Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Safety Standards for Invasive Procedures (SSIPs)

This is a new procedural document: Please read in full.

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Executive Sponsor(s):	Medical Director
Author/reviewer: (this version)	Lesley Barnett Deputy Director of Quality and Governance
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Target audience:	All staff involved with patients who are undergoing invasive procedures, Divisional managers, Heads of Clinical Service, Matrons, Sisters, Theatre users, Consultants and their specialty teams, Admissions teams, Anaesthetists, Theatre and Endoscopy staff, Radiographers, Ward and Clinic Procedural Teams.

Amendment Form

Version	Date Issued	Brief Summary of Changes	Author
Version 1	17 May 2021	• This is a new procedural document, please read in full	L Barnett Deputy Director of Nursing Cancer and Chemotherapy

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1 INTRODUCTION

This Policy has been written in order to comply with the NHS England mandate to implement the National Safety Standards for Invasive Procedures (NatSSIPs). The ultimate aim of NatSSIPs is to eradicate the occurrence of the Patient Safety Never Events, which occur around invasive procedures.

The aim of this policy is to:

- Standardise the management of invasive procedures in the non-theatre settings in line with recognised theatre practice during the pre-operative, intra-operative and post-operative stages.
- Provide a clear definition of invasive procedures, multidisciplinary team roles and responsibilities.
- Provide the standard against which Local Safety Standards for Invasive Procedures (LocSSIPs) are developed within procedural areas and outside areas where procedures are performed.
- Ensure the monitoring and governance as a continuous cycle of improvement.
- Maintain a safe culture to promote team work, minimise avoidable complications, and prevent patient safety never events.
- Ensure the intended site for all invasive procedures, including surgery, is marked to provide clear indication.

Where local procedures deviate from the Safety Standards for Invasive Procedures Policy a LocSSIP is required using the template (see Appendix 1). The Safety Standards for Invasive Procedures Policy is to be used as a basis in the creation, or modification of the Local Safety Standards for Invasive Procedures - LocSSIPs. Each of the LocSSIPs should include the key elements of the NatSSIPs guidance (see appendix 2 for Theatres and 3 for Endoscopy and 4 for CVC), five organisational and eight sequential steps for the patient on the pathway to undergo an invasive procedure.

The five organisational elements are guidelines and processes which support the safe delivery of the procedural care.

- Governance and audit
- Documentation of invasive procedures
- Workforce
- Scheduling and list management
- Handovers and information transfer

The eight sequential steps are a logical set of actions which should be performed for every procedure list and every patient.

- Procedural verification and site marking
- Team Brief
- Sign in

- Time out
- Prosthesis verification
- Prevention of retained foreign objects
- Sign out
- Debrief

2 PURPOSE

This cross-divisional policy applies to all members of the multidisciplinary team who will be involved in the care of the patient during the pre-operative, intraoperative and post-operative periods of the patient who is undergoing invasive procedures.

This policy applies to all areas where invasive procedures are performed, including pre and post op areas such as the wards, Depts. and recovery areas ,including Theatres, Interventional Radiology, Medical Imaging, MRI, Out Patient DCC, Endoscopy and ED.

This policy includes any procedure where:

- a cut or hole has been made to gain access to the inside of the body;
- access to a body cavity (such as the digestive system, airway, or bladder) is gained without cutting into the body, for example endoscopy;
- Electromagnetic radiation is used such as with x-rays, lasers, gamma rays, ultraviolet light for treatment, for example using a laser to treat skin lesions or ocular management.

The purpose of this policy is to ensure there is a robust mechanism in Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust for ensuring that elective and emergency, invasive and surgical procedures are performed on the intended patient and correct site. This will contribute greatly to minimising errors related to wrong site surgery or procedure.

This policy excludes cannulation, nasogastric tubes and urethral catheter insertions, as they are outside the scope of the national guidance.

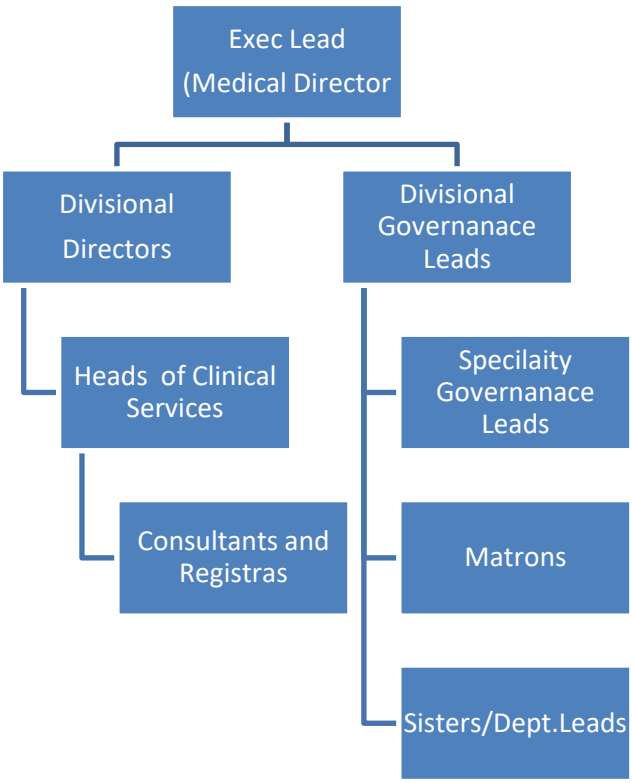
3 DUTIES AND RESPONSIBILITIES

Responsibility of the care of the patient is a shared responsibility and all members have a responsibility to speak up if they have concerns related to the safe delivery of care during an invasive procedure.

All staff involved in the pathway of a patient who is undergoing an invasive procedure:

- are responsible for the safe delivery of care to the patient;
- are aware of and understand the Safety Standards for Invasive Procedures and Local Safety Standards;

- are required to follow the Safety Standards for Invasive Procedures and Local Safety Standards accurately for every patient;
- may be required to participate in the creation, implementation and audit of LocSSIPs;
- will participate fully in the agreed safety checks and the steps built into the Safety Standards;
- will participate in routine and frequent team building and team training;
- will ensure that adverse events are documented, through Datix and investigated when appropriate.



Responsible for performance and monitoring

Responsible for ensuring the policy is adhered to

The Executive Lead (Medical Director) is responsible for:

- overseeing compliance, and governance, of the Safety Standards for Invasive Procedures and LocSSIPs.
- approving the information provided in this policy in their capacity as the Executive Lead.

The Divisional Senior Management team and Governance Leads are responsible for:

- overall performance and monitoring of the Safety Standards for Invasive Procedures and Local Safety Standards for Invasive Procedures.

Heads of Clinical Service (HOCS) Deputy Directors of Nursing and Speciality Governance leads are responsible for:

- ensuring the multidisciplinary team is performing as per the Safety Standards for Invasive Procedures;
- auditing, reviewing the audits and feeding back to the local teams;
- ensuring that any change in local practice or national guidance is updated and communicated to the local teams;
- ensuring that adverse events are documented through Datix, investigated using an RCA process and there is learning gained from the events which is communicated back to the local teams and SIMS training is carried out.

All staff involved in the procedure are responsible for:

- adhering to the policy;
- developing Local Safety Standards (LocSSIPs) for Invasive procedure when practice differs from the policy;
- ensuring that team members are aware of, understand and are compliant with the Safety Standards for Invasive Procedures and LocSSIPs;
- ensuring appropriate escalation of non-compliance (see Appendix 2).

Circumstances where marking may not be applicable:

- Emergency / urgent life-saving surgery - should not be delayed due to lack of completed pre-operative marking checklist.
- Teeth and mucous membranes.
- Cases of bilateral simultaneous organ such as bilateral tonsillectomy.
- Situation where the laterality of surgery needs to be confirmed following examination under anaesthetic or exploration in theatre such as the revision of squint correction.
- Certain surgical procedures such as, Hysterectomy, Colectomy.

Patients Lacking Capacity

Sometimes it will be necessary to provide care and treatment to patients who lack the capacity to make decisions related to the content of this policy. In these instances staff must treat the patient in accordance with the Mental Capacity Act 2005 (MCA 2005).

