Moorfields Eye Hospital NHS
NHS Foundation Trust

City Road Theatres Operational Policy

Incorporating local standards for Invasive Procedures (locSSIPs)

Policy Summary
The purpose of this policy is to explain the measures that must be taken to provide and maintain a safe and protective environment for patients, personnel and others when undergoing surgery in CR theatres. The document acts as a reference point to ensure the principles of the National Safety Standards for Invasive Procedures are adhered to within the operating department

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Executive Summary

The provision of one document outlining all aspects of care delivery within the Operating Department is common place. This document includes guidance for staff, users and visitors in relation to how the department is managed on a strategic and operational level.

The document should be used as a reference guide and will be issued to all staff and will include reference to our compliance with the National Safety Standards for Invasive Procedures (NatSSIPs) which provide the baseline for the development of Local Safety Standards for Invasive Procedures (LocSSIPs).

The document aims to present in a logical manner actions to be taken during the care of the perioperative patient.

1. Introduction

1.1 It is the aim of the Operating Department staff and management to provide high quality care in an environment that adheres to all safety standards, whilst optimising theatre utilisation

1.2 Mission statement

"The Operating Department team will provide a, patient focused technologically advanced surgical service supported by skilled medical and multidisciplinary theatre staff, in a reliable and safe environment"

1.3 The department comprises:

- A reception area, incorporating the theatre managers office
- 8 refurbished operating theatres, with fully equipped anaesthetic rooms: adjacent preparation rooms; scrub rooms; storage facilities and sluice
- Separate adult and paediatric recovery

1.4 The strategic management of the department is the responsibility of the General Manager and Clinical Director of the Surgical Services Directorate. The day to day management is devolved to the Theatre Manager, who is accountable for budget, staff and delivery of quality safe care.

The Manager is supported on a daily basis by 3 Theatre Coordinators; these Coordinators oversee the daily management and coordination of the department, supporting the Manager in ensuring the adherence to policies and procedures including the operational policy. The coordinators act as clinical leaders and are visible to staff and service users.

1.5 The speciality teams are led by band 6 Team Leaders who act as the first point of contact for the users of the service, working closely with the surgical team to ensure the provision of equipment and modernising care delivery. The Team Leaders act as line manager for the remainder of the team. The Team Leaders are supported by dedicated Theatre Practitioners and Health Care Assistants who act as scrub and circulating staff and ensure that each theatre is prepared on a daily basis

1.6 Each theatre will be supported by an Anaesthetic Nurse/ Operating Department Practitioner working as part of the wider theatre team, but primarily in support of the anaesthetist.
Recovery staff will be allocated to a specific theatre according to the requirements of the list.

1.7 Every member of the Department's team is responsible for the delivery of safe care and will be held accountable for the same to the registering body and the Trust.

1.8 This policy applies to all employees of the Trust and its contractors who visit the City Road Operating Department

2. Scope

This operational policy applies to City Road Operating Theatres only

3. Purpose

The policy is intended to act as a reference guide for staff working with the department in addition to users of the department.
The policy provides clear guidance and therefore outlines the expectations for the delivery of the service.

The policy ensures compliance with the National Safety Standards for Invasive Procedures published in September 2015 with the express intention of preventing never events

4 Workforce

The Theatre Manager has an inclusive management style, operating an open door policy in addition to the weekly staff conversation meetings (Monday 8.15 in the theatre coffee room).

4.1 Staffing levels

Safe care of patients depends upon having the correct numbers of appropriately trained, skilled and experienced staff working together as a team. It is the intention to provide each main theatre list with a minimum of 1 practitioner working in recovery; 2 registered practitioners and 1 HCA in the surgical support team along with 1 registered practitioner in the anaesthetic support role. Minor ops lists will have 2 practitioners in the surgical support role. No team member will be expected to work beyond the scope of their ability. The off duty will be provided 4 weeks in advance and the allocations published on a weekly basis to ensure that the staff numbers stated are in evidence. In the event of last minute leave or sickness the Coordinator on duty will take all appropriate actions to ensure the provision of these staffing levels. This will include trying to get bank/ agency; reallocating staff working in a non- clinical role (including themselves) or amalgamating lists if possible. The Coordinator must inform the Theatre Manager if this is proving difficult to achieve

4.2 Annual Leave

Whilst the operating department annual leave is managed in accordance with the Trust annual leave policy, each Team coordinates their own off duty, ensuring that only one team member is off at any one time

4.3 Induction

New staff will attend corporate induction and will be expected to complete the New to Ophthalmology course if they have limited or no ophthalmic experience. The Local induction will include a local theatre orientation, covering recovery, anaesthetics, surgery and CSSD. This will be evidenced by the completion of theatre competencies.
All new staff will be assigned a mentor/link nurse to assist in their orientation into the department and completion of competencies to be reviewed annually.

