Five Steps to Safer Surgical Interventions

Local Safety Standards for Invasive Procedures
**Policy Title:** Five Steps to Safer Surgical Interventions

**Executive Summary:** A definitive policy for the roles and responsibilities of the key clinical staff involved in the process of the WHO checklist 5 steps to safer surgery. The policy also reflects the LocSSIPs based on NatSSIPs relevant to the aspects of perioperative care covered.

**Supercedes:** Policy V1.1

**Description of Amendment(s):** 12/09/2018 Appendix 6 - Inclusion of compatibility checks for prosthesis verification for total hip replacements.

**This policy will impact on:**

Clinical practices, administrative practices, employees.

**Financial Implications:**

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<th>Effective Date</th>
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<th>Author</th>
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**APPROVAL RECORD**

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<td>Consultation</td>
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Introduction

The Safer Surgery Saves Lives initiative was launched by the World Health Organisation (WHO) in 2008 to reduce the number of surgical errors and enhance patient safety during the perioperative phase of care. In one year from 1st January 2009 to 31st December 2009 the National Patient Safety Agency (NPSA) National Reporting and Learning System (NRLS) received just over 155,000 reports of patient safety incidents from surgical specialities in England and Wales. The nature of the report varied greatly with the vast number reported as leading to no harm, however over 1000 where reported to have led to severe harm or even death.

The launch saw the introduction of a new surgical safety checklist for surgical teams to use in perioperative environments which can also be adapted for radiological suites and endoscopy units as part of a major drive to make surgery safer worldwide (DoH, 2008).

The NPSA (2009) has adapted this checklist for use in England and Wales and it is intended for use with ALL patients undergoing surgical procedures. The goal is to strengthen the commitment of ALL clinical staff to address safety issues in the perioperative setting. The checklist highlights generic core safety standards that may be applied to all perioperative settings and forms part of the Five Steps to Safer Surgery initiative (NPSA, 2010). The NPSA guidance recommends that the core standards can be added to but must not be removed when adapting checklists for local use.

The Five Steps are:

STEP 1: BRIEFING
STEP 2: SIGN IN
STEP 3: TIME OUT
STEP 4: SIGN OUT
STEP 5: DEBRIEFING
The above process is intended to incorporate the following outcomes:

- Improved communication within teams
- Improved anaesthetic safety practices
- To ensure correct site surgery
- Reduced surgical site infections

In 2015 NHS England Patient Safety Domain published the National Safety Standards for Invasive Procedures [NatSSIPs] (NHS England Patient Safety Domain, 2015). These NatSSIPs are intended to provide a framework to produce Local Safety Standards for Invasive Procedures (LocSSIPs). These build on the WHO Safer Surgical Checklist to further improve patient care and safety. They aim to reduce never events with regard to both technical and human factors. This policy is benchmarked against the NapSSIPs to create LocSSIPs for this organisation.

1. Policy Aim

This policy aims to provide local standards for the safe care of patients undergoing invasive surgical procedures. The WHO Surgical Safety Checklist is used as a core set of safety checks, identified for improving performance at safety critical time points within the patients’ perioperative pathway including correct site surgery and forms part of a 5 step process. The 3 steps in the checklist (Sign In, Time Out, Sign Out) are not intended as a tick-box exercise but as a tool to initiate effective communication between relevant members of the clinical team to ensure the safety of surgery. A guidance tool has been devised to inform staff how to complete the checklist (Appendix 1). The checklist is intended for use within any perioperative environment. This policy aims to improve communication between professionals to minimize the risk of adverse events during the perioperative pathway.
2. Roles and Responsibilities

**Chief Executive** - Has ultimate responsibility for the implementation and monitoring of the policies in use in the Trust. This responsibility may be delegated to an appropriate colleague.

**Clinical Director** – It is the responsibility of the Clinical Directors and Associate Directors of the service lines to ensure that all staff are aware of and follow this policy.

**Lead Clinicians** – Responsible for communicating and ensuring compliance with the policy by clinical teams.

**Clinical Manager, Theatres** – Responsible for the operational implementation, supporting staff and auditing compliance with the policy.

**Theatre Co-ordinator & Team Leaders** for scrub, anaesthetics and recovery are responsible for leading by example, supporting and ensuring their teams comply with the policy.

**Practice Educator** (Theatres) – Ensuring all existing staff are aware of policy and that all new staff receive education and training on induction.

**All perioperative and clinical staff** are responsible for ensuring that they read and understand the policy and related documents and implement the guidance into their practice.

3. Policy

The WHO surgical checklist must be completed for all patients including those having procedures under local anaesthesia and/or sedation. The addition of briefing and debriefing sessions before and after the operating list are key in delivering the cultural change required to strengthen the safety process.

The checklist is designed to be adapted for local use; however the core safety elements are not to be removed from the amended checklist (NPSA, 2009). The WHO checklist forms part of the Five Steps to Safer Surgery.

The Trust has adopted and adapted the WHO surgical Checklist (Appendix 2). It is the responsibility of the registered practitioner to ensure the checklist is completed accurately and held within the patient’s care document.
Template guidance checklists are available from the WHO website as follows;

- WHO Surgical Safety Checklist adapted for England and Wales
- WHO Surgical Safety Checklist: for cataract surgery only
- WHO Surgical Safety Checklist: for obstetric cases only
- WHO Surgical Safety Checklist for paediatric cases only
- WHO Surgical safety Checklist: for radiological interventions only
- WHO Surgical Safety Checklist for endoscopy procedures

3.1: BRIEFING

Briefings are a simple way for the perioperative team to share vital information about patients for surgery and discuss potential and actual safety issues before and after the list/procedure takes place (NatSSIPs 4.7, 2015, DoH, 2008, NPSA, 2009). Briefings should encourage an environment where the team can share this information without fear of reprisal, integrating the reporting of patient safety incidents into everyday routine.

A safety briefing is performed before the start of every elective, unscheduled or emergency theatre list. As many of the procedural team as possible should be present. This must include the surgeon and anaesthetist who have seen and obtained consent from the patient.

The briefing will be carried out in a discreet location to allow patient confidentiality to be maintained and ideally before the first patient arrives. If the first patient in the morning arrives in the department prior to the completion of the brief they will be placed in Recovery until the brief is completed.

Any member of the procedural team may lead the brief but it is most commonly lead by the senior operating surgeon.

Each member of the team involved in the session will be introduced by name and role with particular introduction of unfamiliar staff (students, agency, new medical staff). Any substitutes to the team throughout the list session should also be introduced at an appropriate time.

