><strong>Non Ionising Radiation Ultra Violet Infa-red</strong></td>
<td>At no more risk than other workers. (N.B. Extreme overexposure to radio frequency radiation could raise body temperature, which may cause</td>
<td>Ensure exposure to electric and magnetic fields is within exposure limit.</td>
</tr>
</tbody>
</table>
Generic Theatre Standard No 32 - Human Resource Management

- **These documents relate to staff employment in the operating department:**
  - **Disclosure and Barring Checks Policy**
    - All new theatre staff are required to have a current enhanced DBS check before commencing employment.
    - Staff transferring to new roles within the trust will also require 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.
  - **Management of Corporate and Local Induction Policy**
  - **Core Training Policy**
    - See operating theatre standard 32

- **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 manager in the first instance or if this is not possible the Clinical Matron, Divisional Nurse or HR team.
  - The trust has a number of Independent Listeners available who will support any member of staff contactable on 07775035356

- **Grievance and Disputes Policy and Procedure**

- **Disciplinary procedures**
  - **Disciplinary Procedure**
  - **Capability Policy and Procedure**

- **Nurses and operating department practitioners responsibility**
  - All registered staff are responsible for maintaining their own professional registration.
  - Staff who allow their professional registration to expire will not be allowed to work in a registered capacity until proof of registration is received and salary will be adjusted for the time they have been unregistered.

- **Professional Registration Policy**

- **Whistle-blowing**
  - **Raising Concerns In The Public Interest (Whistleblowing) Policy**

- **Complaints**
  - **Compliments, comments, concerns and complaints (the 4C’s) policy & related procedures**

- **Harassment and Bullying**
  - **Dignity At Work Policy Procedure and Guidance**
• **Educational Support**
  o **Induction All Staff**: All newly appointed staff will receive a tailored induction/orientation program that facilitates their integration into the operating department.
  o **Management of Corporate and Local Induction Policy**
  o **Core Training Policy**
  o **Medical Devices Training Policy**
  o **Preceptorship guidance and framework policy**
  o **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 Theatre Managers.
  o Theatre Managers 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.

• **Staff Competence in the Operating Theatre Practice at RCHT**
  o All staff in the operating department will be required to complete and retain for further development the relevant perioperative Skills Passport relevant to their banding and role.
  o Individuals who have completed the passport relevant to their current banding may seek to utilise the passport of the band above for personal development. This can only be used within 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.
  o 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.
  o **Theatre 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 ODP must comply with the HCPC Standards of Conduct Performance and Ethics: 3 Work within the limits of your knowledge and skills; Keep within your scope of practice.
    - 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.

• **Capability Policy and Procedure**
  o It is not assumed that experienced perioperative staff have the skills or knowledge required when transferring to a new area of care (e.g. orthopaedics to ophthalmics). Careful assessment of basic skills, using the Perioperative Quality Care Passport (OQCP) and a period of orientation are essential before competence can be achieved.
  o Experienced staff (registered for more than one year) should be expected to undertake relevant and recognized courses on teaching and assessing in the clinical areas that will meet the needs of all learners in that area.
  o 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.
• **Professional Development**
  - All members of the workforce must receive regular updates and continuous professional development (CPD).
  - Theatre Managers are 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 Theatre Manager 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 Divisional Nurse for review and allocation of funding / time if deemed appropriate.
  - In order to support the maximum development for the workforce as a whole, degree modules will be funded at 50% of the current cost.
  - 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.
  - 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.

• **Pre-Registration Learners**
  - All operating department areas offer training placements for pre-registration nurses and operating department practitioners.
  - All pre-registration students will be allocated a practice mentor who has completed the appropriate training and assessment in order to fully complete the role.
## Appendix 1. Governance Information