- A person lacking capacity should not be treated in a manner which can be seen as discriminatory.
- Any act done for, or any decision made on behalf of a patient who lacks capacity must be done, or made, in the persons Best Interest.
- Further information can be found in the MCA policy, and the Code of Practice, both available on the Extranet.

There is no single definition of Best Interest. Best Interest is *determined on an individual basis. All factors relevant to the decision must be taken into account, family and friends should be consulted, and the decision should be in the Best interest of the individual. Please see S5 of the MCA code of practice for further information.*

4 DEFINITIONS

National Safety Standards for Invasive Procedures (NatSSIPs): The national standards which were developed to set out key actions necessary to deliver safe care of patients undergoing invasive procedures. These standards allow organisations to standardise, harmonise and educate the patient care processes in order to provide safe patient care.

NatSSIPs Steering Group: the Trust committee responsible for oversight and implementation of the Safety Standards for Invasive Procedures.

Safety Standards for Invasive Procedures (SSIPs): The Trust response to the NatSSIPs.

Local Safety Standards for Invasive Procedures (LocSSIPs): Locally adapted safety standards for invasive procedures based on the Safety Standards for Invasive Procedures Policy and variations from it. Including specialty specific procedures or group of procedures for which LocSSIPs apply.

Invasive procedures include:

- All surgical endoscopic and interventional procedures performed in operating theatres, outpatient treatment areas, inpatient treatment areas, other procedural areas within the organisation including Imaging, DCC, ED ward and depts., Any procedure where a device has been used to gain access such as a scope to view the bladder, airway, or gastrointestinal tract.
- Invasive cardiology procedures such as cardiac catheterisation, angioplasty and stent insertion.
- Interventional radiological procedures.
- Thoracic interventions such as bronchoscopy and the insertion of chest drains.
- Biopsies and other invasive tissue sampling.
- Ocular interventions including intra vitreal treatment / ocular laser
- Insertion of devices including chest drains, Ascitic drains.

Never Events are patient safety incidents that are wholly preventable where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and have been implemented by healthcare providers. (Revised Never Events Policy and Framework NHSI 2018).

Surgical Safety Checklist: Based on the World Health Organisation (WHO) Surgical Safety Checklist which is a core set of safety checks at critical time points set within the pathway of the patient undergoing an invasive procedure. The five steps, 'Team brief', 'Sign In', 'Time

Out', 'Sign Out' and 'Debrief' are tools to initiate detailed communication between members of the multidisciplinary team in order to improve patient safety during surgery or an invasive procedure.

Procedural area: the area where invasive procedures are performed; includes the operating theatres, XMRI, Interventional Radiology, Medical Imaging , Outpatients, Endoscopy and ED wards , Depts. Critical Care, and any other treatment area within the organisation.

Procedural team: all members of the multidisciplinary team who are involved in the performance of procedures.

Operator: the person performing the procedure.

Anaesthetist: the person administering the anaesthetic during the invasive procedure.

Anaesthetic practitioner: the Registered Anaesthetic Nurse or Registered Operating Department Practitioner assisting the anaesthetist during an anaesthetic.

Scrub practitioner: the Assistant Practitioner, Anaesthetic Practitioner, Nurse Associate or Registered Nurse assisting the operator during a procedure.

Circulator: the practitioner in charge of the list.

Bluespier, Electronic patient or hard copy documentation: data entry system to capture patient journey through theatres and feed into reporting tools.

Datix: a risk management system that is used for incident reporting, complaints, PALS, risk registers.

5 GOVERANCE AND AUDIT

The organisation will ensure that all appropriate personnel are made aware of the Safety Standards for Invasive Procedures and LocSSIPs for the area of practice.

As a minimum, an annual audit across Theatres, Endoscopy, OP depts. and other areas where invasive procedures are undertaken will be conducted to focus on key areas of this policy:

- 'Team Brief'
- Completion of pre-operative checks
- Completion of sign-in
- Surgical Site marking
- Completion of 'Time Out'
- Staffing issues
- Any equipment /prosthesis issues
- Formal handover between ward, dept. theatre, and recovery, DCC /ITU

- Quality of engagement in the Surgical Safety Checklist
- Audits will be led by the Deputy Director of Patient and supported by the Clinical Audit department.
- The audit will focus on the quality to which processes are completed, and engagement in processes.

Monitoring of the effectiveness of the Safety Standards for Invasive Procedures will also be done through the learning from incident reporting Datix system, and information gained and reported to the Specialty Clinical Governance meetings, Patient Safety Review Group and Clinical Governance Committee Meetings.

Incident reporting provides an opportunity for adverse events to be documented, analysed and used for learning and improvements in practice. Additional information for Datix can be found in the Incident Reporting Management Policy.

Learning points from near misses and clinical incidents will be shared on a regular basis by relevant Specialty Clinical Governance meetings, Patient Safety Review Group and Clinical Governance Committee Meetings. Any trends of themes identified can be used to support decision making and learning, where improvement is required.

6 EDUCATION AND TRAINING-SEE APPENDIX 5

The local induction of all staff involved in the performance of invasive procedures must include:

- Reading the Safety Standards for Invasive Procedures policy
- Reading any relevant Local Safety Standards for Invasive Procedures.
- Referring to Safety Standards for Invasive Procedures -: https://extranet.dbth.nhs.uk/national-safety-standards-for-invasive-procedures-natssips/
- Completing the relevant E Learning package via ESR on an annual basis:
  Theatres
  Endoscopy
  Out Patients
  Emergency Pathway

Opportunities for regular teamwork management and human factors simulation training will be made available for all staff involved in the performance of invasive procedures.

Preparation for training will include a review of LocSSIPs and identification of learning needs from near misses and incidents.

7 DOCUMENTATION

Standardised documentation should be completed in all procedural areas to ensure the recording clearly all essential information throughout the patient pathway and this may include:

- pre-procedural assessments
- clerking
- consent
- electronic patient record
- the pre-operative WHO safety checklist
- WHO safety Checklist for non –Theatre areas
- perioperative/integrated care plan
- anaesthetic record (if appropriate)
- post-operative notes
- discharge planning

Documentation should include evidence of handovers, 'Team Brief', 'Sign In', 'Time out', 'Sign Out', surgical site verification, prosthesis verification, and the prevention of the retention of foreign objects.

Staff present at each stage of the patient pathway should be identified. This includes any learners present

All procedural activity should be captured in an electronic format, or paper if electronic systems not in use. If in the event that the electronic patient record system is down, the appropriate downtime paper form should be completed.

All documentation must be clear, concise, legible, and concurrent, timed, dated and signed.

No abbreviations should be used in any document.

Laterality must be written in full (Right, Left).

Complete all records at the time or as soon as possible after an event.

All records must be kept securely.

The time and alteration of any document must be recorded.

Documenting of adverse events and near misses should be recorded in the Datix system.

8 SCHEDULING AND LIST MANAGEMENT

Patient safety during the performance of invasive procedures is dependent upon adequate preparation, the accurate scheduling of procedures and the management of the procedural lists.

This policy requires procedural teams to ensure that lists accurately reflect the plans for patients and the procedures they are planned to undergo.

The named clinical team for the list is responsible for scheduling of the procedure/s, list management, cancellation and rescheduling. They must coordinate when other specialties are involved to be available at the correct time. For endoscopy the schedule is agreed with the senior sisters and these lists are planned by the sister.

The named clinical team for the list is responsible for deciding the order of the procedures within a list. Clinical criteria are to be considered in determining the order of the list. Examples of the clinical criteria are: clinical need, urgency, age, allergies (latex), pre-existing conditions (MH), infection status or other medical conditions (diabetes, sickle cell).

Scheduling of the list must take into account the expected workload and other factors which include:

- Time must be included in the scheduling process for the 'Team Brief', 'Sign In', 'Time Out', 'Sign Out', 'Debrief' and other safety steps in the Safety Standards for Invasive Procedures.
- Induction and emergence from anaesthesia or any other anaesthetic procedure.
- Patient positioning and preparation.
- Availability and preparation of all necessary equipment and instrumentation.
- Familiarity, skill-mix and expertise of all members of the procedure team.
- Cleaning and turning over equipment, supplies and instrumentation on lists when multiple procedures are being performed.
- Multiple, concurrent, same specialty lists.

The Standard Operating Procedure for Scheduling and List management should be referred to for further details of the processes.