Existing staff will complete the Competency Annual Review to maintain their skills and practice for their job roles.

4. Scheduling and list management

The timetable at City Road encompasses elective and emergency NHS activity within a rolling 5 week format. In addition the Private Patient activity is accommodated and detailed with the PP timetable (see attached)

Indicatively the sessions run to these list times, though exceptions can be made in advance with negotiation with the entire team

- Morning lists 08:30 to 13:00
- Afternoon lists 13:30 to 18:00
- All Day lists 08:30 to 18:00
- Evening lists 18.00 to 20.30
- Weekend lists - 09.00 to 17.30

5.1 Scheduling

All theatre lists will be compiled and managed through the theatre scheduling policy. The admission co-ordinator will plan the list in conjunction with the Medical and Management team to ensure maximum utilisation of the resources and time available. The use of abbreviations is not permitted. The clinical team performing the procedures is responsible for deciding the order of procedures within a list of cases. In determining the order of a list, priority should be given to clinical criteria, e.g. urgency, extremes of age, allergies such as latex allergy, and medical conditions that make early or predictable start times desirable, e.g. diabetes or sleep apnoea.

5.2 Weekly Scheduling Meeting

The Theatre Manager chairs the delivery of a weekly scheduling meeting. Designed to optimise the use of theatre time and improve patient care through forward planning and organisation of elective admissions aiming

- To implement a standardised process for the management, formulation and submission of theatre lists, including negotiating temporary/permanent changes to allocation and timetable
- To achieve optimal utilisation of operating sessions including scheduling to deliver the activity plan
- To promote safe and efficient throughput of patients
- Identify responsibilities of key staff involved in the compilation and submission of theatre lists
- Equipment requirements and availability is established
- Underutilised sessions or potential over runs are identified and actions agreed
- Sessions that are not booked for the following two weeks will be reallocated

Operating lists must be compiled taking into account the following

- Operating time available
- LA, LAS or GA requirements
- Expected duration of procedure including anaesthetic time
- Grade of operating surgeon
- Any special equipment/ implant/ additional resources
- RTT of the patient

5.3 Process for Confirming/Cancelling Allocated Theatre Operating Sessions

It will be assumed that all theatre sessions will be used by the allocated speciality and Consultant unless otherwise notified. However, some changes will always be required to meet specific (short-term) demands.

It is imperative that the information recorded on Open eyes and Galaxy matches the operating Surgeon if the specialty have arranged cross cover, as this will affect specialty information reports and is in line with clinical governance requirements.

Any changes to the planned theatre timetable must be changed in Open eyes and communicated to the Galaxy System Administrator to enable the relevant amendments to be made on Galaxy.

If a session is not going to be utilised by a consultant or one of their team, it can be offered out to other specialties. Cancelled or dropped lists can be utilised by any available surgeon who requires additional capacity. The timetable will however be finalised 2 weeks in advance at the weekly scheduling meeting

At less than two weeks' notice, lists cannot be reinstated without the approval of Theatre Manager and Lead Clinician in anaesthetics.

5.4 Planned changes to start/finish times

Where it is anticipated that the complexity of the procedure(s) or the nature of the operative case(s) will result in a longer than scheduled operating time it is the responsibility of both the Consultant surgeon and Anaesthetist to liaise with the Theatre co-ordinator to discuss the potential for an early start/late finish and the organisation of appropriate resources

5. Local Safety Standards during the Perioperative Period

The members of the theatre team should not change during the course of the operating list and if this does occur a new team brief should be instigated. The Operating Department will provide an anaesthetic practitioner, a three person scrub team and a recovery nurse.

Anaesthetic Practitioners will be allocated to a list for the duration of the shift. The anaesthetic practitioner's primary duty is to aid the anaesthetist during the list. On some lists there will not be an anaesthetist present and the primary role of the anaesthetic practitioner will be to ensure the patient is adequately supported emotionally as well monitoring according to AAIGB guidelines.

In addition to this the practitioner will work as part of the theatre team and aid in circulating duties and the running of the list.

- Prior to each list commencing the anaesthetic practitioner will open the anaesthetic room and check equipment in accordance with the SOP Opening the anaesthetic room and checking equipment and closing the anaesthetic room.
- Controlled drugs are to be counted and checked in accordance with the SOP Collecting and holding CD keys and the Controlled Drug Policy.
- Practitioners will prepare intravenous medications as specified in the SOP for the preparation of intravenous medications.
- All patients will be monitored in accordance with AAIGB guidelines appropriate for the type of anaesthetic they are receiving.

