East Cheshire NHS Trust

Theatre Policy for Surgical Hand Antisepsis, Gowning and Gloving

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30th May 2017

East Cheshire NHS Trust

Policy Title:	Theatre Policy for Surgical Hand Antisepsis, Gowning and Gloving
Executive Summary:	The policy describes the correct approved methods of surgical hand antisepsis, gowning and gloving within the Operating Department. It aims to help reduce the incidence of post-operative wound infections and to protect both patients and staff from potential contaminants.
Supersedes:	July 2007, September 2011, July 2014, July 2017
Description of Amendment(s):	Updated scrubbing guidance from AfPP (2016). New poster Appendix 1

This policy will impact on:
Theatre peri-operative and medical staff, health and safety, infection control.

Financial Implications:
Provision of appropriate scrub solutions, sterile surgical gowns and sterile gloves.

Policy Area:	Clinical practice, Operating Theatre, Infection control	**Document Reference:**	ECT002749
Version Number:	V1.4	**Effective Date:**	May 2017
Issued By:	Theatre Manager	**Review Date:**	May 2020
Author:	Practice Development Sr	**Impact Assessment Date:**	May 2017

APPROVAL RECORD

	Committees / Group	**Date**
Consultation:	Infection Control Clinical Risk Group	**Oct 2005** **Oct 2005**
	Association of Perioperative Practice Standards and Recommendations	**May 2016**
Approved by Director:	Infection Control Clinical Risk	**Oct 2005** **Oct 2005**
Received for approval:	Planned Care SQS	**May 2017**

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Contents

1.0 Introduction

The fundamental principles of aseptic technique must be adhered to when performing surgical hand antisepsis, gowning and gloving prior to surgical intervention. Surgical hand antisepsis should be undertaken immediately prior to donning sterile gowns and gloves to reduce the risk of cross infection in the event of glove perforation. A standardised procedure for surgical hand antisepsis, gowning and gloving based on current evidence and best practice will help to reduce the risk of contamination of the operator and operative field (AfPP, 2016).

2.0 Purpose

The purpose of this document is to provide guidelines for all staff who need to undertake hand antisepsis, gowning and gloving prior to surgical or invasive procedures. A standardised procedure will allow competence to be assessed and standards maintained.

3.0 Roles and responsibilities

The Chief Executive has ultimate responsibility for the implementation and monitoring of the policies in use in the Trust.

Associate Director Planned Care Is responsible for overseeing the development of this policy and ratifying the contents in line with Trust guidance policy on procedural documents

Theatre Manager / Co-ordinator is responsible for ensuring the policy is implemented and monitored within the Trust supporting education needs within the theatre department.

Practice Development Facilitator for Theatres is responsible for acting as author and for updating the policy reflecting changes in evidence which influences practice. They are responsible, with the theatre manager / coordinator, to ensure all staff are aware of the guidance to follow and that all new and existing staff are deemed competent within their practice.

Perioperative Practitioners are responsible for ensuring they maintain their competence, follow the guidance outlined in this policy and keep up to date with relevant changes in best practice. They are responsible for recognising poor practice in others and referring them to the policy or PDF as appropriate for further training.

Scope of this policy

The guidance within this policy relates to all personnel who are required to scrub, gown and glove prior to surgery or any invasive procedure

4.0 Processes and procedures

4.1. SURGICAL HAND ANTISEPSIS

4.1.i. The aim of surgical hand antisepsis is to remove debris and transient microorganisms, minimize resident microorganisms and to inhibit rebound growth on the hands, nails and forearms of surgical personnel (AORN 2014).

4.1.ii. All staff should wear the correct theatre attire before starting the surgical hand antisepsis procedure which includes a clean, correctly sized theatre top with short sleeves and trousers.

4.1.iii. All hair must be covered by a surgical hat. Paper disposable hats are provided. Cloth hats may be worn if freshly laundered and changed daily. If a turban or other religious head wear is worn it must be freshly laundered and changed daily.

4.1.iv. All jewellery, with the exception of a wedding ring and plain stud earrings, must be removed. This is to prevent the harboring of microorganisms beneath the jewellery and to avoid accumulation of scrub solution in crevices which may predispose towards microbial contamination or an allergy development.

4.1.v. Finger nails must be clean and short. Nail polish and artificial nails, including gel and acrylic, must not be worn. Artificial nails may harbor microorganisms which cannot be easily removed.

4.1.vi. Hands must be clean and free from any breaks in skin integrity. Any individual with a large or infected wound must not scrub. Minor abrasions may be covered with a waterproof dressing.