9 WORKFORCE

Staffing should be based upon the Safe Staffing Escalation for In-patient Areas Policy (Nursing & Midwifery) - PAT/PS 18 on the Trust website.

Staffing requirements for the care of patients undergoing invasive procedures should be based on:

- Skill mix and competence of the practitioners including appropriately trained assistant(s).
- Complexity of the patient's needs and/or list.
- Type and complexity of procedure.
- Medical devices, technology and equipment being used.
- Number of patients on the list.
- Time needed to turnover between patients.
- Multi skilled staff, who are competent across specialties.

Lists must include time:

- to set up of the theatre equipment instruments and supplies.
- to calibrate and perform safety checks on specialist equipment.
- for staff to complete safety briefing and debriefing; and the sign in, time out and sign out for each patient.
- to turnover between patients.
- for routine and infectious cleans as required.
- for patient to be handed over to the next clinical area.

Staffing should be reviewed on a regular basis by the appropriate team leaders and Deputy Directors of Nursing.

A procedure must only begin when the required number of staff members, with the appropriate skill mix for that procedure or list is present unless agreed otherwise between senior members of the Medical and Nursing teams.

The same set of staffing standards applies equally to inside and outside of normal working hours.

The person in charge for each procedural area should confirm the availability of the appropriate staffing levels and skill mix prior to the beginning of the list and report any issues to the co-ordinator or matron. When a procedure or list is performed with inadequate numbers a Datix form should be completed.

Staff must be familiar and trained within the area they are working, in order to facilitate an emergency situation, and the staffing needs at nights and weekends. When there are instances where increased staffing is needed on weekends or nights, this should be escalated through the clinical site team and Senior Manager on call.

10 HANDOVER AND INFORMATION TRANSFER

There are formal handover points within the patient pathway at which professional responsibility and accountability is transferred between individuals or teams.

There are also opportunities for planned and unplanned changes in the members of the procedural team which occur during procedures or lists of procedures. Changes in personnel in the midst of a procedure should be kept to a minimum to minimise risk.

Patient safety prior to, during and after the performance of an invasive procedure is dependent upon thorough communication of information during each of the handover points of the patient pathway.

Handover of individual patients are conducted taking the following into consideration:

- Must be performed using the appropriate aide memoire, or handover form.
- Participation of the patient should be encouraged when appropriate.
- All members of the team should be given the opportunity to clarify information and ask questions.

There must be a handover of the patient from the admission unit or ward to the procedural team. This will be conducted in the anaesthetic room, procedure room or designated location in Endoscopy, Outpatients or ward where appropriate.

Handovers once a procedure has commenced should be avoided. However, there are situations which warrant a handover between members of the perioperative team during the middle of a procedure such as when a staff member goes on a break, or at the end of a shift.

Handover of Patient post invasive procedure:

- A formal handover from the procedural team to the post procedural area must be performed, once the patient is monitored appropriately and clinically stable using the appropriate aide memoire or handover sheet, where appropriate.

Handover of Patient from Recovery to Ward:

- Once the patient meets the discharge criteria the handover between the recovery practitioner and the ward registered nurse will take place either in the recovery room or in the ward as per ward hand over aide memoir where appropriate.

Handover of the patient from the procedural area to the intensive care areas:

See the Handover Policy - PAT/PA 31.

- A formal handover to the care team will be performed once the patient is transferred, appropriately monitored and clinically stable as per the Transfer Policy - PAT/PA 24

11 PROCEDURAL VERIFICATION AND SITE MARKING

All patients undergoing invasive procedures under general, local anaesthesia, or under sedation, must undergo safety checks that confirm the procedure to be performed, the site and the side marked when appropriate.

Surgical site marking is mandatory for all procedures for which it is possible to do so. In cases where there is an exception to site marking it should be clearly detailed on the consent form.

For dental procedures the teeth should be clearly marked on the surgical consent and on a dental x-ray which must then be displayed on PACS theatre.

All staff involved in the invasive procedure pathway have a responsibility to voice any discrepancies that they have observed with the theatre list, patient's consent, or site marking.

If there are any discrepancies following any of the checks, the procedure should not be commenced until clarification has been obtained.

If necessary the patient should be returned to the ward until all discrepancies have been clarified.

The procedure for surgical site marking and verification is as follows:

- The marking must be performed by the operator or a nominated deputy who will be present during the procedure.
- The operator / nominated deputy confirm patient identity with patient/parent against the patient's clinical record, the labelled consent form and the operating list in the pre-procedure area or ward.
- The operator /nominated deputy confirms procedure and procedural site with patient/parent, clinical record, consent form, investigation results such as imaging and operating list.
- Operator /nominated deputy marks site with single use permanent marker pen using an arrow only, close to the procedural field so it will be visible at all time after the prep and sterile drapes have been applied.
- If there is more than one procedural site, mark all sites with an arrow. If multiple procedures on multiple sites are planned then a body diagram should be used indicating the specific site/s and procedures.
- The arrow should be applied on the ward, not in the anaesthetic room or procedure room and documented on the consent form.
- The non-operative side must never be marked.
- Confirm with patient/parent if site marking not appropriate and document on consent form.
- An arrow to indicate the site of the procedure(s) should be checked on the ward/Dept. and documented as part of the pre-op checklist if applicable.

- If an arrow is not present refer to consent form for an explanation.
- If the consent does not clearly state why the arrow is not present, the operator /nominated deputy must be contacted for clarification and the issue resolved prior to the patient going to the procedural area.
- In event of patient refusal for site marking or an inability to site mark- document in notes and consent form. Agree with parents that site marking will occur once patient anaesthetised.
- Arrow should be checked by anaesthetist and anaesthetic practitioner at 'Sign In' with patient/parent and ward nurse against consent form and operating list.
- Site marking and planned procedure should be verified by multidisciplinary team, including the operator (and the nominated deputy if the operator was not the site marker) and scrub practitioner, at the 'Time Out' against consent form, operating list, and patient's clinical record and imaging.
- Each check must be recorded on the correct check list. Checks one and two are to be recorded on the Theatre Preparation Check List (IPOC 323), checks three (before induction of anaesthesia) and four (before incision) are to be recorded electronically within Bluespier.
- For procedures when the patients position is changed or the patient is having multiple procedures performed in multiple locations the procedural site should be re-verified and the procedural arrow checked.

12 TEAM BRIEF

The 'Team Brief' must take place prior to any invasive procedure including theatre and non-theatre settings scheduled, add-on, emergency, General Anaesthetic (GA) or non-GA in order for each member of the team to have a clear understanding of the list order, the invasive procedures being performed, the staff and equipment required and any other key issues.

This must occur after each patient has been seen by both the operator and anaesthetist if applicable.

The 'Team Brief' must be repeated throughout the day on a case by case basis in the following circumstances:

- Staggered admissions.
- New sessions.
- Change in key team members during a sessions.
- Additional patients added to the list.

The 'Team Brief' should be conducted in a location that is quiet and free from distraction that also ensures patient confidentiality. This location should preferably be in the area where the procedure will be carried out.

The whole team should be present including, but not limited to:

- Senior operator, Clinical Specialist, Practitioner and supporting team.
- Anaesthetic team (if applicable)
- Anaesthetic practitioner. (if applicable)
- Scrub team. (if applicable)
- Team leader/Senior person in charge of the list.
- Any other healthcare professionals involved in the procedure, e.g. radiographer, (if other team members are not present at the Team Brief a robust mechanism for handover must be in place.)

Each team member must be recorded in the patient's procedural pathway document.

Any nominated team member may lead the briefing.

Only one member of the team should speak at a time.

There should be minimal use of abbreviations. If they are used and a member of the team is unfamiliar with the term it should be clarified.

Every team member should be encouraged to ask questions, seek clarification or raise concerns about any aspect of patient care or the planned procedure

Each team member should introduce themselves and their roles.

The operator, scrub practitioner and anaesthetist if relevant must be identified for each case listed. Any changes to the team members during the day should also be recorded in this document or notice, and should be the subject of an appropriate briefing if anticipated.