On a daily basis each Theatre will have the speciality Team Leader or a designated theatre practitioner from the team to manage the list to ensure the following occur

The final version of the operating list should be agreed a minimum of 24 hours in advance. Changes to the list should then be avoided. Any changes must be agreed by key members of the team, discussed during team briefing and should result in the production of new operating lists

Prior to each list all instrument sets, materials and equipment are present or will be available prior to the commencement of the list. Any deficiencies being notified to the Theatre Coordinator immediately and the Surgeon as soon as possible.

Patients are sent for automatically at 8:20 for the morning list and 13:20 for the pm, unless the Team Leader is notified in advance that there is an issue

Patients will either walk to theatre (or sit in a wheelchair) accompanied by a member of clinical staff or be transferred on a trolley or a bed accompanied by both a member of staff and a porter according to the “Walking to Theatre” policy.

6.1 Surgical Site Marking All patients must undergo site and side marking. The operator or nominated deputy must mark the side shortly before the procedure with an indelible marker but not in the anaesthetic room or theatre.

6.2 Safety Briefing A theatre team brief must be held with the entire team before the operating list starts, and should be repeated if any members of the team change or arrive late. It is key to ensuring the delivery of safe patient care as part of the WHO Surgical Safety Checklist.

- Ideally prior to the first patient arriving (820 for morning lists and 13.20 for pm lists)
- Any member can lead the briefing, though the Practitioner in charge of the scrub team should ensure it occurs
- Each member of the team and their role should be announced and the operator, scrub practitioner and anaesthetist if relevant must be identified for each case listed.

- The safety briefing should consider each patient on the procedural list in order from an operator, anaesthetic and practitioner perspective. The discussion should be include when relevant:
    a. Diagnosis and planned procedure.
    b. Availability of prosthesis, implant or lens, including corneal grafts.
    c. Side of procedure.
    d. Infection risk, e.g. MRSA status.
    e. Allergies.
    f. Relevant comorbidities or complications.
    g. Need for antibiotic prophylaxis.
    h. Patient positioning.
    i. Equipment requirements and availability, including special equipment or 'extras'.
    j. Postoperative destination for the patient, eg recovery or directly to the ward. The expected duration of each procedure
    k. Type of anaesthetic and who will administer
- Any additional concerns from an operator, anaesthetic or practitioner perspective must be discussed, and contingency plans made.
- Every team member should be encouraged to ask questions, seek clarification or raise concerns about any aspect of patient care or the planned procedure.
- A record should be made of the team briefing, and should be displayed in the procedural area for reference during the procedure list.
- If a significant issue about the care of a patient arises during the briefing, a clear and contemporaneous note of this should be made in the patient's records.
- Any issues raised in the briefing that may have relevance for the care given to other patients by the organisation should be reported to the Theatre Coordinator on duty for onward communication

6.3 Handovers to Procedure Team. A formal handover will take place from the ward team to the practitioner receiving the patient (typically the Operating Department Practitioner or Anaesthetic Nurse. The handover will include

- Patient name, with patients identifying themselves, checked against an identity band.
- Correct documentation of weight.
- Allergies.
- Procedure
- Site marking
- A completed biometery sheet if applicable
- Fasting status.
- Relevant clinical features, e.g. blood sugar for diabetic patients/INR/MRSA
- An appropriate patient record
- A properly completed consent form
- If there are any discrepancies or omissions they must be resolved before proceeding further

6.4 Sign in All patients will undergo further safety checks and this is part of the WHO Surgical Safety Checklist. The sign in must be performed by at least two people. For procedures involving an anaesthetist this should be the anaesthetist and anaesthetic assistant and for those without, this should be the operator and another practitioner. The patient should be encouraged to participate and the checks should include

- Patient name checked against the identity band.
- Consent form.
- Surgical site marking if applicable.
- Anaesthetic safety checks: machine, monitoring, medications.
- Allergies.
- If there are any discrepancies or omissions they must be resolved before proceeding further

6.5 Stop Before you Block immediately before the insertion of a block the anaesthetist and anaesthetic assistant must simultaneously check the surgical site marking

6.6 Time Out (NatSSIPs) All patients undergoing invasive procedures under general, regional or local anaesthesia, or under sedation, must undergo safety checks immediately before the start of the procedure: *the time out*. Along with the sign in and sign out, this is based on the checks in the WHO Surgical Safety Checklist. Participation of the patient (and/or parent, guardian, carer) in the time out should be encouraged where possible. The time out should not be performed until any omissions, discrepancies or uncertainties identified in the sign in have been fully resolved.