Each patient will be discussed individually and include when relevant:

- Planned procedure, site and side
- Relevant co-morbidities, complications and special needs
- Extra equipment required
- Infection risk
- Need for blood/blood products
- Patient position
- Anaesthetic issues
- Allergies
- Antibiotics
- Post-operative destination – HDU, ICU
- Identification of list overrun.

A template is provided to help guide the briefing if required (Appendix 3)

The Registered Practitioner in charge of the list is responsible for escalating issues arising from the briefing to the Theatre Co-ordinator if they affect the progress of the session or that may have relevance to the care given to other patients. The Trust Datix system is available to report governance issues.

### 3.2: SIGN IN

All patients coming to the operating theatre will have a series of safety checks on arrival. Each patient will have a double sided pink preoperative Surgical Safety Checklist and Sign In / Time Out / Sign Out checklist [Appendix 4] (NatSSIPs, 4.8 & 4.2, 2015).

The surgical safety checklist is completed between the patient, anaesthetic practitioner and accompanying ward nurse. The participation of the patient and/or parent/guardian, carer or birth partner is encouraged at all times. The accompanying nurse must stay with the patient until the pre-operative checklist is completed. Any discrepancies identified at the checklist phase must be resolved before the Sign In is carried out.

The checklist includes assurance that the surgical site has been marked with an arrow that extends to or near to, the incision site. For digits on the hand and foot, the mark should extend to the correct specific digit. Correct site surgery policy must be adhered to.


The Sign In checklist is completed with the anaesthetist and anaesthetic practitioner before any intervention is commenced. If the procedure is carried out under local
anaesthesia this will be done by the operator and perioperative practitioner in conjunction with the Time Out check.

During the Sign In silent focus will be observed. However, when children are in the anaesthetic room, the play therapist/accompanying parent are able to occupy the child whilst the anaesthetist and the anaesthetic practitioner complete the checklist

The Sign In checklist is read out loud and tick boxes completed as indicated. Any issues identified during the Sign In phase will be addressed before induction of anaesthesia. This includes:

- Has the patient confirmed his/her identity, site, procedure and consent?
- Is the surgical site marked?
- Is the anaesthesia machine and medication check complete?
- Is the pulse oximetry on the patient and functioning?
- Does the patient have a known allergy?
- Does the patient have a difficult airway/aspiration risk?
- Does the patient have a risk of > than 500ml blood loss (7mls/kg in children)?
- Blood product available/G&S
- Two IVs/central venous access
- Need for active warming

If regional anaesthesia is to be used the Anaesthetist and Anaesthetic practitioner must re-check the surgical site mark corresponds to the site and side of the intended block immediately prior to the intervention (Appendix 5)

The Sign In checklist is ticked by the anaesthetic practitioner as the questions are asked to evidence completion. The anaesthetic practitioner will tick the sign in box on the electronic Galaxy system to evidence completion.

In emergency situations such as Category 1 Caesarean section there may not be time to complete the pre-op checklist and Sign In stage fully due to the critical condition of mother and/or baby. This is recognised by the staff concerned and the necessary checks and documentation are completed when appropriate to do so.

3.3: TIME OUT

The Time out will not be started until any discrepancies indicated at the Sign in have been resolved.

Participation of the patient and/or parent, carer or birth partner will be encouraged where appropriate.

This must be done after the patent is safely positioned and relevant monitoring in situ and prior to the patient being prepped and draped. All members
of the clinical team including the anaesthetist and operating surgeon are required to be present during the time out phase. It may be led by any member of the team. All those involved will be asked for their attention, stop other tasks and maintain silent focus during the Time Out. Each section of the time out phase of the checklist must be read out loud systematically by the nominated lead. Everybody within the team is required to STOP, LISTEN and CONTRIBUTE whilst the Time Out phase is being undertaken (Implementing Human Factors in Healthcare 2010).

The Time out checklist is developed from The WHO guidance (NatSSIPs, 4.9, 2015, NPSA 2009, WHO, 2008). It is read out loud and tick boxes completed as indicated. Any issues identified during the Time Out phase will be addressed before commencement of the invasive procedure.

The Time out section must be completed in a timely manner without due delay to the surgery commencing.

To the team:
- Confirm all team members have introduced themselves by name and role
- Surgeon, anaesthetist and Registered Practitioner confirm patient’s name, hospital number, consent form and intended procedure?
- Any patient allergies
- Has antibiotic prophylaxis been administered in the last 60 minutes?
- Has venous thromboembolism prophylaxis been undertaken?

To surgeon:
- What are the critical or non-routine steps?
- How long will the case take?
- What is the anticipated blood loss?

To anaesthetist:
- Are there any specific patient concerns?

To nursing team
- Is sterility of equipment confirmed?
- Are there and equipment issues or concerns?
- Is essential imaging displayed/available?

The Time Out area on the Galaxy system will be ticked once completed to evidence completion.

3.3.1 Prosthesis verification
A prosthesis or implant is a medical device used for artificial replacement of a joint or repair or support of a structure within the body. This can include joint replacements, fracture fixation items, surgical mesh, ophthalmic lenses, stents and breast prostheses and expanders. Verification is essential for correct surgical placement of the appropriate prosthesis (NatSSIPs, 4.10, 2015). The Team Brief is used for identification or confirmation of prosthesis required or expected (NatSSIPs 4.7, 2015).

Prosthesis verification is carried out with silent focus, at designated times in the procedure, as with all other aspects of the five steps to safer surgery (WHO, 2008, Human Factors in Healthcare 2010). Records are kept of prosthesis used in clinical notes, appropriate joint registry and perioperative care plan documentation (Appendix 7). Records are also kept to allow appropriate re-stocking of items used.

Prosthesis verification guidelines and flowchart can be found in Appendix 6.

3.3.2 Prevention of retained foreign objects

All items used during an invasive procedure are accounted for at the beginning, during and at the end of the procedure to avoid unintentionally retained items either in or around the patient. Items include both surgical and anaesthetic potentially retainable items (NatSSIPs, 4.11, 2015).

Guidance to ensure the accurate reconciliation of items used in invasive procedures can be found in the Perioperative swab instrument and needle count policy ‘The Count’ [http://www.eastcheshire.nhs.uk/About-The-Trust/policies/P/Principles%20of%20Safe%20Practice%20in%20the%20Perioperative%20Environment%20Swab%20instrument%20and%20needle%20counts%20ECT2105.pdf](http://www.eastcheshire.nhs.uk/About-The-Trust/policies/P/Principles%20of%20Safe%20Practice%20in%20the%20Perioperative%20Environment%20Swab%20instrument%20and%20needle%20counts%20ECT2105.pdf)

Trust policy ‘The Count’ describes the process for all scrub practitioners to follow to ensure all instruments and sundries used during an invasive procedure are accounted for. This is updated in response to any alerts or incidents. The policy indicates which items to be included in the count. All scrub practitioners are obliged to read and follow this policy within their practice.