4.1.vii Face masks, spectacles, magnifying glasses and head-lamps must be positioned before the procedure is undertaken. Masks must only be handled by the ties and must cover the nose and mouth. Face masks must be removed at the end of the procedure when worn by the scrub team and disposed of in the clinical waste. They must not be worn around the neck when in rest rooms or non-clinical areas. Masks with visors are available for procedures where there is higher risk of particulate or fluid spray. Glasses should be designed to protect the sides of the face and eyes. It is recommended that face masks and eye protection are used to protect scrub personnel against splash injury from blood or body fluid (AfPP, 2016)

4.1.viii. It may be necessary to wear additional protective clothing such as a lead collar or apron beneath the theatre gown if x-ray exposure will occur during

the procedure. Any reusable item must be clean before use and in place prior to beginning hand antisepsis.

4.2. THE SURGICAL HAND ANTISEPSIS PROCEDURE.

An appropriately sized gown should be chosen and outer wrapper peeled open and laid on the allocated gowning ledge or trolley. Gloves should be placed close for the circulator to open when needed.

4.2.i For the first surgical hand antisepsis of the day the hands should be washed with soap or an antimicrobial solution and running water immediately before beginning the surgical hand asepsis procedure.

The procedure must be carried out as follows:

4.2.ii Water should be at a comfortable temperature with a steady flow. Taps should be elbow operated to avoid contaminating washed hands on tap heads.

4.2.iii Hands and arms must be wet before applying the antimicrobial solution. Antimicrobial handwash solutions containing chlorhexidine gluconate or providone iodine are available in all scrub areas. Personnel who are allergic to conventional surgical scrub solution may use an appropriate alternative following discussion with Occupational Health and Infection control.

4.2.iv. Hands must remain above the level of the elbows and away from the theatre attire to avoid contamination from splashing.

4.2.v. Nails should be cleaned using a soft scrub brush and/or disposable pick under running water if required. When proceeding from one case to another nail cleaning is not required each time. The use of scrubbing brushes, other than directly to nails, is not recommended, as there is limited evidence to support any benefit in reducing bacterial counts. Their use on hands can potentially increase skin shedding and lead to damage.

4.2.vi. The first wash should encompass the hands and forearms up to the elbows Use 5 mls of scrub solution (1-2 depressions of the scrub solution dispenser) and use a systematic method to encompass all areas.

4.2.v. Wash hands using the following steps. Each step consists of 5 passes of each of the following strokes with 5mls of solution (Appendix 1).

- Palm to palm (work solution over hands and forearms to just below the elbow).
- Right palm over back of left hand and vice versa with fingers interlaced.
- Palm to palm, fingers interlaced.
- Rotational rubbing backwards and forwards with clasped fingers of right hand in left palm and vice versa.
- Rotational rubbing of right thumb clasped in left palm and vice versa.
- Rub fingertips on palms for both hands.
- Continue with rotating action down opposing arms working to just below the elbows

The above steps should take approximately 2 minutes (AfPP 2016)

Association for perioperative practice (2016).
https://www.youtube.com/watch?v=UxJEYN7MB2M&feature=youtu.be

Rinse and repeat the above steps keeping hands above elbows at all times. This wash should now cover the hands and two third of the forearms only to avoid compromising the cleanliness of the hands. The steps may be repeated a third time to the wrists only. The process should take at approximately 4 minutes as described.

4.2.vi. Hands must be thoroughly rinsed from the fingertips to the elbows allowing excess water to drain from the elbows into the sink.

4.2.v.ii The surgical hand antisepsis procedure should be timed when possible to ensure accuracy. All subsequent procedures should be the same as the initial one.

4.2.v.iii Hands must be dried thoroughly using one towel per hand. Firstly place one hand behind the towel and blot the skin on the opposite hand. A corkscrew movement is then used to dry from the hand to the elbow, using one towel per hand. The towel must not be returned to the hand once the arm has been dried. The towel is then discarded. The process is repeated for the other hand. Hands should be held higher than the elbows and away from surgical attire during the process.

4.3. GOWNING

All surgical gowns and clean air suits are classified as medical devices and are controlled by standard EN 13795 (BSI, 2011).

Gowns must be tested for the following characteristics:

Resistant to microbial penetration (dry and wet)
Clean (free from microbial and particulate matter)
Linting
Resistance to liquid penetration
Bursting strength (dry and wet)
Tensile strength (dry and wet)

Standard EN 13795 requires that gowns are able to withstand the user performing all that is required from the surgical procedure without compromising the sterile field, and to be resistant to liquid and microbial penetration, with minimal release of particles.