- Any member of the procedure team may lead the time out.
- All team members involved in the procedure should be present at the time out.
- The team member leading the time out should verify that all team members are participating. This will usually require that they stop all other tasks and face the time out lead.
- A time out must be conducted immediately before prepping & draping or the start of the procedure. It should include checks of:
    a. Patient's name and identity band against the consent form.
    b. The results of any relevant tests that must be present and available in theatre such as biometry
    c. Check of any IOL by the operating surgeon to include dioptre, type, expiry date and sterility (Prosthesis verification (NatSSIPs)
    d. The procedure to be performed.
    e. Verification of surgical site marking.
    f. Any specific equipment requirements or special investigations.
    g. Any critical or unexpected steps.
    h. Any patient specific concerns.
    i. Patient's ASA Physical Status.
    j. Monitoring equipment and other specific support,
    k. Confirmation of sterility of instruments and equipment.
    l. Any equipment issues or concerns.
    m. Antibiotic prophylaxis.
    n. Patient warming.
    o. Glycaemic control.
    p. Hair removal.
    q. VTE prophylaxis.
    r. Patient allergies.

Any omissions, discrepancies or uncertainties identified during the time out should be resolved before the procedure starts.

6.7 Aseptic Technique

The members of the scrub team shall complete the surgical scrub as defined in the Hand Hygiene policy hand hygiene policy http://mehhome/ uploads/documents/policy-documents/hand-hygiene.pdf following the removal of all jewellery including wristwatch and all but a plain metal ring

It is important that the principles of maintaining a sterile field are maintained,

- Checking the integrity of packages, along with the indicators of sterility
- Assuming that only the area between the waist and shoulders and above the table to be sterile
- Scrubbed staff should refrain from leaning over the sterile field
- Present the inner packaging to the scrub nurse to avoid contamination
- Avoid dropping items onto the sterile field
- Do not leave the sterile field unattended
- Covering the trolley or a sterile field is not a means of maintaining sterility
- Keep movement to a minimum
- Pass back to back when scrubbed
- Be seated when scrubbed if the table is at that level
- Ensure that all doors to the theatre are kept shut
- Ensure that the flow of supplies moves from clean to dirty and not back

6.8 Prevention of Retained Foreign Objects

Although it is the responsibility of the user to return all items, the scrub practitioner implements and manages the checking procedure in order to be able to state categorically to the operating surgeon that all items are accounted for at appropriate points.

The count must be audible to those present and must be conducted by two members of staff, one of whom must be an appropriately qualified member of the perioperative team (i.e. a Registered Nurse or Operating Department Practitioner).The other staff member may be a non-registered practitioner who has attained a validated count assessment through national or locally validated training. The 2 staff members must be aware of the names of all instruments and be able to recognise them

The team brief should discuss the staff allocation to scrub and count which should remain consistent throughout the procedure.

Should it be necessary to replace the scrub practitioner during the procedure, a complete count should be performed, including a full instrument check, recorded and signed by the incoming and outgoing practitioners. The name of the replacement practitioner/s must be recorded on the intra-operative record.

Should it be necessary to replace either person temporarily, the relieving practitioner should follow the standard procedure and note and sign any additions on the intraoperative record. The name of the replacement or relieving practitioner must be recorded on the intra-operative record.

If a scrub practitioner is not required during procedures the circulating practitioner should be competent to undertake the count with the operating surgeon as per local policy.

Items which are to remain in the patient by intention must be recorded in the intra-operative record and documentation that will be accessed by staff in the area that will be responsible for the removal of the item. The removal must also be recorded, including the time, date, name and designation of the practitioner removing the item.

All items must remain in the operating theatre until the procedure has been completed and all counts have been performed, including laundry and clinical waste containers/bags.

Clinical waste bags should be labelled with the patient's number, date of operation and theatre identity.

The initial full swab, instrument and sharps count must be performed immediately prior to the commencement of surgery. A second count should occur before closure of a cavity before wound closure begins, and finally at closure or at the end of the procedure giving a total of a minimum of three counts. When additional items are added to the field, they should be counted at the time and recorded on the count documentation. (sop performing surgical counts in the surgical setting)

6.8.1 Missing or unaccounted for item

in the event of an item being declared as missing, the operating surgeon must be informed immediately and a thorough search implemented at once. Missing micro items (e.g. needles which cannot be detected on X-ray) should be recorded on the intra-operative record and electronic record.