Each patient should be discussed one at a time and in list order from the perspective of the operator, anaesthetist and scrub practitioner, in turn, using the printed checklist and the 'Team Brief' aide memoire. The discussion should include:

- Diagnosis and planned procedure.
- Site and side of procedure.
- Anticipated blood loss and location of blood products if required.
- Specific patient and/or procedural concerns.
- Availability of special equipment and/or resources. This includes prosthesis/ loan kits/single 'one off' instruments, expiry dates on equipment checks (please refer to SOP for the Management of 'one of a kind Sterile Instrument Sets).
- Requirement of imaging.
- Requirement of a throat pack.
- Requirement for the Surgical Site Infection bundle e.g. warming devices and antibiotics.
- Infection status.
- Requirement for venous thromboembolism prophylaxis.
- Pregnancy testing.
- Can we give a drink?

- Consent for research if applicable.
- Confirmation of the operator and scrub practitioner.
- Concerns regarding staffing availability.
- Concerns regarding available time.
- Confirmation of bed availability and/or postoperative higher dependency requirement and availability.
- Confirmation of procedure list order. Any alterations will necessitate reprinting the procedures list.
- Confirmation of the person who will be sending for the patients.

Where specialty-specific Trust Surgical Safety Checklists exist, these should be used and the relevant printed checklist used as an aide memoire.

Any additional concerns from an operator, anaesthetic or practitioner perspective must be discussed, and contingency plans made.

The operating/procedure list should be updated to reflect any additions, cancellations, changes to the list order and changes to the procedure.

A summary of the brief should be made and displayed in the procedural area for reference during the list where applicable.

If a significant issue about the care of the patient arises during the briefing, a clear and concise note should be entered in the patient's records and if more investigations or information needs to be obtained the team should reconvene to continue the brief after the information has been obtained.

13 SIGN IN

The 'Sign In' is the safety check patients undergo upon arrival to the procedural area prior to an invasive procedure.

The 'Sign In' should not be performed until any omissions, discrepancies or uncertainties identified in the handover from the ward or admission area to the receiving practitioner in the procedure area or anaesthetic room have been fully resolved. On rare occasions, the immediate urgency of a procedure may mean that it may have to be performed without full resolution of any omissions, discrepancies or uncertainties. Such occurrences should be reported as safety incidents.

'Sign In' must occur prior to the induction of general anaesthesia, local anaesthesia or sedation.

When general anaesthesia is not used, 'Sign In' should occur prior to the start of the procedure.

The 'Sign In' must be performed by at least two people involved in the procedure. For procedures performed under general or regional anaesthesia, these should include the anaesthetist and anaesthetic assistant. For procedures not involving an anaesthetist, the operator and an assistant should perform the Sign In. This includes involvement of the patient/parent/carer.

Safety checks included as part of the 'Sign In':

- Patient details checked with the patient (when appropriate) and/or family (when available) against the printed identity band, consent form and operating list.
- Surgical site marking to be checked with the patient (when appropriate) and/or family (when available) against the consent and operating list.
- Ensure that the ward preoperative checklist is completed, if not please refer back to the ward nurse.
- Allergy status.
- Last administration of antibiotics or paracetamol.
- Gastrostomy/nasogastric tube aspirated if present.

Procedure specific checks:

- Before performing a regional local anaesthetic block, a repeat check of the site and side of the procedure by the anaesthetist and anaesthetic practitioner is required. "Stop before you block."
- Blood availability must be checked and location confirmed.

After the 'Sign In' is completed, the preoperative checklist should be signed off by the Anaesthetic Practitioner and pre-operative ward nurse. The 'Sign In' should then be documented on the electronic patient record.

14 TIME OUT

The 'Time Out' represents the final opportunity to confirm the correct patient is having the correct procedure at the correct site prior to the start of the invasive procedure. It is an opportunity for any staff member to speak up with any concerns.

The 'Time Out' should not be performed until any omissions, discrepancies or uncertainties identified in the Sign In have been fully resolved. On rare occasions, the immediate urgency of a procedure may mean that it may have to be performed without full resolution of any discrepancies. Such occurrences should be reported as safety incidents and a Datix form should be completed.

Any member of the procedural team may lead the 'Time Out'. The team member leading the 'Time Out' should verify all team members who are participating, introduce any new team members or visitors and use the Time Out section of the Surgical Safety Checklist

The whole team involved with the procedure must be present such as:

- Senior operator and assistant.
- Anaesthetic team
- Scrub team.
- Circulating person in charge of the list.
- Any other healthcare professionals involved in the procedure, e.g. radiographer,

Using the 'Time Out' section of the Surgical Safety Checklist the following safety checks are included as part of the 'Time Out':

- Patient details checked with the patient (when appropriate) and/or family (when available) against the printed identity band, consent form and operating list
- Surgical site marking to be checked with the patient (when appropriate) and/or family (when available) against the consent and operating list
- Allergy status
- American Society of Anaesthesiologists Scoring Status (ASA)
- Confirmation of sterility of instruments and equipment
- Confirmation of the availability of the implant if needed
- Any equipment issues or concerns
- Antibiotic prophylaxis
- Patient warming
- Thromboprophylaxis
- Throat pack inserted
- Local anaesthetic dose
- Any new concerns since induction
- Pressure areas checked

Any omissions, discrepancies or uncertainties identified during the 'Time Out' should be resolved before the procedure starts. If these cannot be resolved, the procedure may need to be cancelled.

15 PROSTHESIS/IMPLANT VERTIFICATION, ONE OFF SETS AND LOAN KIT

A prosthesis or implant is defined as an internal or external, permanent or temporary medical device used to replace or repair a structure.

A loan kit is defined as a set of specialised instruments which include implants used to replace or repair a structure.

Pre-operative planning is essential when loan kits and one off sets/instruments are required for a planned procedure to ensure the correct prosthesis equipment is available.

Pre-operative considerations:

- Identification of the prosthesis/implant/loan kit required in pre-op planning.
- Type, Design or style.
- Material.
- Size.
- Manufacturer.
- The procedure list should state the specific prosthesis/implant or implant system anticipated to be used.
- The Sister / Scrub team leader must be notified by the procedural team of Implant to be used at the time of booking the case.
- The Theatre Sister / Scrub team will confirm arrival of the correct implant. If the implant or implant system will not be available for the date of the scheduled procedure, the Sister or scrub team will notify the surgical team prior to the day of surgery.
- If a bespoke implant/prosthesis is needed, the surgeon will provide the specifications; the manufacturer will be informed and will provide an estimated date of availability in order to book the patient onto a procedural list.

Prior to the 'Team Brief' all essential instruments/equipment, prosthesis/implants, or loan kits are checked for availability, expiry dates and external sterility and then report an issues.

During the 'Team Brief' the operator is to inspect the available prosthesis/implant or loan kit and confirm the correct range of implant/prosthesis and any necessary instrumentation is available and in a sterile condition prior to the patient being sent to the procedural area.

All essential instruments/equipment/loan sets are opened and checked for sterility prior to the patient being anaesthetised.

Before the prosthesis/implant is placed onto the surgical field a final check by the operator to confirm the following with the team:

- Type, design, or style.
- Material Compatibility.
- Size.
- Laterality (Left, Right, Bilateral).
- Manufacturer.
- Expiry date.
- Compatibility of multi-component prosthesis.
- Any other characteristics.

Once the correct item(s) has/have been selected any prosthesis not being used should be clearly separated from those being used.

Any prosthesis used must be documented with the above information on:

- Electronic/hard copy patient record.
- Intraoperative care plan.

- Service implant book.
- Devices template spread sheet.
- Patient notes and operative record.
- Devices registries.

Instances of failed prosthesis verification, wrong prosthesis insertion and 'near misses' should be recorded and openly discussed at the Debrief, a Datix should be completed and fed into local governance processes to promote learning and development of new or altered processes for patient safety.

When manufacturers labelling, packaging or implant defects contribute to the failure of prosthesis verification, or there is a defect in the implant/device the manufacturer must be informed and a Datix must be completed.

16 PREVENTION OF RETAINED FOREIGN OBJECTS

This standard supports safe and consistent practise in accounting for all items used during invasive procedures in order to minimise the risk of an unintentional retained item and causing harm to the patient.

The Surgical Count Policy in the document library must be followed to ensure the accounting of all items used in an invasive procedure and minimise the risk of a foreign object being retained in a patient and causing patient harm.