This also describes what to do in the event of a sharps injury.

Instrument sets are rationalised to contain the appropriate type and amount of instruments required for each procedure. A list of all the instruments in each set is
included in the set to check the contents against. This is done by 2 people and
signed before, during and after the procedure as policy dictates.

All sundries, extra instruments, swabs and sharps are contemporaneously recorded
on the theatre white board and Perioperative Care Plan to maintain a continuous
record and means of checking items used. A list describing countable items can be
found in ‘The Count’ policy.

All swabs used have radio opaque markers.

The procedure for failed reconciliation is described in ‘The Count’ policy. Datix is
used to record any incidents which are escalated to the appropriate governance
department (NatSSIPs, 4.11.4, 2015).

For items used in invasive procedures in the anaesthetic room, after Sign In but
before Time Out, guidance can be found in SOP: Central line insertion and safe
retrieval of guidewire (Appendix 8), Stop Before You Block poster (Appendix 5)
http://www.rcoa.ac.uk/sites/default/files/SBYB-PosterA4.pdf and Intravenous device
Insertion: management and removal policy
http://www.eastcheshire.nhs.uk/About-The-
Trust/policies/I/Intravenous%20Device%20Insertion%20Management%20and%20R
emoval%20Procedure%20ECT2608.pdf
The insertion and removal of anaesthetic related items such as throat packs are
witnessed and signed on the Perioperative Care Plan document (Appendix 7).

Local anaesthetic implants may be administered into patient’s eyes prior to
ophthalmic procedures on the ward as directed in the ward based PGD. The
administering nurse signs for the insertion and details of the implant on the indicated
record. The anaesthetist, ophthalmic surgeon or practitioner who removes the
implant prior to the procedure will sign the indicated record to evidence that removal.

Any items intentionally retained, such as packs, are recorded on patient’s perioperative care pathway and medical documentation with a planned date for
removal (NatSSIPs 4.11.5, 2015). This is communicated to the receiving ward/ICU
on handover from Recovery.

3.4: SIGN OUT

The Sign Out commences at the completion of the procedure before any of the
perioperative team leave the operating theatre.

All members, or representatives, of the perioperative team will be present at the Sign
Out (NatSSIPs, 4.12,2015). It may be led by any member of the team but is usually
led by the scrub practitioner. It must be completed immediately following the final surgical count. All those involved will be asked for their attention during the Sign Out.

The Sign out checklist is developed from The WHO guidance as directed. It is read out loud and tick boxes completed as indicated to evidence completion.

- Registered Practitioner verbally confirms with the team the name of the procedure to be recorded in the perioperative documentation.
- Registered Practitioner verifies that the instruments, swabs and sharps counts are correct (or not applicable)
- Specimens are checked for correct labelling including laterality
- Identify any equipment problems
- What the key concerns for recovery and management of this patient are for handover to Recovery.

Any issues identified during the Sign out phase will be communicated to the appropriate area eg Recovery Team, Theatre Coordinator, HSDU, equipment providers.

The Sign out area on the Galaxy system will be ticked once completed to evidence completion

3.4.1: Handover

There are formal handover points in the patient’s perioperative pathway where professional responsibility and accountability is transferred between individuals or teams. (NatSSIPs, 4.5, 2015)

The ward nurse must complete and sign the pre-operative checklist for each patient before leaving the ward. The participation of the patient and/or parent/guardian, carer or birth partner is encouraged at all times

There is a formal handover from the ward staff to the anaesthetic / perioperative team. This handover involves re-checking the pre-operative checklist. The ward nurse remains with the patient until this is completed. The participation of the patient and/or parent/guardian, carer or birth partner is encouraged at all times. Any discrepancies are resolved prior to completion of the Sign In phase.

The perioperative anaesthetic team (anaesthetic practitioner and anaesthetist) complete the Sign In phase of the Surgical Safety Checklist prior to commencement of anaesthesia. The Time Out phase of the Surgical Safety Checklist is completed prior to commencement of the procedure with both anaesthetic and theatre scrub
teams. The Sign Out phase of the Surgical Safety Checklist is completed at the end of the procedure with both anaesthetic and theatre scrub teams.

If the procedure is lengthy there may be need for relief or replacement of one of the perioperative team members. The incoming and outgoing team members are responsible for giving and receiving information all relevant information. If there is a change of scrub team member during a procedure a complete check of swabs, instruments and needles is undertaken as indicated in ‘The Count’ policy. The operator is informed of the change of team member and verification of count.

There is a formal handover of care from the anaesthetist to the recovery team and from the scrub team and the recovery team. The patient is received, airway secured and monitoring applied before the handover is given. These handovers include:

- Name, age, ID band
- Relevant co-morbidities
- Airway status
- Allergies
- Special needs eg hearing, vision, learning disability
- Performed procedure and surgical course
- Intraoperative medications including analgesia, anti-emetics and antibiotics.
- Post-operative management plan including analgesia
- Anticipated problems
- IV cannula including flushing and fluid requirements
- Dressings, drains and catheters
- Other information relevant to the patient.

The patient is stabilised and remains in Recovery until the agreed discharge criteria is met or the patient is considered suitable for discharge to the ward / HDU / ICU. Discharge criteria guidance is documented on the standard anaesthetic chart. There is a formal handover from the Recovery practitioner to the receiving ward nurse involving relevant information as listed above and post-operative care instructions.

If the patient is transferred to HDU / ICU the receiving nurse completes a yellow handover form documenting relevant patient, surgical and post-operative instructions along with the Recovery Practitioner at handover.

3.4.2: Documentation of Invasive Procedures

Standardised documentation is used for patients undergoing invasive procedure which contributes to safe working by its design. Key safety checks are performed in sequence and are documented (NatSSIPs, 4.2, 2015).

Each patient coming to theatre has a pre-operative checklist completed by the ward nurse which includes important and relevant information regarding the patient and the care they require. This is checked on arrival into theatre department. Signatures are recorded to evidence the checks completed. This form and the completion of the
Sign In, Time Out and Sign Out are recorded and this form is kept in the patient’s notes.