Any investigations that need to be done for an unaccounted item must be undertaken before the end of surgical intervention (i.e. **before** the patient leaves the operating theatre). All staff should assist in the search examining the operative field, instrument trolley, drapes floor, rubbish bags under the shoes and on the sole of shoes and the prep and anaesthetic rooms and disposal hatch.

The Coordinator on duty must be immediately informed and enter into a discussion with the operating surgeon. X-rays should be performed at the discretion of the surgeon.

All missing items must be documented in the patient's notes along with completing an electronic incident form. The patient must be made aware of any missing item in accordance with the Duty of Candour. Any formal investigation that may follow must be in accordance with local policy.

6.9 Sign out All patients must undergo safety checks at the end of the procedure but before the handover to the post-procedure care team: the sign out. Along with the sign in and time out, this is based on the checks in the WHO Surgical Safety Checklist and forms part of the Five Steps to Safer Surgery. Noise and interruptions should be minimised during the sign out. Any member of the procedure team may lead the sign out. All team members involved in the procedure should be present at the sign out. The team member leading the sign out should verify that all team members are participating. This will usually require that they stop all other tasks and face the sign out lead.

Sign out checks should be conducted at the end of the procedure and before the patient is awoken from general anaesthesia or, when general anaesthesia is not used, before the patient leaves the procedure room. These checks should include

1. Confirmation of the procedure performed, to include site and side if appropriate.
2. Confirmation that instruments, sharps and swab counts are complete
3. Confirmation that any specimens have been labelled correctly, to include the patient's name and site or side when relevant.
4. Discussion of post-procedural care, to include any patient-specific concerns.
5. Equipment problems for inclusion in the debriefing.

6.10 Recovery and Post Operative Handover

On a daily basis recovery practitioners will be allocated to a list for the duration of their shift. One practitioner will be allocated to coordinate breaks for the recovery team.

The recovery practitioners primary duty is to manage the patients postoperative care following surgery. In addition to this the practitioner will work as part of the theatre team and aid in circulating duties and the running of the list when not required in the recovery department.

- Prior to each list commencing the recovery practitioner will open the recovery areas in accordance with the SOP Opening and closing the recovery room.
- Controlled drugs are to be counted and checked in accordance with the SOP Collecting and holding CD keys and the Controlled Drug Policy.
- Practitioners will receive patients from theatre along with a verbal and written handover and should occur when the patient is clinically stable. There must be a supplementary handover to the ward. This handover should include
- Name of patient, checked against identity band.
- Relevant comorbidities.
- Allergies.
- Planned and actual procedure(s) performed, with site and side if relevant, and surgical course.
- Relevant intraoperative medications, including opioids, anti-emetics and antibiotics.
- Target range for physiological variables.
- Course of anticipated recovery and problems anticipated.
- Postoperative management plan, to include provision of analgesia
- Plan for oral or intravenous intake.
- Medications.
- VTE prophylaxis.
- Information given to the patient about the procedure, or any plans for information to be given after the procedure.
- Any patient safety incidents.
- Surgical complications and interventions to correct these
- Surgical site dressings, tubes, drains or packs.
- Any missing instruments and the plan to inform the patient
- ASA physical status
- Anaesthetic complications and interventions to correct these.
- Any problems related to the airway.
- Confirmation that intravenous lines and cannulae have been flushed.
- Confirmation that the lumens of multi-lumen catheters have been both clamped shut and occluded with caps or needleless connectors. • Confirmation that any throat pack has been removed.
- Intravenous fluids and blood products given, with estimated losses
- All patients will be monitored in accordance with AAIGB guidelines appropriate for the type of anaesthetic they have received.

- The recovery practitioner will ensure that all relevant paper work is correct and present and the ICP is complete prior to handing the patient over to the ward staff.

When the patient is transferred directly to the ward from theatre, the handover should be completed by the theatre team.

6.11 Debrief

The debriefing should be seen as being as important a part of the safe performance of an invasive procedure as any of the other steps outlined in this document.. A debriefing should be performed at the end of all sessions. The debriefing may need to be conducted on a case-by-case basis if there is a change in key team members during a procedure session. The debriefing should occur in a manner and location that ensures patient confidentiality, while enabling inclusivity and contribution from all team members.. Every member of the procedural team should take part in the debriefing. Any team member may lead the debriefing, but the operator and anaesthetist (if an anaesthetist has been involved) must be present. If any team member, and especially the senior operator, scrub practitioner or anaesthetist, has to leave before the debriefing 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 debriefing. In this circumstance, their absence from the debriefing should be recorded and included in routine audit of compliance with this document . Members of the team must note any key points for consideration at the debriefing as the procedure list progresses. This can be on a personal record or annotated in the team briefing record.
For each patient, the discussion should include,