All gowns used in theatres must comply with the specification outlined and should be the wrap around style.

Theatre staff must understand:

- The gown specification
- How the gown is packed and presented
- How the gown is donned
- Once donned, what area of sterility it affords the wearer and precautions required.

Single use gowns are used for all invasive procedures within the department.

The gown pack should be checked for damage and sterilization expiry date prior to opening. A variety of sizes are available to suit individuals.

4.3.i. The surgical hand antisepsis procedure must be completed.

4.3.ii The folded gown should be lifted from the gown pack in such a way as not to contaminate the contents. The gown itself should only be touched by the scrub practitioner following surgical hand antisepsis

4.3.iii The person who is donning the gown only touches the inside of the garment, locating the neck and holding it securely. The rest of the gown is released with the inside facing towards the scrubbed individual. The armholes are located and both arms are inserted but hands should not protrude through the cuff of the gown.

4.3.iv. The circulating practitioner assists the scrubbed personnel to secure the gowns'
fastenings taking care not to stand too close to avoid any contact with the gown. The wrap around ties should be fastened with the help of another

scrubbed person, or using the card attached, once the gloves have been donned.

4.3.v. Once the surgical procedure is over, the gown must be unfastened by the circulating practitioner. The scrubbed practitioner must then pull the gown forward over the hands, folding it onto itself and place it in the contaminated linen receptacle.

4.4. GLOVING

Gloves act as a barrier to prevent transmission of infection between staff and patients and as a personal protection barrier after the surgical scrub procedure has been completed. Surgical gloves must fit so that they are comfortable and enable dexterity and sensitivity in use.

All surgical gloves must comply with standard BS EN 455 – 1 (BSI, 2000).

Care must be taken when wearing gloves but there is always a risk of penetration due to sutures, sharp instruments, bone fragments, finger nails and natural 'wear and tear'. This is a common cause of hand contamination with blood and body fluids.

If a sharps injury should occur to the operating staff the appropriate steps must be taken and documentation completed as outlined in the Occupational Health Department Sharps, Needlestick Injury and Body Fluid Exposure Management Policy and Procedure (ECNHST, 2014).

Double gloving provides an extra layer of protection and has been shown to reduce the number of perforations to inner gloves in all types of surgery. Double gloves may be worn for high risk cases if deemed appropriate. It is known, however, that double gloving reduces hand dexterity and sensitivity. Those reluctant to double glove may consider wearing double gloves on the non-dominant hand which is more at risk of puncture (Parteke, 2009 in AfPP, 2016).

Within the orthopaedic theatre double gloves must be worn for all joint replacement surgery to enable gloves to be safely changed at several appropriate points throughout the procedure.

An alternative selection of gloves are provided in theatres for personnel who are sensitive to latex or other chemicals in gloves and for use with patients who are sensitive to latex products. Please refer to Theatre Latex Guidelines and Latex Policy V2 (ECNHST, 2013).

4.4.i. The appropriate size and type of sterile glove is selected and the outer wrapping is opened by the circulating practitioner. The gloves are ideally taken by the scrubbed practitioner or dropped onto the sterile field afforded by the opened gown pack.

4.4.ii The closed method of gloving is the preferred method for donning sterile gloves to avoid contamination of the outer surface of the glove. (AfPP, 2016)

4.4.iii If gloves need to be changed intra-operatively due to puncture or contamination the glove must be removed in such a way as to avoid further contamination. A new glove may be donned with assistance from another member of the surgical team or by using the closed method.

4.4.iv. On completion of the operative procedure gloves should be removed by ensuring the glove surface comes into contact with glove and skin with skin. When removing the gown, contaminated gloved hands must not be used to undo the ties. Gloves must be treated as clinically contaminated waste and discarded into the orange clinical waste receptacle.

4.4.v. Following glove, gown and face protection removal hands should be inspected for signs of contamination and washed with soap and water.

4.5 INTRAOPERATIVE PROTOCOL

4.5.i. Following, surgical hand antisepsis, gowning and gloving perioperative personnel must be aware the area of sterility includes

- Their gloved hands and forearms
- Below nipple to waist level. Hands should be at or above waist level and below shoulder level and visible at all times to avoid inadvertent contamination.

4.5.ii. Scrubbed personnel must only touch items or areas that are sterile.