Copies of written documents used to record the patient care are also kept in the patient’s medical notes. These may include:

- Anaesthetic record
- Catheter insertion
- Central Intravenous line insertion
- Perioperative Care Plan
- Postoperative surgical notes including pre-printed notes ie breast surgery
- Specific procedure observation charts
- PCA/Epidural/Rectus sheath/Local Anaesthetic Peripheral Infusion forms
- Prescription charts/Insulin charts/blood transfusion charts
- Other documentation specific to the patient’s care eg VTE, sick notes

These forms are kept together with the patient’s clinical notes folder and returned to the ward with the patient on discharge.

The patient pathway through the perioperative phase is recorded on the Galaxy electronic system. This is planned sequentially, with inability to move forward without addressing each step, to ensure all safety checks and points of care are recorded. The Galaxy system allows audit information to be collected. The system can be altered to reflect changing needs of information recorded by the Trust IT providers.

Team members are identified on the Galaxy electronic system for each procedure.

The Datix system is available to record any adverse incidents in care or its documentation.

3.5. DEBRIEF

Debrief is performed at the end of the operating session or on a case by case basis if key members of the procedural team changes (NatSSIPs,4.13, 2015). This may occur following the Sign Out of the final case, before any of the team leave the theatre or following the completion of the list and transfer of the final patient to Recovery.

Any member of the procedural team may lead the debrief. Content discussed includes things that went well, any identified problems with equipment or process and areas for improvement. A template is available to help guide the debrief if required.

The Registered Practitioner in charge of the list is responsible for escalating issues arising from the debriefing to the Theatre Co-ordinator for action. The Trust Datix system is available to report governance issues.
4: Training requirements

All theatre staff will read this policy and associated trust policies and appendices.

All perioperative staff new to theatres will be introduced to this policy and associated trust policies and appendices at induction to the department. They will be supported during their induction period to take an active part in the Five Steps to Safer Surgical Interventions guidance and are responsible for incorporating this into their practice.

All medical staff will be introduced to this policy and associated trust policies and appendices at induction to the department. They will be supported during their induction period to take an active part in the five steps to safer surgical interventions guidance and are responsible for incorporating this into their practice.

5: Audit process

Audit of compliance with this policy will be carried out by the Theatres Manager and results fed back to the perioperative team to allow further training and improvement. The information collected on the Galaxy system is subject to monthly review for accuracy of data collected and utilisation activity.

6: References

http://webarchive.nationalarchives.gov.uk/+//www.dh.gov.uk/en/Aboutus/MinistersandDepartmentLeaders/ChiefMedicalOfficer/AboutTheChiefMedicalOfficerCMO/CMOAtLarge/DH_085832


http://www.nrls.npsa.nhs.uk/resources/clinical-specialty/surgery/

http://www.nrls.npsa.nhs.uk/EasySiteWeb/getresource.axd?AssetID=93286


Sign in

**Key People Involved:**
- Lead Anaesthetist (responsible for initiating ‘sign in’)
- Anaesthetic Practitioner
- Escort Nurse

**Where?**
- Anaesthetic Room

**How?**
- Observe a Silent focus per checklist
- Anaesthetic Practitioner completes ‘sign in’ on electronic system

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Appendix 1: Surgical Safety Checklist – “How to”

**Key People involved:**
- Lead Surgeon (responsible for initiating ‘time out’)
- Lead Anaesthetics
- All Team Members

**Where?**
- In Theatre

**How?**
- Observe a Silent Focus on patient
- Lead Surgeon initiates and identifies team member to read checklist aloud as per checklist
- The theatre team respond as per checklist on electronic system completed

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Sign Out

**Key People Involved:**
- All Team Members-Scrub Practitioner to initiate ‘sign out’
- Lead Surgeon
- Lead Anaesthetics

**Where?**
- In Theatre

**How?**
- Observe a Silent Focus on patient
- Scrub Practitioner initiates and identifies team member to read checklist aloud
- The team member reads aloud all parts of the ‘sign out’ as per checklist
- Identified team member completes ‘sign out’ on electronic system
- The person who read ‘sign out’ confirms ‘sign out’ completed
- Lead Surgeon documents on his operation notes that all parts of the Safe Surgery checklist were completed satisfactorily

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No Silent Focus: ALL team members direct full attention to Surgical Safety Checklist

- NO music, interruptions or distractions
- NO non-essential conversation
Appendix 2

SIGN IN (ODA & ANAESTHETIST)  
SURGEON

TIME OUT (NURSE, ANAESTHETIST & SURGEON)

SIGN OUT (NURSE, ANAESTHETIST & SURGEON)

BEFORE SKIN INCISION

- Confirm all team members have introduced themselves by name and role
- Confirm the patient’s name, procedure and where the incision will be made
- Has antibiotic prophylaxis been given within the last 60 mins?
  - Yes
  - No
- Has VTE prophylaxis been undertaken?
  - Yes
  - Not applicable

Anticipated critical events:

To Surgeon:
- What are the critical or non-routine steps?
- How long will the case take
- What is the anticipated blood loss

To Anaesthetist:
- Are there any patient specific concerns?

To Nursing Team:
- Has sterility (including indicator results) been confirmed?
- Are there any equipment issues or any concerns?

Is essential imaging displayed?
- Yes
- Not applicable

BEFORE PATIENT LEAVES OPERATING ROOM

Scrub nurse verbally confirms with the team:
- The name of the procedure
- Completion of instrument sponge and needle counts
- Specimen labelling (real labels out loud, including patient name)
- Whether there were any equipment problems to be addressed

Surgeon, anaesthetist & scrub nurse:
- What are the key concerns for the recovery and management of this patient?

BEFORE INDUCTION OF ANAESTHESIA

- Has the patient confirmed his/her identity, site, procedure and consent?
  - Yes
  - No
- Is the surgical site marked?
  - Yes
  - Not applicable
- Is the anaesthetic machine and medication check completed?
  - Yes
- Is the pulse oximeter on the patient and functioning?
  - Yes
- Does the patient have a known allergy?
  - No
  - Yes
- Difficult or aspiration risk?
  - No
  - Yes, & equipment/assistance Available.
- Risk of >500ml blood loss (7ml/kg in children)?
  - No
  - Yes, Blood products available/G&S
  - Yes, Two IVs/central venous access

JH 01/18
Appendix 3
Pre-operative Briefing Checklist

To be undertaken before the first case of the list, with all members of the team, to ensure a shared understanding of the plan for that list

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Brief Leader ____________________________________________

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<td>Are all team members present?</td>
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<td>Does everyone know each other?</td>
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<td>Is anyone missing?</td>
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<thead>
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<td>Are there any changes to the list order or patient location?</td>
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<tr>
<td>Discuss each case individually – plan, expectations, special considerations.</td>
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<td>Inform Recovery if relevant.</td>
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<tr>
<td>Are there any equipment issues?</td>
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<td>Do we need anything non-routine?</td>
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</tr>
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<tbody>
<tr>
<td>Do we need input from other agencies e.g. x-ray, scan, other specialties?</td>
<td></td>
</tr>
<tr>
<td>Who will co-ordinate this?</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NOTES</th>
<th></th>
</tr>
</thead>
</table>
**Appendix 4**

**Pre-operative De-briefing Checklist**

To be undertaken after the last case of the list, with all members of the team

<table>
<thead>
<tr>
<th>Date _______________</th>
<th>Theatre</th>
<th>Debrief Leader ________________________________</th>
</tr>
</thead>
</table>

Please ✔ if discussed & record any issues arising.