This must address the processes to be followed for the counting of all swabs, sharps, instruments and small items used in an invasive procedure and the points when a count is necessary to be performed.

The Surgical Count Policy addresses a clear process to be followed in the event that an item is unaccounted for during or at the end of the procedure. The process should include: consideration for a further count, communication to the operator, surgeon and procedure team, undertaking a thorough search, performing a radiological exam when necessary and not moving the patient from the procedure room until there is a resolution.

Any incorrect counts must be documented and section 10 "Count Discrepancy" of the Surgical Count Policy must be followed.

16.1 Intentionally retained item/s:

In the case of an intentionally retained item/s it is expected the LocSSIP must address the following:

- Notification of the patient/family, impact of the retained item on the health of the patient and completion of incident form.

- Documentation in the medical notes and perioperative care plan which includes a description of the item/s left behind, location and the plan for removal.
- If there is no plan for removal, there must be clear documentation of the item left behind and explanation to the patient/family. This should include Type, design, material and size
- A clear verbal and written handover processes of item/s left behind.

16.2 Instrumentation

All instrument trays must come with an up-to-date list of the items.

Instruments sets must undergo regular inspection as per the Trust Decontamination Policy.

The service terms of agreement must be followed by both the instrument processing service and the end user for the care, maintenance, cleaning, processing, identification, counting, and reconciliation of all single instruments and instrument sets.

Each instrument must undergo a periodic inspection to ensure they are fit for purpose. If they are found to be unfit they are to be repaired or replaced as advised.

Integrity of instruments should be checked before and after use.

17 SIGN OUT

All patients undergoing invasive procedures under general, regional or local anaesthesia, or under sedation, must undergo safety checks at the end of the procedure but before the handover to the post-procedure care team: the sign out.

'Sign Out' should occur at the conclusion of the procedure and/or before emergence from general anaesthesia.

Team members should not leave the procedure room until 'Sign Out' is complete, unless there are exceptional circumstances.

When general anaesthesia is not used, 'Sign Out' should occur prior the patient leaving the procedure room.

Any member of the team can lead the 'Sign Out'.

Using the Trust Surgical Safety Checklist as an aide memoire, the following should be checked:

- Confirmation of the procedure performed.
- Confirmation of the site and side of the procedure.

- Confirmation that all procedures on the consent form have been performed.
- Confirmation that instrument, sharps and swab counts are complete and correct.
- Confirmation against patient id band that any specimens have been labelled correctly; check the patient's name, site and side of specimen where applicable and the laboratory where the specimen is to be sent. This information will then be placed in the specimen log by a member of the scrub team.
- The operator and anaesthetist should discuss any post-procedure patient plans and concerns
- Discussion of any issues, equipment, instruments etc.
- Procedure specific checks.

18 DEBRIEF

'Debrief' is an opportunity for teams to facilitate reflection, conversation and learning; improve practise and patient safety at the end of all elective procedure lists, after an unscheduled procedure or emergency procedure or should be done case by case basis when there is a change in the team members involved.

The 'Debrief' emphasises the following:

- Whether the Safety Standards for Invasive Procedures or LocSSIPs are being effectively implemented.
- Any specific challenges and safety concerns.
- Identification of any areas where the improvements may be required.
- Identification of themes and trends to be escalated where appropriate.

The 'Debrief' should occur in a place which is free from noise, interruption and ensures patient confidentiality.

Every member of the procedural team should take part in the 'Debrief'.

Any team member may lead the 'Debrief'.

If any team member has to leave before the 'Debrief' is conducted, they should have the opportunity to comment and document any positive feedback or issues for improvement they wish to see addressed during the 'Debrief' and their absence should be recorded.

Members of the procedural team may note any key points for consideration during the procedure/ list to be discussed during the Debrief.

Any issues noted during the 'Debrief' should be followed up by the Team Leader / Nurse in Charge.

If a significant issue about the care of a patient arises during the 'Debrief', a clear and concise note should be made in the patient's records and a Datix form should be completed.

19 DEVELOPMENT, IMPLEMENTATION AND REVIEW OF LOCSSIPS

A Local Standard for Safety Standard for Invasive Procedure (LocSSIP) is required for any invasive procedure where the process deviates from what is set out in the Safety Standards for Invasive Procedures Policy.

Any new invasive procedure introduced to the Trust or to a procedure introduced to a new procedural area must be assessed to ascertain if a LocSSIP is required.

A review must be carried out to ensure that creation of a new document is not duplicating an existing document.

There should be a local owner for each LocSSIP who is a senior and substantive member of the team involved in doing the procedure.

The LocSSIP template guide and the Safety Standards for Invasive Procedures policy are to be used for the development of a specialty/procedural LocSSIPs.

The standards covered in each LocSSIP should consider the organisational and the sequential steps included in the patient pathway from the point of decision to perform an invasive procedure, to the point of discharge from the procedural area.

In some procedural environments, the combination of two sequential steps may be logical, for example, performing a combined Sign In and Time Out for procedures when sedation is not used and the operator provides local anaesthesia. If two steps are combined, the key safety elements of both steps set out in this document should be retained in the single, combined step and a LocSSIP created.

Electronic record keeping will support the correct, complete and sequential performance of the Surgical Safety Checklist in the LocSSIPs and will provide an accurate record of both the members of the team performing the checks and the actual checks performed.

Areas will use aide memoires in the format of the Surgical Safety Checklist and ensure that every step is completed for every patient undergoing an invasive procedure.

LocSSIPs should stipulate all necessary induction, training and competencies for the procedural area prior to carrying out a role.

LocSSIPs are local standard operating procedures. They are not Trust policies and therefore should be agreed locally with the relevant clinical staff and approved by the Speciality Governance Lead, Matron, Associate Director of Nursing and Divisional Governance lead Clinical Lead, prior to ratification by the Divisional Governances Committee.

The LocSSIP owner is responsible for consulting with relevant clinical and non-clinical staff and ensuring that the minimum requirements for the content of a LocSSIP are met.

A LocSSIP will be approved by the Speciality Clinical governance/PSRG subject to the following conditions:

- There is evidence of appropriate local consultation, and sign of from the Matron, Associate Director of Nursing and Clinical Lead, Divisional Director Speciality Clinical governance /PSRG.
- All sections of the LocSSIP have been completed to a satisfactory standard.
- The LocSSIP demonstrates a commitment to maintaining a safe culture to promote team work, minimise avoidable complications, and prevent patient safety never events.
- Is published with an agreed date for future review.

The PSRG will maintain oversight of all LocSSIPs and ensure that LocSSIPs are reviewed every three years through Divisional Governance reports.

LocSSIPs and specialised checklists will be published on the Safety Standards for Invasive Procedures intranet page.

20 EQUALITY IMPACT STATEMENT

The Trust aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are disadvantaged over others. Our objectives and responsibilities relating to equality and diversity are outlined within our equality schemes. When considering the needs and assessing the impact of a procedural document any discriminatory factors must be identified.

An Equality Impact Assessment (EIA) has been conducted on this procedural document in line with the principles of the Equality Analysis Policy (CORP/EMP 27) and the Fair Treatment for All Policy (CORP/EMP 4).

The purpose of the EIA is to minimise and if possible remove any disproportionate impact on employees on the grounds of race, sex, disability, age, sexual orientation or religious belief. No detriment was identified. (See Appendix 6)

21 ASSOCIATED TRUST PROCEDURAL DOCUMENTS

Safe Staffing Escalation for In-Patient Areas Policy (Nursing & Midwifery) - PAT/PS 18
Transfer of Patients and their Records - PAT/PA 24
Handover Policy - PAT/PA 31
Mental Capacity Act 2005 Policy and Procedure, Deprivation of Liberty Safeguards (DoLS) - PAT/PA 19
Privacy and Dignity Policy - PAT/PA 28.
Fair Treatment for All Policy – CORP/EMP 4
Equality Analysis Policy – CORP/EMP 27

22 DATA PROTECTION

Any personal data processing associated with this policy will be carried out under 'Current data protection legislation' as in the Data Protection Act 2018 and the UK General Data Protection Regulation (GDPR) 2021.