4.5.iii. Scrubbed personnel should be aware of and protect the sterile field around themselves and the patient throughout the procedure from inadvertent contamination. If not involved in a sterile procedure they should stand with their hands within the accepted sterile area.

4.6 SKIN CARE

Personnel should care for their hands to ensure adequate decontamination and good practice. Antiseptic solution should only be applied to wet hands and hands must be rinsed thoroughly to remove any soap residue and dried properly. Hand creams should be used to maintain good skin condition. Abrasions must be covered with occlusive dressings and those with infected lesions must not scrub and report to Occupational Health.

5.0 MONOTORING COMPLIANCE

The policy and updates will be shared with the Perioperative team, Surgeons and Anaesthetists.
New starters will be instructed and assessed as competent by their allocated mentor/preceptor or the PDF as part of their preceptorship.
Practice will be monitored by the Senior Perioperative Practitioners within the clinical area.
The policy will be reviewed every 3 years or sooner if new evidenced based practice is recommended by PDF or Theatre Manager / Coordinator

6.0 REFERENCES

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British Standards Institution (2000). *Medical gloves for single use: Requirements and testing for freedom from holes*. BS EN 455-1. London: BSI British Standards.

ECNHST (2016) Latex Policy V2.0
Accessed from:
http://www.eastcheshire.nhs.uk/About-The-Trust/policies/L/Latex%20Policy%20ECT2577.pdf

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APPENDIX 1

A guide to surgical hand antisepsis

Purpose

The purpose of the surgical hand antisepsis is to remove or destroy transient microorganisms and inhibit the growth of resident microorganisms (Tanner et al 2008).

Preparation of personnel and personal protective equipment prior to scrub process

All staff should be in the appropriate theatre attire before commencing surgical hand antisepsis. Expert opinion asserts that headwear (AfPP 2011), masks (AORN 2014) and attire should be comfortable, safe and unlikely to need adjustment after the scrub procedure thus avoiding potential contamination. Scrub suit sleeves must be rolled up well past the elbows and nail varnish, false nails, rings, watches and bracelets should be removed. Expert opinion (AfPP 2011) proposes that this type of accessory is likely to harbour pathogenic organisms which could contaminate surgically scrubbed hands and arms (NICE 2008). Any skin abrasions to digits, hands or arms must be occluded with a waterproof dressing. Wear appropriate mask and eye protection or a face shield as guided by local governance (AfPP 2011) to protect mucous membranes of the eyes, nose and mouth during procedures that are likely to generate splashes or sprays of blood, body fluids, secretions or excretions.

Select an appropriate sized surgical gown and double glove system as recommended by Tanner and Parkinson (2006). Peel open outer wrapper of gown pack, lay this on gowning station, scrub up ledge or trolley surface. Place gloves close by ready for circulator to peel open for you.

Procedure

Nail picks are recommended in UK theatre practice (AfPP 2011), nails are cleaned in the subungual area, however if nails are too short, then a nail brush is recommended. Nail brush use, other than directly to nails, is not recommended (AfPP 2011). In US literature (CDC 2002) brushes were advocated to commence the procedure, hence the outdated term of 'scrubbing' which lingers on.

Process

Each step of surgical 'scrubbing' consists of five strokes rubbing backwards and forwards and adapts Ayliffe's six step technique (Ayliffe et al 2000) into nine steps. Sources of evidence drawn on include AfPP's Standards and Recommendations for Safe Perioperative Practice (AfPP 2011), AORN's recommended practices (Paulson 2004), and Ayliffe's six step hand washing technique (Ayliffe et al 2000).

Preliminary wash

For the first antisepsis of day the hands should be washed with plain soap or an anti-microbial solution under running water before beginning the surgical hand antisepsis (AfPP 2011).

The temperature and flow of the water must be adjusted before the procedure is started to achieve comfort and avoid getting the scrub suit wet. Open nail brush and pick pack.

Ensuring that no part of the sink or taps is touched wet the hands and arms up to the elbow working from the fingertips towards the elbow in one direction only, keeping the hands higher than the elbows.

Wash hands and arms with a dose of antimicrobial solution (5mls) or plain soap (if using alcohol) up to the elbow, working from the fingertips toward the elbows.

Load brush with antiseptic and clean tips of finger with brush.

Use pick to gently remove debris from underneath tips of nails on each hand, and then discard.

Rinse hands and forearms up to elbow.

Surgical scrub

During each of the following steps keep hands (clean area) above the elbows (dirty area) allowing water to drain away, avoid splashing surgical attire.