<table>
<thead>
<tr>
<th>What went well and why</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Did we work well as a team?</td>
<td></td>
</tr>
<tr>
<td>Did we speak up when needed?</td>
<td></td>
</tr>
<tr>
<td>Were we well prepared?</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What did not go well and why</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Did the briefing miss any information?</td>
<td></td>
</tr>
<tr>
<td>Was there any confusion in the team?</td>
<td></td>
</tr>
<tr>
<td>Were there any errors/near misses?</td>
<td></td>
</tr>
<tr>
<td>Does an incident need reporting on datix?</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Close the loop, feedback and actions</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>What do we need to change?</td>
<td></td>
</tr>
<tr>
<td>Does anything require escalation?</td>
<td></td>
</tr>
<tr>
<td>What can we do to improve?</td>
<td></td>
</tr>
<tr>
<td>Who will take action forward?</td>
<td></td>
</tr>
<tr>
<td>Do we need external/senior support?</td>
<td></td>
</tr>
<tr>
<td>Do we need to plan for the next session?</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Action Plan</th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Team leader signature</th>
<th></th>
</tr>
</thead>
</table>
STOP before you block

Notice for anaesthetists and anaesthetic assistants

- A STOP moment must take place immediately before inserting the block needle
- The anaesthetist and anaesthetic assistant must double-check:
  - the surgical site marking
  - the site and side of the block
Appendix 6

Guidance for the provision and checking of prostheses in the perioperative environment

This guidance relates to all procedures where single or multi-component prostheses are implanted within the surgical environment as part of or as the sole surgical procedure. A prosthesis is considered to be an artificial substitute for a body part, implanted for functional or cosmetic reasons, whether this be a temporary or permanent implantation.

Standards for selection of prostheses within ECNHST

- Purchase of prostheses will be through the SBS system. Providers of prostheses will have a contract with the Trust to supply items as consignment stock or on a ‘sale or return basis’.
- All manufacturers of prostheses must provide evidence of the clinical effectiveness and quality of their product.
- Manufacturers must provide support and training for medical and perioperative staff when requested as part of their contract.
- Surgeons who implant prostheses must have undergone training and supervision in the use of the individual prosthesis and the procedure must be part of the Surgeon’s regular clinical practice.
- All prostheses must have identifying lot numbers to allow for accurate tracking and traceability.

Implantation of prostheses in the Perioperative environment

It is the responsibility of the Speciality Team Leader, in collaboration with the Stores Co-ordinator, to ensure a full range of appropriate prostheses and their related instrumentation is available. The operating surgeon is responsible for contacting the Stores Co-ordinator for the ordering of individual patient specific prostheses e.g. breast prostheses, joint prostheses or ophthalmic lenses. If arrangements have been made to have particular prostheses, components or instrumentation available this must be checked prior to the patient being admitted to the theatre department by the Scrub Practitioner in charge of the list. This should be confirmed at ‘Team Brief’ at the beginning of the list.

- For total joint replacement surgery the component sizes required are decided following the ‘Trial’ phase of the operative procedure. This is verified before the matching implantable prosthesis is opened. If more than one prosthesis/component is required compatibility must be verified at this point and prior to opening the implantable prosthesis. There is a laminated compatibility poster located in orthopaedic theatre referring to total hip joint replacement component compatibility for reference.
The checking process is the responsibility of the clinical team including the Operating Surgeon, Scrub Practitioner and Circulating Practitioner. The choice of prosthesis remains the Surgeon’s responsibility.

- The prosthesis must be received onto the sterile field as near to insertion time as possible to reduce the risk of contamination.
- The surgeon must request the prosthesis by specifying make/model, size and laterality if appropriate.
- Lead Surgeon, Scrub Practitioner and Circulating Practitioner must jointly confirm make/model, size, laterality, expiry date and compatibility for total hip replacements by visual and verbal confirmation. This process should be conducted in the same manner as ‘Time Out’ with a silent focus and continuity of personnel involved. It must be done before any prosthesis is opened.
- In Ophthalmic surgery the dioptre and laterality of the lens required is written on the theatre white board and confirmed as part of the modified Ophthalmic Safe Surgery Checklist at the ‘Time Out’ phase.
- Prosthesis sterility and integrity of packaging must be confirmed prior to receiving it onto the sterile field.
- Prostheses must be accepted onto the sterile field using aseptic technique.
- Once opened any size or laterality markings on the prosthesis must be checked against the product labelling in case of product mismatch.
- Handling of prostheses must be kept to a minimum prior to implantation to reduce the risk of contamination or damage.
- The Scrub Practitioner with reconfirm the make/model, size and laterality of the prosthesis on handing it to the surgeon for implantation.