1. Things that went well.
2. Any problems with equipment or other issues that occurred.
3. Any areas for improvement.

Each team should have an identified member who is responsible for feeding this information to the theatre coordinator. 8. If a significant issue about the care of a patient arises during the debriefing, a clear and contemporaneous note of this should be made in the patient's records this must also be reported to the Theatre coordinator

7 Sharps Management

Please refer to the Trust sharps management policy
http://mehhome/_uploads/documents/policy-documents/sharps-management.pdf

The department has endeavoured to supply and mandate the use of safer sharps where available with full risk assessments in place.

Staff must never transport or carry devices or products with the sharps attached. Dispose of sharps directly into the sharps bin at the point of use.

When passing instruments to and from the operating surgeon, a hands free technique should be followed.
When returning a needle the operating surgeon should stick the needle directly onto the sharps pad.

In the event of an accident or injury all staff must adher to the guidance outlined in the sharps management policy along with notifying immediately the coordinator on duty.

8 Handling of Specimens

Specimens must not to be removed from Theatre before the end of a case unless on special instructions from the Consultant e.g. frozen section.

Specimens for histological examination will be potted in the Theatre and placed in a container in the Sluice Room with the appropriate identification sticker to await transportation to the Pathology Department at the agreed times

It is the responsibility of the Scrub Nurse to ensure the specimen is correctly labelled, checking with the operating surgeon, and entered in to the Specimen Book ready for transportation to the lab as detailed above.

Specimens for culture and sensitivity should be transported to the Pathology Department as soon as possible.

Excised tissue **not** required for histological examination will be placed in the appropriate bags and taken by the orderlies (porters) for incineration.

9 Theatre Environment

All Theatres should be maintained at humidity 45% -55% and temperature of 19° -21° degrees
Traffic must be kept to a minimum at all times for reasons of Infection Control and to maintain a patient's Privacy & Dignity.

Noise levels must be kept to a minimum at all times. Mobile phones must be switched off upon entry to the department; and only used in the rest rooms or outside corridors.

Staff must not consume food and drink any Clinical Areas i.e. Anaesthetic Rooms, Operating Theatres and Recovery

PPE must be worn when cleaning the theatre environment.

In order to provide a clean environment for the patients the theatre must be cleaned daily using detergent and water (or detergent wipes), then dry any excess as per trust policy. This should be documented that this has been completed.

All spills and splashes should be cleaned up per trust policy.

Cleaning should also occur between each patient especially all equipment that has come into contact with the patient. Any patient that poses a high risk of transmitting infections should be at the end of the operating list and the theatre environment cleaned as trust policy.

Equipment should been cleaned as per manufacturers recommendations.

10. Dress Code

10.1 Theatre staff

All Theatre personnel should change into their own clothing where possible when leaving the Theatre complex.
Theatre personnel may only wear theatre scrub suits in the designated clinical areas.
Theatre hats, masks and gloves must never be worn outside of the Theatre complex.
On return to the Theatre complex staff must enter the changing rooms provided and change into clean theatre scrub suits

10.1.1 Masks

The Team Leader responsible for each list will ensure that surgical masks are worn correctly and appropriately in accordance with this guidance.

Surgical masks, when appropriate, must be worn correctly, completely covering the nose and mouth. If sneezing should occur, the head must not be turned away from operation site or the instrument trolley, as bacteria will be expelled out the side of the surgical masks.

Surgical masks should be changed when they become wet as a mask with exhaled moisture has increased resistance to airflow and is less efficient at filtering bacteria.

The circulating nurse should wear a surgical mask during trolley preparation to ensure sterility and whilst the case is on the table as she/ he will be opening items/ instruments as required during the case.

Masks should be comfortable and cover both the nose and mouth completely. The fit should assure that there is no tenting at the sides of the mouth that would allow dispersion or entry of microbes. A small pliable strip at the nose area should be used in order to ensure a close fit.

Once removed from the face, surgical masks must be discarded into a clinical waste bag as they contain collected micro-organisms

Hands must be decontaminated following removal of surgical mask.
Surgical masks must **never** be left hanging around the neck or placed in pockets and then reused, as this is a source of contamination.

Other theatre personnel such as the anaesthetist, anaesthetic practitioner do not normally need to wear surgical masks.

When removing the surgical mask, in order to minimise cross contamination, untie or break bottom ties, followed by top ties or elastic and remove by handling the ties only and discard into the appropriate waste bin. On completion hand hygiene should be undertaken.