<table>
<thead>
<tr>
<th><strong>Document Title</strong></th>
<th>Theatre Practice Standards - Generic</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Date Issued/Approved:</strong></td>
<td>24 Feb 14</td>
</tr>
<tr>
<td><strong>Date Valid From:</strong></td>
<td>01 May 2017</td>
</tr>
<tr>
<td><strong>Date Valid To:</strong></td>
<td>01 May 2020</td>
</tr>
<tr>
<td><strong>Directorate / Department responsible (author/owner):</strong></td>
<td>Sue Preston, Divisional Nurse, Theatres</td>
</tr>
<tr>
<td><strong>Contact details:</strong></td>
<td>01872 258188</td>
</tr>
<tr>
<td><strong>Brief summary of contents</strong></td>
<td>Consolidation of theatre practice guidelines that cover all theatre areas</td>
</tr>
<tr>
<td><strong>Suggested Keywords:</strong></td>
<td>Generic theatre practice.</td>
</tr>
<tr>
<td><strong>Target Audience</strong></td>
<td>RCHT</td>
</tr>
<tr>
<td><strong>Executive Director responsible for Policy:</strong></td>
<td>Medical Director</td>
</tr>
<tr>
<td><strong>Date revised:</strong></td>
<td>May 2017</td>
</tr>
<tr>
<td><strong>This document replaces (exact title of previous version):</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Approval route (names of committees)/consultation:</strong></td>
<td>DGMM, TMG</td>
</tr>
<tr>
<td><strong>Divisional Manager confirming approval processes</strong></td>
<td>Duncan Bliss, Divisional General Manager</td>
</tr>
<tr>
<td><strong>Name and Post Title of additional signatories</strong></td>
<td>Dr T Skinner, Mr A Widdison, Divisional Directors S Preston, Divisional Nurse</td>
</tr>
<tr>
<td><strong>Signature of Executive Director giving approval</strong></td>
<td>{Original Copy Signed}</td>
</tr>
<tr>
<td><strong>Publication Location (refer to Policy on Policies – Approvals and Ratification):</strong></td>
<td>Internet &amp; Intranet</td>
</tr>
<tr>
<td><strong>Document Library Folder/Sub Folder</strong></td>
<td>Clinical / Theatres</td>
</tr>
<tr>
<td><strong>Links to key external standards</strong></td>
<td>None</td>
</tr>
<tr>
<td><strong>Related Documents:</strong></td>
<td>None</td>
</tr>
<tr>
<td><strong>Training Need Identified?</strong></td>
<td>Yes- Learning and Development department have been informed for inclusion in mandatory training</td>
</tr>
</tbody>
</table>
### Version Control Table

<table>
<thead>
<tr>
<th>Date</th>
<th>Version No</th>
<th>Summary of Changes</th>
<th>Changes Made by</th>
</tr>
</thead>
<tbody>
<tr>
<td>24 Feb 14</td>
<td>V1.0</td>
<td>Initial Issue</td>
<td>Sue Preston, Senior Matron, Theatres</td>
</tr>
<tr>
<td>May 2017</td>
<td>V2</td>
<td>Compliance with Natsips</td>
<td>Cathy Edwards</td>
</tr>
</tbody>
</table>

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*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**

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## Appendix 2. Initial Equality Impact Assessment Form

<table>
<thead>
<tr>
<th>Name of the strategy / policy / proposal / service function to be assessed (hereafter referred to as policy)</th>
<th>Provide brief description: Theatre Practice Standards - Generic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Directorate and service area: Clinical / Theatres</td>
<td>Is this a new or existing Policy?</td>
</tr>
<tr>
<td>Name of individual completing assessment: Sue Preston, Senior Matron, Theatres</td>
<td>Telephone: 01872 258188</td>
</tr>
<tr>
<td>1. Policy Aim*</td>
<td>See para 1.</td>
</tr>
<tr>
<td>Who is the strategy / policy / proposal / service function aimed at?</td>
<td></td>
</tr>
<tr>
<td>2. Policy Objectives*</td>
<td>See para 1.4</td>
</tr>
<tr>
<td>4. *How will you measure the outcome?</td>
<td>As per para 3 of this guideline.</td>
</tr>
<tr>
<td>5. Who is intended to benefit from the policy?</td>
<td>All patients admitted to theatre.</td>
</tr>
<tr>
<td>6a) Is consultation required with the workforce, equality groups, local interest groups etc. around this policy?</td>
<td>No</td>
</tr>
<tr>
<td>b) If yes, have these *groups been consulted?</td>
<td></td>
</tr>
<tr>
<td>C). Please list any groups who have been consulted about this procedure.</td>
<td></td>
</tr>
</tbody>
</table>

### 7. The Impact

Please complete the following table.

<table>
<thead>
<tr>
<th>Equality Strands:</th>
<th>Yes</th>
<th>No</th>
<th>Rationale for Assessment / Existing Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sex (male, female, transgender / gender reassignment)</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Race / Ethnic communities /groups</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disability - Learning disability, physical disability, sensory impairment and mental health problems</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Religion / other beliefs</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marriage and civil partnership</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pregnancy and maternity</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual Orientation, Bisexual, Gay, heterosexual, Lesbian</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

You will need to continue to a full Equality Impact Assessment if the following have been highlighted:
- You have ticked “Yes” in any column above and
- No consultation or evidence of there being consultation- this excludes any policies which have been identified as not requiring consultation. or
- Major service redesign or development

8. Please indicate if a full equality analysis is recommended.  

| Yes | No ✓ |

9. If you are not recommending a Full Impact assessment please explain why.

| Signature of policy developer / lead manager / director | Date of completion and submission |

| Names and signatures of members carrying out the Screening Assessment | 1. Sue Preston
2. |

Keep one copy and send a copy to the Human Rights, Equality and Inclusion Lead, c/o Royal Cornwall Hospitals NHS Trust, Human Resources Department, Knowledge Spa, Truro, Cornwall, TR1 3HD

A summary of the results will be published on the Trust’s web site.

Signed ____________________
Date ____________________