Orthopaedic Surgery
- Details of the implanted prosthesis must be recorded in the patient notes on the National Joint Registry Form and the Theatre Elective Prosthesis Book. Details of the used prosthesis must be given to the Stores Co-ordinator for reordering as soon as possible following the procedure. This must be accompanied by a patient identification label which is securely attached.
- Breast Surgery – Details of the implanted prosthesis is recorded in the patient’s notes, on Galaxy and in the Theatre Breast Reconstruction Book. The stores co-ordinator must also be given details of used prostheses to enable reordering of consignment stock.
- Ophthalmic Surgery - Details of the implanted prostheses is recorded in the patient’s notes, on Galaxy and in the Theatre Ophthalmic Book. Details are also recorded on the Consignment Replenishment Form which is given to the Stores Coordinator for re-ordering.
- The details of used prostheses from any speciality must be given to the Stores Co-ordinator for reordering as soon as possible following the procedure.
Prosthesis checking flowchart

Pre-surgery
Check availability of prosthesis, range and components

During Surgery
Surgeon requests prosthesis
Make/model, size laterality from ‘Trial’. Check white-board if used

During Surgery
Prior to prosthesis opened - Silent Focus. Check white-board if used.
Visual and verbal check – make/model, size, laterality, expiry, compatibility

During Surgery
Received onto sterile field using aseptic technique. Minimal handling of prosthesis

During Surgery
Reconfirmation of make/model, size, laterality, expiry immediately prior to insertion

During Surgery
Complete all patient documentation

Post Surgery
Reorder used prosthesis
Perioperative Checking of Prostheses

Surgeon to request prosthesis
Make/model, size, laterality
‘Trial’ size written on white-board

Prior to opening
Surgeon, Scrub Practitioner, Circulating Practitioner
Review ‘Trial’. Make/model, size, laterality, expiry, compatibility
Check – white-board

Scrub Practitioner
check
Information on prosthesis with labelling

Scrub Practitioner and Surgeon
check
Make/model, size, laterality, expiry

Complete documentation

Reorder via Stores Co-ordinator
**APPENDIX 7**

**Standard Operating Procedure**

<table>
<thead>
<tr>
<th>Title of Standard Operation Procedure (SOP):</th>
<th>Central line insertion and safe retrieval of guidewire</th>
</tr>
</thead>
<tbody>
<tr>
<td>No:</td>
<td>Version No:1.1</td>
</tr>
<tr>
<td>Issue Date: August 2016</td>
<td>Review Date: August 2018</td>
</tr>
<tr>
<td>Purpose and Background</td>
<td>To ensure the safe retrieval and disposal of guide wire following central line insertion</td>
</tr>
<tr>
<td>Scope (i.e. organisational responsibility)</td>
<td>Patient care in the perioperative period</td>
</tr>
<tr>
<td>Vital functions affected by this SOP:</td>
<td>Checking of equipment prior to use</td>
</tr>
<tr>
<td></td>
<td>Ensuring safe management of sharps during CVC insertion</td>
</tr>
<tr>
<td>Audit:</td>
<td></td>
</tr>
<tr>
<td>Escalations (if you require any further clarification re the process outlined please contact):</td>
<td>Theatre Manager</td>
</tr>
<tr>
<td>Author:</td>
<td>John Corke</td>
</tr>
<tr>
<td>Approval Record:</td>
<td>Committee/Group</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Background**

In recent years there has been an increase in research to identify factors contributing to failure to remove guidewires following CVC insertion.

Lines are often inserted under stressful conditions with the possibility of clinical distractions in unstable patients and, in some scenarios, lack of immediate supervision to trainees. All these factors were found to be associated with inadvertent failure to remove guidewires during placement of CVCs (Williams et al, 2014).

National safety Standards for Invasive Procedures (2015) supports safe and consistent practice in accounting for all items used during invasive procedures and minimising the risk of them being retained unintentionally.

This SOP has been created in order to minimise these events within the trust through appropriate procedure/paper documentation.

**Scope**

This SOP applies to all East Cheshire NHS Trust staff involved in the insertion of CVC in theatres. This policy does not apply to arterial line insertion or any other form of invasive device.

**ANTT**

During the procedure the Administering Anaesthetist and (where applicable) their assistant must undertake the necessary steps to comply with the Aseptic Non Touch Technique policy.

The observer will ensure that this is undertaken and stop the procedure in the event of a significant breach of aseptic technique.

**Definitions**

For the purpose of clarity the term ‘CVC insertion’ will be used throughout this document to describe the procedure for which this SOP is related.

The designation ‘Administering Anaesthetist’ will be used to describe the anaesthetist responsible for CVC insertion.
Operating Procedure

Considerations

To minimise the risk of distraction the following items should be considered:

- Personnel entering or exiting the room should be avoided whilst the procedure is performed.
- Careful consideration should be given to the presence of non-essential staff in the area of the procedure.
- Administering Anaesthetist should be adequately competent to undertake the procedure whilst teaching (where applicable).
- All equipment required should be prepared and nearby.

Procedure

1. Administering Anaesthetist and Observer (or student where applicable) should discuss any non-standard items required for the procedure, these should be collected prior to commencement so that both team members can be present throughout.

2. Administering Anaesthetist to check all sharps prior to the procedure and if necessary count and document the amount present.

3. Procedure to be carried out as per ANTT guidelines.

4. Following the procedure the Administering Anaesthetist and Observer will clarify together that the guide wire has been removed and that all sharps are accounted for.

5. All sharps should be disposed of as per the ‘Health and Safety Safer Sharps Procedure’

6. Observer to fill out the ‘Matching Michigan Checklist’ (Copies in anaesthetic store room).

Additional Information

References


Williams TL, Bowdle TA, Winters BD, Pavkovic SD, Szekendi MK. Guidewires unintentionally retained during central venous catheterization. Journal of the

Links

ECNHST – Aseptic Non Touch Technique policy and posters
ECNHST - Health and Safety Safer Sharps Procedure

SOP Back up information)
## Appendix 8

### Peri-operative Care Plan

<table>
<thead>
<tr>
<th>Theatre</th>
<th>Date</th>
<th>Consultant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consent form checked</td>
<td>Y □</td>
<td>N □</td>
</tr>
<tr>
<td>WHO Checklist Completed</td>
<td>Y □</td>
<td>N □</td>
</tr>
<tr>
<td>Theatre Pressure Ulcer Risk Assessment (SK1IN form) completed</td>
<td>Y □</td>
<td>N/ A □</td>
</tr>
<tr>
<td>Procedure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Active Patient Warming</td>
<td>Forced Air □</td>
<td>Fluids □</td>
</tr>
<tr>
<td></td>
<td>Not used □</td>
<td></td>
</tr>
<tr>
<td>Skin Prep used</td>
<td>Chlorhexidine □</td>
<td>Providone Iodine □</td>
</tr>
<tr>
<td></td>
<td>Chloroprep □</td>
<td>Other □ (specify)</td>
</tr>
<tr>
<td>Diathermy pad site checked</td>
<td>Y □</td>
<td></td>
</tr>
<tr>
<td>Comment:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urinary catheter insertion</td>
<td>Y □</td>
<td>N □</td>
</tr>
<tr>
<td>Allergies</td>
<td>Y □</td>
<td>N □</td>
</tr>
</tbody>
</table>

Signature of responsible practitioner

---

Full detailed perioperative information accessed via Galaxy IT system. Contact Main Theatres x1401.
## Peri-operative Care Plan