10.1.2 Jewellery

The department observes bare below the elbows and this should be the case within recovery, anaesthetic rooms and operating theatres. In addition to this, those working in (a scrub capacity should not wear necklaces or drop earrings due to the risk of potential harm if they drop into the operative field) All rings except a plain wedding band should be removed prior to scrubbing

10.1.3 Fingernails

Staff are to ensure nails are kept short and clean. Those working in a clinical area should not wear nail polish or artificial nails

10.2 Ward staff and other Personnel

During the timetabled operating session, ward staff involved in the direct transfer of patients into the anaesthetic room and collection of patients from recovery will be permitted to go through into the Theatre area up to and including the anaesthetic room and recovery areas

An identification badge must be worn at all times for all ward staff.

Ward staff should not enter individual operating theatres except in an emergency scenario or unless they are wearing scrub suits and theatre shoes

All other personnel e.g. visitors, firm representatives estates staff entering the department must announce themselves at reception, and will become the responsibility of the member of theatre staff they are visiting during their time in the department. If the visitor plans to enter an operating theatre at any point during their stay the must change into theatre scrubs, hat and shoes and observe the Trust Bare Below the Elbows policy. In the event that a visitor is not entering an operating theatre, they must ensure that they have observed the trust handwashing protocol, and be accompanied by a member of Trust personnel.

10.3 Patients

LA Patients may keep their own clean clothing on if appropriate

GA Patients must remove clothing from the upper half of their body and dress in the appropriate theatre gowns provided

Patients should wear a theatre hat or cap only if their hair is going to interfere with the operating field

There is no need for relatives or those accompanying patients to the anaesthetic room to wear a gown or hat.

Please note overshoes are not to be worn

11. Emergency patients

City Road Operating Department has the provision to support emergency surgery. In addition to the scheduled lists for VR Emergencies we should seek to facilitate true genuine emergencies be they NHS or Private patients.
In the event of VR emergency activity outstripping the available resource the VR coordinator should make this known as early as possible in the day ideally by 11am, to the theatre coordinator who will scrutinise the theatre lists and identify additional capacity.
In the event that additional capacity is not available they should inform the Theatre Manager who will discuss with the General Manager for Surgical Services, the VR consultant on call and if necessary the Medical Director in order to identify an elective list that should be stood down.

If another non VR emergency presents, the operating surgeon should inform the theatre coordinator on duty as soon as feasibly possible. The process outlined above should be followed

12. Private Patients

City Road operating department works closely with Moorfields Private in order to provide expert theatre support. The Moorfields Private theatre timetable is managed in conjunction with the lead nurse and admin manager and the theatre management team. In order to make optimum use of the available resource Moorfields private admin manager should aim to inform the theatre team of any unused sessions 1 week in advance but at an absolute of 48 hours so these staff can either be stood down or utilised to provide emergency lists.

The reimbursement of costs is managed through the financial teams billing the agreed tariff. The use of additional high cost items such as toric lenses should be notified to the theatre team in advance of the procedure; the cost of the item should be notified and the decision to proceed should be determined and recorded.
Once the item is used the sticker should be placed in the patient's notes and recorded within the theatre department in the private patient high cost item log. This log will be submitted on a weekly basis to both the private patient's admin manager and the surgical services finance partner

Any private patient specific equipment or consumable will be the responsibility of Moorfields Private to purchase and maintain

13 Medicines Management

All registered practitioners that have any involvement with medicines (e.g. administration) are responsible for:

Ensuring that they are familiar with the procedures and fully aware of their roles and responsibilities when dealing with medicines http://mehhome/_uploads/documents/policy-documents/medicines.pdf

13.1 Controlled Drugs and Medicine Management in Operating Theatres

The Nursing and Clinical Staff have overall responsibility for the storage, safe keeping and administration of drugs within the Operating Departments

The Anaesthetic Practitioner must be a qualified Nurse or ODP with the relevant training and/or the relevant signed off Competencies (S:\Theatres\Education and Training).

Pharmacy will be ordered as required by Recovery and checked by RN/ODP's on their arrival in the Departments.

13.2 General measures for appropriate storage of CDs.

CD cupboards/cabinets must be kept locked when not in use. The lock must not be common to any other lock in the hospital. The cupboard should be dedicated to the storage of CDs and no other medicines or items should normally be stored in the CD cupboard. An exception to this is suspected illicit substances, which should be stored in a sealed envelope in the CD cupboard until such time as they can be returned to the pharmacy department for destruction or given to the police for further investigation. All CDs must be locked away when not in use. All CDs must be kept in the original container or a suitable container dispensed by the pharmacy department.