For further information on data processing carried out by the trust, please refer to our Privacy Notices and other information which you can find on the trust website: https://www.dbth.nhs.uk/about-us/our-publications/information-governance/

23 REFERENCES

NHS England (2015). National Safety Standards for Invasive Procedures (NatSSIPs). https://improvement.nhs.uk/uploads/documents/natssips-safety-standards.pdf

NHS England (2015). Revised Never Events Policy and Framework. https://improvement.nhs.uk/uploads/documents/never-evnts-pol-framwrk.pdf

National Institute for Health and Care Excellence (NICE) (2016). NICE interventional procedure guidance. https://www.nice.org.uk/about/what-we-do/our-programmes/nice-guidance/nice-interventional-procedures-guidance

Coates, T, Guckian Fisher, M. Staffing for patients in the perioperative setting. Harrogate: Association for Perioperative Practice (AfPP). www.afpp.org.uk

Association for Perioperative Practice (AfPP) (2011). Standards for recommendations for safe perioperative practice. Harrogate: Association for Perioperative Practice (AfPP) 3rd Edition. www.afpp.org.uk

National Patient Safety Agency (NPSA) (2012). Never Events. http://www.nrls.npsa.nhs.uk/resources/collections/never-events/

Department of Constitutional Affairs
Mental Capacity Act (2005): Code of Practice, 2007 www.dca.gov.uk

Revised Never Events Policy and Framework, NHSI 2018 improvement.nhs.uk

Department of Constitutional Affairs Mental Capacity Act (2005): Code of Practice, 2007 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/497253/Mental-capacity-act-code-of-practice.pdf

APPENDIX 1 – GENERIC LOCSSIP

IPOC1750
WPR47690 GIP Chec

APPENDIX 2 - DBTH SURGICAL SAFETY CHECKLIST (THEATRES)

Before Induction of Anesthesia
Theatre Practitioner and Anaesthetist

Has the patient confirmed his / her identification, site, procedure and consent?

☐ Yes

Is the site marked?

☐ Yes
☐ Not applicable

Stop before you block

☐ Yes
☐ Not applicable

Is the anaesthetic machine and medication check complete?

☐ Yes

Does the patient have a known allergy?

☐ No
☐ Yes

Difficult airway or aspiration risk?

☐ No
☐ Yes, and equipment / assistance available

Risk of >500ml blood loss (7ml/kg in children)?

☐ No
☐ Yes, and two IVs/central access and fluids planned

Lens / implant size available, checked and correct?

☐ Yes

These characteristics may include but are not limited to:

- Type, design, style or material.
- Size.
- Laterality.
- Manufacturer.
- Expiry date.
- Sterility.
- Dioptre for lens implants.

Before Skin Incision (Time Out)
With Nurse, Anaesthestist and Surgeon

Confirm all team members have introduced themselves by name and role at team brief
☐ Yes

Are any other staff expected to join the team?
☐ Yes – agree who will provide handover
☐ No

Confirm the patients name, procedure, and where the incision will be made
☐ Yes

Confirm the patients pregnancy status
☐ Positive
☐ Negative
☐ Not applicable

Are there any implants that need to be considered?
☐ Yes – what are these
☐ No

Has antibiotic prophylaxis been given within the last 60 minutes?
☐ 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?
☐ Are there any patient specific concerns?

To Anaesthetists:
☐ Are there any patient specific concerns?

To Nursing Team:
☐ Has sterility been confirmed / packaging and autoclave tape intact?
☐ Are there any equipment issues or any concerns?

Is essential imaging displayed?
☐ Yes
☐ Not applicable

Before Patient Leaves Operating Room
With Nurse, Anaesthetist and Surgeon

Nurse verbally confirms:

- ☐ Name of the procedure performed
- ☐ Length of incision
- ☐ Skin closure used
- ☐ Dressing type
- ☐ Number of drains
- ☐ Correct instrument, swab, blade and needle counts including throat packs
- ☐ Specimen labeling (read specimen labels aloud, including patient's name)
- ☐ Are there are any equipment problems to be addressed.
  Have these been escalated?
- ☐ Yes
- ☐ Not applicable

To Surgeon, Anesthetist and Nurse:

Are there any concerns regarding recovery and management of this patient?

- ☐ Yes – to be recorded in patient documentation and handed over to recovery staff
- ☐ Not applicable

APPENDIX 3 - DBTH SAFETY CHECKLIST (ENDOSCOPY)

The aim of this policy is to:

- Standardise the management of invasive procedures during the pre-endoscopic, intra-endoscopic and post-endoscopic period.

Endoscopy Team Brief (appendix 1)
The 'Team Brief' must take place prior to any list commencing which includes invasive procedures. This includes:

- Scheduled procedures.
- Add-on procedures.
- Emergency procedures.

This is order for each member of the team to have a clear understanding of the list order, the invasive procedures being performed, the staff and equipment required and any other key issues.

- The 'Team Brief' must be repeated at the start of a new session.

The 'Team Brief' should be conducted in a location that is quiet and free from distraction that also ensures patient confidentiality. This location should preferably be in the area where the procedure will be carried out with as many members of the whole team as possible should be present.

The team brief currently comprises of the following considerations:

- Skill mix and competence of the practitioners including appropriately trained assistant(s).
- Complexity of the patient's needs and/or list.
- Type and complexity of procedure.
- Medical devices, technology and equipment being used.
- Number of patients on the list.
- Time needed to turnover between patients.
- Multi skilled staff, who are competent across specialties.

A logical set of actions which should be performed for every procedure list and every patient.

- Team brief
- Procedural verification
- WHO checklist/Sign in
- Sign out

All Endoscopy staff must complete the relevant eLearning module via the MyESR Portal on an annual basis: https://extranet.dbth.nhs.uk/training-education/training-education/myesr-portal-elearning/elearning-courses/

Endoscopy WHO safety checklist/sign in (Appendix 2)

Inpatients

A copy of the checklist should be with the patient's notes with an ID label affixed.

Outpatients

The WHO checklist/ sign in forms part of every outpatient IPOC utilised in endoscopy.

Every patient having a procedure should have a WHO safety checklist completed prior to the procedure commencing with all staff present.

The process is as follows:

- Patient to always be prepared in numerically correlating preparation room to scoping room.
- Patient to be consented in the allocated preparation room prior to procedure.
- Nursing team to use WHO safety checklist/sign in when collecting patient from preparation room to confirm patient identity, name identity bracelet and check consent form has been signed.
- Upon entering scoping room the team to introduce patient and team members.
- Patient Identification confirmed in the treatment room with WHO checklist, patient ID bracelet and patient case notes.
- Nurses and endoscopist(s) must be present in the treatment room during patient identification/safety checks.
- Patient asked to confirm his/her signature on the consent form.
- Scoping team to check correct notes are in room with correct patient.
- Entire WHO safety checklist/ sign in is then completed with all team members present.

Appendix 1

ROOM TEAM BRIEF 2020.doc

Appendix 2

IPOC 1654 WPR45970 no crops.

APPENDIX 4 – CENTRAL VENOUS CATHETER INSERTION CHECKLIST

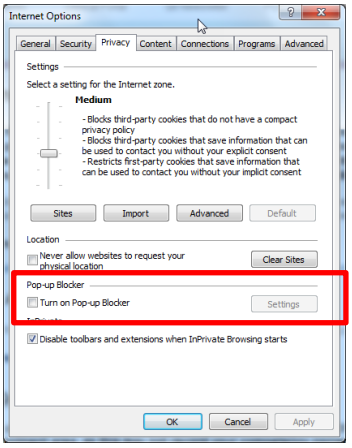
CVC checklist v1.7.pdf

APPENDIX 5 - TRAINING FOR DBTH STAFF

Enrolling on the Learning Certification
272 WHO Surgery Safety Checklist (Theatres)
272 WHO Endoscopy Safety Checklist
272 WHO Out Patient/Dept. Safety Checklist

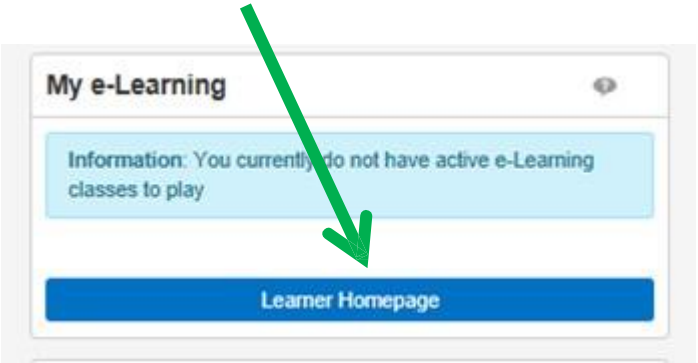
272 WHO Surgery Safety Checklist eLearning module

It is recommended you use Internet Explorer 11, however, eLearning should would work on other web browsers (e.g. Google Chrome, Safari).
Within Internet Explorer (IE) go into the sprocket and 'Internet Options' and ensure the 'Turn on Pop Up Blocker' is unticked.