<table>
<thead>
<tr>
<th><strong>Throat pack</strong></th>
<th>Insertion (sig)____________________</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Removal (sig)____________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Implants / tracking labels</strong></th>
<th>Affix all product identification labels:</th>
</tr>
</thead>
<tbody>
<tr>
<td>(e.g. prostheses, drains, urinary catheters)</td>
<td></td>
</tr>
</tbody>
</table>

**Any other relevant information:**
# Perioperative Count Sheet

Theatre No _______________

Date _____________________

<table>
<thead>
<tr>
<th>Item</th>
<th>Initial Instrument Count</th>
<th>Initial Instrument Count</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Scrub Practitioner</td>
<td>Circulating Practitioner</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Item</th>
<th>Initial Swab / Sharps Count</th>
<th>Initial Swab / Sharps Count</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Scrub Practitioner</td>
<td>Circulating Practitioner</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Item</th>
<th>Additional / Relieving Scrub Practitioner</th>
<th>Relieving Circulating Practitioner</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Scrub Practitioner</td>
<td>Circulating Practitioner</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Size</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>4 x 4</td>
<td></td>
</tr>
<tr>
<td>6 x 4</td>
<td></td>
</tr>
<tr>
<td>9 x 9</td>
<td></td>
</tr>
<tr>
<td>12 x 12</td>
<td>Laprascopic Retrieval Bag</td>
</tr>
<tr>
<td>18 x 18</td>
<td>Pledgets</td>
</tr>
<tr>
<td>Sutures</td>
<td>Tapes/Slings</td>
</tr>
<tr>
<td>Suture Reels</td>
<td>Cotton wool balls</td>
</tr>
<tr>
<td>Hypo Needle</td>
<td>Digital Tourniquet</td>
</tr>
<tr>
<td>Blades</td>
<td>Other/Supps</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Count</th>
<th>Correct</th>
<th>Scrub Practitioner</th>
<th>Circulating Practitioner</th>
</tr>
</thead>
<tbody>
<tr>
<td>Final</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If ‘No’ record what action was taken:

JH 01/18
Retained Swabs & Packs

Record number and size ______________________________________

Scrub Practitioner ______________________________________

Removal of Retained Swabs & Packs

Record number and size ______________________________________

Responsible Practitioner ____________________________________

Date ____________________
Pre/Peri-operative Assessment: Complete if Waterlow Score >10 or Operation Time >2 hrs

<table>
<thead>
<tr>
<th>Waterlow Scale (Ward Assessment)</th>
<th>≥10 = At Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Existing skin redness, break in integrity</td>
<td>Category/Description</td>
</tr>
<tr>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>N</td>
<td>Y</td>
</tr>
<tr>
<td>Actions taken</td>
<td>Y</td>
</tr>
<tr>
<td>e.g. gel pads, heel cup</td>
<td>Position changed</td>
</tr>
<tr>
<td>Patient position during procedure</td>
<td>Time</td>
</tr>
<tr>
<td>New position</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Method of transfer</th>
<th>Slide sheet</th>
</tr>
</thead>
<tbody>
<tr>
<td>PAT slide</td>
<td>Y</td>
</tr>
<tr>
<td>Hovermat</td>
<td>N</td>
</tr>
<tr>
<td>Slide sheet</td>
<td>N</td>
</tr>
<tr>
<td>Other</td>
<td>Other</td>
</tr>
</tbody>
</table>

Body Diagram

Anterior

Posterior

Feet Diagram

Right

Left

Date & Time

Sign & Print Name
Post-operative Assessment: Complete if Waterlow Score >10 or Operation Time >2 hrs

<table>
<thead>
<tr>
<th>On admission to Recovery</th>
<th>Category/Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Observe skin condition, record redness or break in integrity</td>
<td>Refer to EPUAP classification tool</td>
</tr>
<tr>
<td>Give details and document on chart</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient position during recovery period</th>
<th>Category/Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient able to change own position</td>
<td>Y</td>
</tr>
<tr>
<td>N</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pressure area assessment on discharge from recovery</th>
<th>Category/Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>N</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Actions taken e.g. aids used, re-positioning</th>
</tr>
</thead>
</table>

EPAUP & NUPAP Pressure Ulcer Categorisations Tool

Addressograph Label

Date & Time

Sign & Print Name
Equality Analysis (Impact assessment)

1. What is being assessed?

| Five Steps to Safer Surgical Interventions Policy |

Details of person responsible for completing the assessment:

- Name: Janet Hatton
- Position: Practice Development Sr
- Team/service: Theatres

State main purpose or aim of the policy, procedure, proposal, strategy or service:

- A definitive policy for the roles and responsibilities of the key clinical staff involved in the process of the WHO checklist 5 steps to safer surgery. The policy also reflects the LocSSIPs based on NatSSIPs relevant to the aspects of perioperative care covered.

2. Consideration of Data and Research

To carry out the equality analysis you will need to consider information about the people who use the service and the staff that provide it.

2.1 Give details of RELEVANT information available that gives you an understanding of who will be affected by this document

Cheshire East (CE) covers Eastern Cheshire CCG and South Cheshire CCG. Cheshire West & Chester (CWAC) covers Vale Royal CCG and Cheshire West CCG. In 2011, 370,100 people resided in CE and 329,608 people resided in CWAC.

**Age:** East Cheshire and South Cheshire CCG’s serve a predominantly older population than the national average, with 19.3% aged over 65 (71,400 people) and 2.6% aged over 85 (9,700 people).

Vale Royal CCGs registered population in general has a younger age profile compared to the CWAC average, with 14% aged over 65 (14,561 people) and 2% aged over 85 (2,111 people).

Since the 2001 census the number of over 65s has increased by 26% compared with 20% nationally. The number of over 85s has increased by 35% compared with 24% nationally.
Race:
- In 2011, 93.6% of CE residents, and 94.7% of CWAC residents were White British.
- 5.1% of CE residents, and 4.9% of CWAC residents were born outside the UK – Poland and India being the most common.
- 3% of CE households have members for whom English is not the main language (11,103 people) and 1.2% of CWAC households have no people for whom English is their main language.

Gender: In 2011, c. 49% of the population in both CE and CWAC were male and 51% female. For CE, the assumption from national figures is that 20 per 100,000 are likely to be transgender and for CWAC 1,500 transgender people will be living in the CWAC area.