Step 1

Apply appropriate amount of appropriate solution: 5ml dose from dispenser (one downward stroke action). Work into hands palm to palm and to encompass all areas of the hands and arms to just below the elbows as follows:

Step 2

Right palm over back of left and vice versa with fingers interlaced.

Step 3

Rub palm to palm, fingers interlaced.

Step 4

Rotational rubbing backwards and forwards with clasped fingers of right hand into left palm hand and vice versa.

Step 5

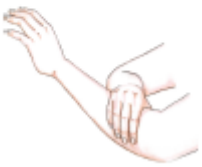
Rotational rubbing of right thumb clasped in left hand and vice versa.

Step 6

Rub finger tips on palms for both hands.

Step 7

Continue with rotating action down opposing arms, working to just below the elbows.



Step 8

Rinse and repeat steps 1-7 keeping hands raised above elbows at all times.

This wash should now only cover two thirds of the forearms to avoid compromising cleanliness of hands.

Local policy may include repeating these steps a third time but to wrists only.

Step 9

Rinse hands under running water – clean to dirty area. Turn off tap using elbows if necessary.

Open gown pack into a squared off surface and take a hand towel. Hands are dried first by placing the opposite hand behind the towel and blotting the skin, then, using a corkscrew movement, to dry from hand to elbow. Discard towel. Using a second towel, repeat the process on other hand and forearm before discarding.

Surgical hand antisepsis: application of alcohol hand rub

(If local policy/governance dictates for subsequent hand antisepsis)

- Application of alcohol rub consists of five strokes rubbing backwards and forwards and adapts Ayliffe's six step technique (Ayliffe et al 2000).
- As above, follow steps 2 – 7.
- Allow alcohol to evaporate before donning gloves to avoid the risk of dermatitis.

Gowning and gloving

Gowning and gloving is achieved by using the closed gloving technique (AfPP 2011) and once prepared, the hands and arms should be kept at waist level as personnel move to the sterile field.

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Equality Analysis (Impact assessment)

Please START this assessment BEFORE writing your policy, procedure, proposal, strategy or service so that you can identify any adverse impacts and include action to mitigate these in your finished policy, procedure, proposal, strategy or service. **Use it to help you develop fair and equal services.**

Eg. If there is an impact on Deaf people, then include in the policy how Deaf people will have equal access.

1. What is being assessed?

Surgical Hand Antisepsis, Gowning & Gloving

Details of person responsible for completing the assessment:

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

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

(usually the first paragraph of what you are writing. Also include details of legislation, guidance, regulations etc which have shaped or informed the document)

- The fundamental principles of aseptic technique must be adhered to when performing surgical hand antisepsis, gowning and gloving prior to surgical intervention. Surgical hand antisepsis should be undertaken immediately prior to donning sterile gowns and gloves to reduce the risk of cross infection in the event of glove perforation
- A standardised procedure for surgical hand antisepsis, gowning and gloving based on current evidence and best practice will help to reduce the risk of contamination of the operator and operative field (AfPP, 2016).
- Standards & Recommendations for Safe Perioperative Practice (2016)

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. Think about the information below – how does this apply to your policy, procedure, proposal, strategy or service

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.
- Gypsies & travellers – estimated 18,600 in England in 2011.

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 at18,700, 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.

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 preparation of the surgical team to perform surgery, a procedure or intervention on any individual regardless of race.

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 preparation of the surgical team to perform surgery, a procedure or intervention on any individual regardless of gender.

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 preparation of the surgical team to perform surgery, a procedure or intervention on any individual regardless of disability.

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 preparation of the surgical team to perform surgery, a procedure or intervention on any individual regardless of age.

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 preparation of the surgical team to perform surgery, a procedure or intervention on any individual regardless of sexual orientation.

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 preparation of the surgical team to perform surgery, a procedure or intervention on any individual regardless of religious belief. Wearing of religious headwear mentioned in point 4.1.iii Theatre gowns will cover arms for Muslim women following hand antisepsis.

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 preparation of the surgical team to perform surgery, a procedure or intervention on any individual regardless of carer status

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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: No other impacts identified.

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 preparation of 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 SQS group

6. Date completed: 26/05/2017 Review Date: 26/05/2020

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?

Action	Lead	Date to be Achieved

8. Approval – At this point, you should forward the template to the Trust Equality and Diversity Lead lynbailey@nhs.net

J Hatton
30th May 2017

Approved by Trust Equality and Diversity Lead:

Date: 31.5.17