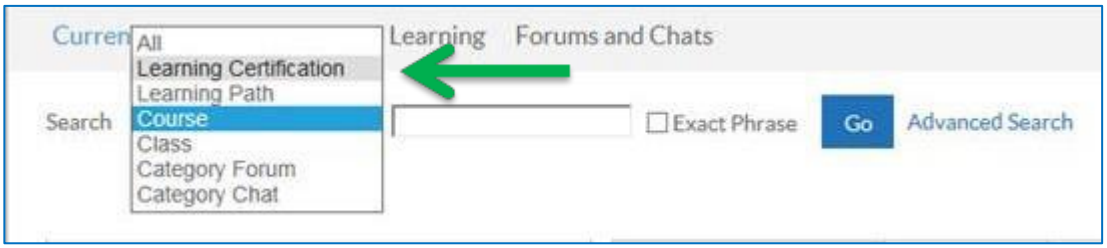
To log into e-Learning via your username & password please locate the MY ESR icon on your desktop…

When logged in this will then show you your ESR Portal Page. Click on the **Learner Home** page

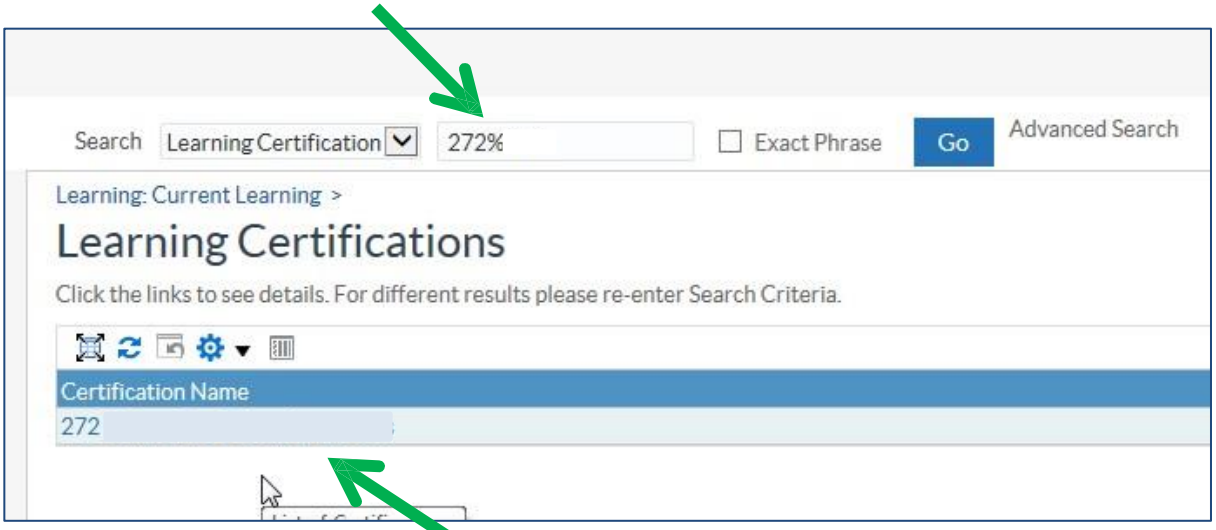


SEARCHING, ENROLLING AND PLAYING CSTP ELEARNING

Change the drop down box to **Learning Certification**

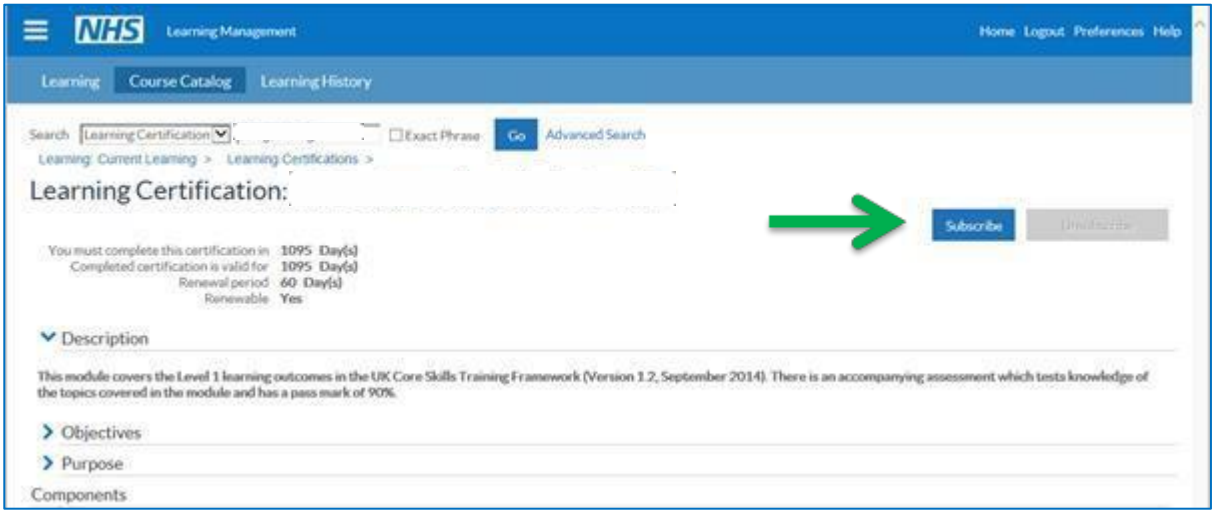


Type ***272%WHO*** into the search box and click on **Go**
(you can use % signs as a wild card)

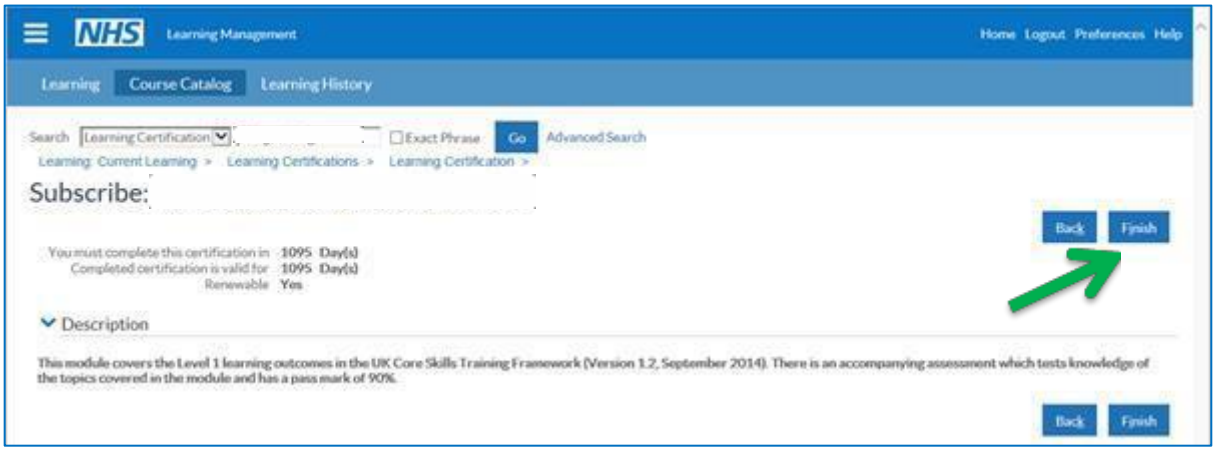


Click on the Learning Certification name of the ***272 WHO Surgery Safety Checklist***
272 WHO Endoscopy Safety Checklist
272 NatSSIPS/LocSSIPS OPD