Disability:
- In 2011, 7.9% of the population in CE and 8.7% in CWAC had a long term health problem or disability.
- In CE, there are c.4500 people aged 65+ with dementia, and c.1430 aged 65+ with dementia in CWAC. 1 in 20 people over 65 has a form of dementia.
- Over 10 million (c. 1 in 6) people in the UK have a degree of hearing impairment or deafness.
- C. 2 million people in the UK have visual impairment, of these around 365,000 are registered as blind or partially sighted.
- In CE, it is estimated that around 7000 people have learning disabilities and 6500 people in CWAC.
- Mental health – 1 in 4 will have mental health problems at some time in their lives.

Sexual Orientation:
- CE - In 2011, the lesbian, gay, bisexual and transgender (LGBT) population in CE was estimated at 18,700, based on assumptions that 5-7% of the population are likely to be lesbian, gay or bisexual and 20 per 100,000 are likely to be transgender (The Lesbian & Gay Foundation).
- CWAC - In 2011, the LGBT population in CWAC is unknown, but in 2010 there were c. 20,000 LGB people in the area and as many as 1,500 transgender people residing in CWAC.

Religion/Belief:
The proportion of CE people classing themselves as Christian has fallen from 80.3% in 2001 to 68.9% in 2011 and in CWAC a similar picture from 80.7% to 70.1%, the proportion saying they had no religion doubled in both areas from around 11%-22%.
- Christian: 68.9% of Cheshire East and 70.1% of Cheshire West & Chester
- Sikh: 0.07% of Cheshire East and 0.1% of Cheshire West & Chester
- **Buddhist:** 0.24% of Cheshire East and 0.2% of Cheshire West & Chester
- **Hindu:** 0.36% of Cheshire East and 0.2% of Cheshire West & Chester
- **Jewish:** 0.16% of Cheshire East and 0.1% of Cheshire West & Chester
- **Muslim:** 0.66% of Cheshire East and 0.5% of Cheshire West & Chester
- **Other:** 0.29% of Cheshire East and 0.3% of Cheshire West & Chester
- **None:** 22.69% of Cheshire East and 22.0% of Cheshire West & Chester
- **Not stated:** 6.66% of Cheshire East and 6.5% of Cheshire West & Chester

**Carers:** In 2011, nearly 11% (40,000) of the population in CE are unpaid carers and just over 11% (37,000) of the population in CWAC.

**2.2 Evidence of complaints on grounds of discrimination:** (Are there any complaints or concerns raised either from patients or staff (grievance) relating to the policy, procedure, proposal, strategy or service or its effects on different groups?)

No

**2.3 Does the information gathered from 2.1 – 2.3 indicate any negative impact as a result of this document?**

No

**3. Assessment of Impact**

Now that you have looked at the purpose, etc. of the policy, procedure, proposal, strategy or service (part 1) and looked at the data and research you have (part 2), this section asks you to assess the impact of the policy, procedure, proposal, strategy or service on each of the strands listed below.
1. RACE:
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, racial groups differently?
Yes ☐ No ☑

Explain your response: Because the policy relates to the safety precautions undertaken by the surgical team to perform surgery, a procedure or intervention on any individual regardless of race. If a patient’s first language is not English, staff will follow the trust interpretation policy.

2. GENDER (INCLUDING TRANSGENDER):
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, different gender groups differently?
Yes ☐ No ☑

Explain your response: Because the policy relates to the safety precautions undertaken by the surgical team to perform surgery, a procedure or intervention on any individual regardless of gender.

3. DISABILITY
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, disabled people differently?
Yes ☐ No ☑

Explain your response: Because the policy relates to the safety precautions undertaken by the surgical team to perform surgery, a procedure or intervention on any individual regardless of disability. On the checklist there is space to indicate if the patient has any particular needs such as learning disabilities, autism or sensory impairment or mental health needs so that the staff are well prepared and can implement any reasonable adjustments required.

4. AGE:
From the evidence available does the policy, procedure, proposal, strategy or service, affect, or have the potential to affect, age groups differently?
Yes ☐ No ☑

Explain your response: Because the policy relates to the safety precautions undertaken by the surgical team to perform surgery, a procedure or intervention on any individual regardless of age. Any particular needs can be noted on the checklist.
5.LESBIAN, GAY, BISEXUAL:
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, lesbian, gay or bisexual groups differently? Yes ☐ No ☑

Explain your response: Because the policy relates to the safety precautions undertaken by team to perform surgery, a procedure or intervention on any individual regardless of sexual orientation.-

6.RELIGION/BELIEF:
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, religious belief groups differently? Yes ☐ No ☑

Explain your response: Because the policy relates to the safety precautions undertaken by the surgical team to perform surgery, a procedure or intervention on any individual regardless of religious belief. Any particular requirements such as use of blood products for Jehovah’s Witnesses or avoiding drugs with porcine content for Muslim patients would have been identified and noted prior to surgery.

7.CARERS:
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, carers differently? Yes ☐ No ☑

Explain your response: Because the policy relates to the safety precautions undertaken by the surgical team to perform surgery, a procedure or intervention on any individual regardless of carer status

8.OTHER: EG Pregnant women, people in civil partnerships, human rights issues.
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect any other groups differently? Yes ☐ No ☑

Explain your response:
Because the policy relates to the safety precautions undertaken by the surgical team to perform surgery, a procedure or intervention on any individual regardless of the above status. There is a WHO Checklist especially pertinent to pregnant women used prior to a surgical intervention to aid childbirth.
4. Safeguarding Assessment - CHILDREN

| a. Is there a direct or indirect impact upon children? | Yes ☐ No ☑ |

b. If yes please describe the nature and level of the impact (consideration to be given to all children; children in a specific group or area, or individual children. As well as consideration of impact now or in the future; competing / conflicting impact between different groups of children and young people:

c. If no please describe why there is considered to be no impact / significant impact on children

Because the policy relates to the safety precautions undertaken by the surgical team to perform surgery, a procedure or intervention on any individual regardless of age.

5. Relevant consultation

Having identified key groups, how have you consulted with them to find out their views and that the made sure that the policy, procedure, proposal, strategy or service will affect them in the way that you intend? Have you spoken to staff groups, charities, national organisations etc?

Policy sent to and approved by Planned Care Directorate SQS

6. Date completed: 13/02/2018  Review Date: 13/02/2021

7. Any actions identified: Have you identified any work which you will need to do in the future to ensure that the document has no adverse impact?

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<tr>
<th>Action</th>
<th>Lead</th>
<th>Date to be Achieved</th>
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8. Approval – At this point, you should forward the template to the Trust Equality and Diversity Lead lynbailey@nhs.net

Approved by Trust Equality and Diversity Lead:

Date: 5 March 2018

JH 01/18