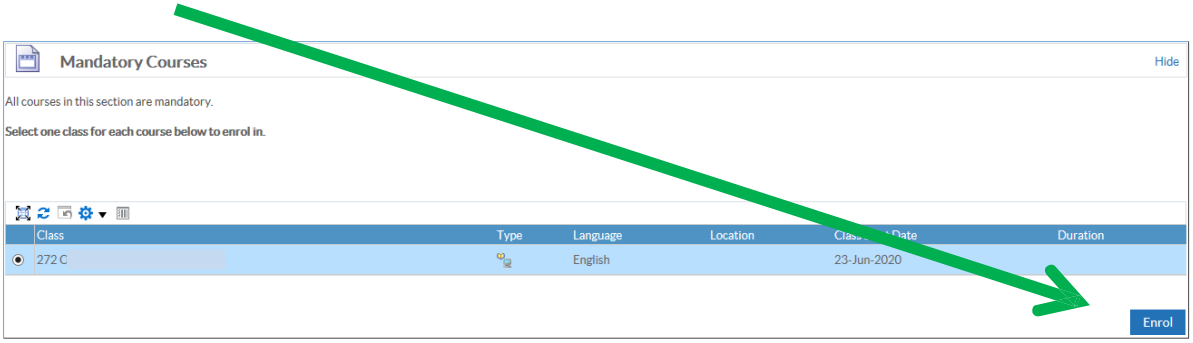
Click on **Subscribe**



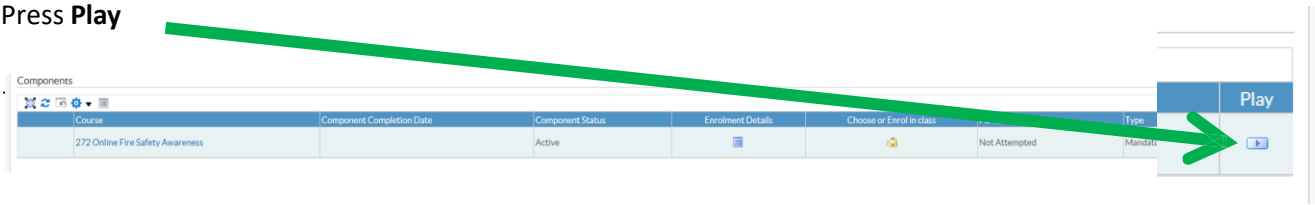
Click on **Finish**



Click the **enrol** icon



Press **Play**



Complete your eLearning

Once you have completed the eLearning material and **BEFORE** exiting, it is extremely vital you take a 'screen shot/print' of the pass confirmation screen.

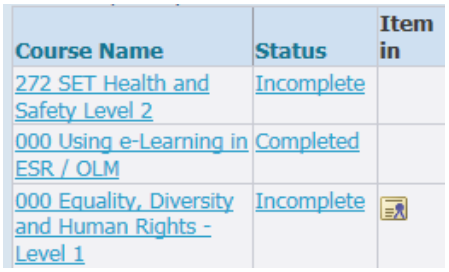
Enrol on the course you wish to undertake and complete.

Take a screen-print of your pass confirmation page BEFORE exiting;

1. Press the print screen button on your keyboard to take a snapshot of your confirmation pass page (you can find this on the top right hand-side of your keyboard)

or

2. Exit the eLearning material by left clicking ONCE on the Home icon exit button

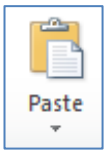


Course Name	Status	Item in
272 SET Health and Safety Level 2	Incomplete	
000 Using e-Learning in ESR / OLM	Completed	
000 Equality, Diversity and Human Rights - Level 1	Incomplete	

If the course shows 'completed' in the status column your compliance will be automatically updated and you can safely exit the eLearning

If the course still shows as 'incomplete' in the status column follow steps 3-6 below

3. Open a blank word document and click on the paste icon



4. An image of your confirmation pass page will be pasted in to the word document

5. Enter the following details at the bottom of the image;
   a. Full name (as appears on your pay slip)
   b. Assignment number (pay roll number)
   c. Date and time course completed

6. Save as you would a normal document; then email as an attachment to dbth.training.department@nhs.net

Or you could use your phone and take a photograph

Take a photograph with your mobile phone of your pass confirmation page BEFORE exiting;

1. Open your email account on your mobile phone and attach the image to the email,
   a. Email address to send the image: dbth.training.department@nhs.net

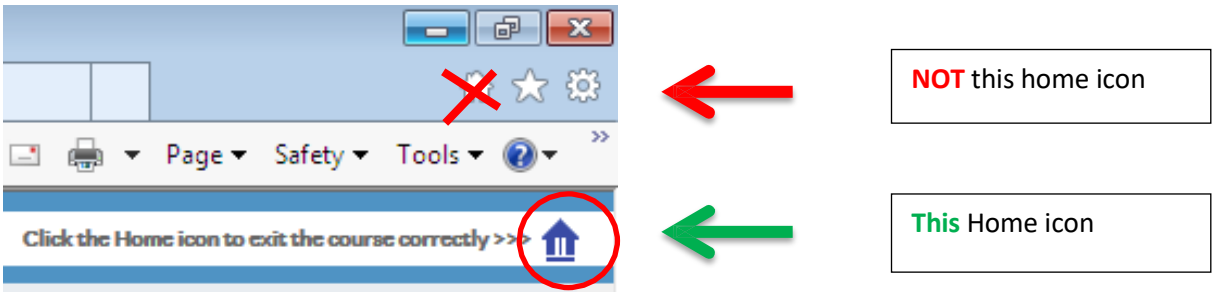
2. Enter the following details within the message area BEFORE pressing 'send';
   a. Full name (as appears on your pay slip)
   b. Assignment number (pay roll number)
   c. Date and time course completed

EXIT THE eLearning MODULE

Local eLearning Modules (272) will open up in a separate window, you will need to exit this window correctly;

- ***Left mouse click ONCE on the Close button in the top right hand corner of the window***

- *This will bring you back to the OLM page*
- *Left click ONCE ONLY the Home icon at the top right hand side of the page*



Please note on some eLearning modules this is represented by a blue 'X' icon

- *Let the page process*
  - *DO NOT click the Home icon twice as you will inadvertently cause an error*
- *The system should return to the Learning Home page and if the course has been completed and the assessment passed this should be reflected in the Status column*

APPENDIX 6 - EQUALITY IMPACT ASSESSMENT PART 1 INITIAL SCREENING

Service/Function/Policy/Project/ Strategy	Division	Assessor (s)	New or Existing Service or Policy?	Date of Assessment
Safety Standards for Invasive Procedures (SSIPs) – PAT/PS 24 v.1	Corporate	Lesley Barnett DDQG	New	March 2021

1) Who is responsible for this policy? Name of Division/Directorate: Medical Director

2) Describe the purpose of the service / function / policy / project/ strategy? Who is it intended to benefit? All staff involved in invasive procedures. What are the intended outcomes? Safe practice and no harm to patients undergoing a invasive procedure.

3) Are there any associated objectives? Legislation, targets national expectation, standards: NHS England mandate to implement the National Safety Standards for Invasive Procedures (NatSSIPs

4) What factors contribute or detract from achieving intended outcomes? – none

5) Does the policy have an impact in terms of age, race, disability, gender, gender reassignment, sexual orientation, marriage/civil partnership, maternity/pregnancy and religion/belief? Details: [see Equality Impact Assessment Guidance] – No

- **If yes, please describe current or planned activities to address the impact** [e.g. Monitoring, consultation] -

6) Is there any scope for new measures which would promote equality? [any actions to be taken] No

7) Are any of the following groups adversely affected by the policy? No

Protected Characteristics	Affected?	Impact
a) Age	No	
b) Disability	No	
c) Gender	No	
d) Gender Reassignment	No	
e) Marriage/Civil Partnership	No	
f) Maternity/Pregnancy	No	
g) Race	No	
h) Religion/Belief	No	
i) Sexual Orientation	No	

8) Provide the Equality Rating of the service / function /policy / project / strategy – tick (✓) outcome box

Outcome 1✓	Outcome 2	Outcome 3	Outcome 4

If you have rated the policy as having an outcome of 2, 3 or 4, it is necessary to carry out a detailed assessment and complete a* **Detailed Equality Analysis form – see CORP/EMP 27.

Date for next review: **March 2024**

Checked by: **Stacey Nutt** **Date:** May 2021