13.3 Controlled Drugs Keys (Key-Holding)

Clinical Areas: The registered nurse or operating department practitioner (ODP) in charge is responsible for the CD key. Key-holding may be delegated to other suitably-trained registered healthcare professionals, but the legal responsibility rests with the registered nurse or ODP in charge. Agency staff cannot hold CD keys. The CD key should be returned to the nurse or ODP in charge immediately after use by another registered member of staff. On occasions, for the purpose of stock checking, the CD key may be handed to an authorised member of the pharmacy staff (e.g. the pharmacy technician responsible for stock control of medicines in Theatres

14 Stakeholder Engagement and Communication

The policy is sent to the nursing and clinical leads within the Trust for review and circulated to members of the Infection Control Committee the agreed policy is then forwarded to the Clinical Governance Committee for ratification. Once ratified, the policy is made available to all staff via the Trust intranet and staff working in the operating department will receive an electronic copy

15 Approval and Ratification

The policy is sent to the Clinical Governance Committee for approval. Once agreed the policy is sent to the Management Executive Committee for ratification

16 Dissemination and Implementation

16.1 Once ratified, the policy will be circulated to all operating department staff, consultant surgeons and anaesthetists and will be sent to communications to post on the Trust intranet under policies, procedures and guidelines

16.2 All staff will be notified of the new policy via Trust weekly communications letter, staff annual updates and induction training sessions, Senior Nurses Meetings and relevant service meetings.

17 Review and Revision Arrangements

17.1 The policy will be reviewed and updated every year by the Theatre Manager

17.2 The policy may be reviewed earlier than this if new guidance is issued

18 Document Control and Archiving

18.1 The current and approved version of this document can be found on the Trust's intranet site. Should this not be the case, please contact the Compliance team.

18.2 Previously approved versions of this document will be removed from the intranet by the Compliance team and archived in the policy repository. Any requests for retrieval of archived documents must be directed to the Compliance team.

19 Monitoring compliance with this Policy

The Trust will use a variety of methods to monitor compliance with the processes in this document, including the following methods:

Measurable Policy Objective	Monitoring/ Audit method	Frequency of monitoring	Responsibility for performing the monitoring	Monitoring reported to which groups/ committees, inc responsibility for reviewing action plans
All policies will be reviewed by their authors at least annually to ensure that they remain valid and in date	Compliance audit of sample of policies (including Review History)	Annual	Director of Corporate Governance	Management Executive

In addition to the monitoring arrangements described above the Trust may undertake additional monitoring of this policy as a response to the identification of any gaps, or as a result of the identification of risks arising from the policy prompted by incident review, external reviews or other sources of information and advice.

This monitoring may include commissioned audits and reviews, detailed data analysis or another focussed study, for example. Results of this monitoring will be reported to the committee and/or individual responsible for the review of the process and/or the risks identified.

Monitoring at any point may trigger a policy review if there is evidence that the policy is unable to meet its stated objectives.

20 Supporting References / Evidence Base

21 Supporting Documents

Supporting Documents/References	Owner

Policy Applicability to Trust sites

This document applies to the City Road site only.

Where the list indicates that the policy does not apply, this implies that the Trust will adhere to the policy of the host. Where a query exists then this must be referred, in the first instance, to either the:

- SDU general/Directorate/nurse manager
- Policy owner
- Accountable director
- Service director

Moorfields Dubai will adhere to their own local policies and procedures and Trust-wide documents will not apply, unless explicitly stated otherwise.

Equality Impact Assessment

The equality impact assessment is used to ensure we do not inadvertently discriminate as a service provider or as an employer.

To be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

		Comments / Evidence
1	Which groups is the policy/guidance intended for? Who will benefit from the policy/guidance? (refer to appropriate data)	All clinical and non-clinical staff. Patients & visitors fitting the criteria in accordance with national guidance
	• Race	
	• Gender (or sex)	
	• Gender Reassignment	
	• Pregnancy and maternity	
	• Marriage and civil partnership	
	• Religion or belief	
	• Sexual orientation including lesbian, gay and bisexual people	
	• Age	
	• Disability (e.g., physical, sensory or learning)	
2	What issues need to be considered to ensure these groups are not disadvantaged by your proposal/guidance?	N/A
3	What evidence exists already that suggests that some groups are affected differently? (identify the evidence you refer to)	N/A
4	How will you avoid or mitigate against the difference or disadvantage.	N/A
5	What is your justification for the difference or disadvantage if you cannot avoid or mitigate against it, and you cannot stop the proposal or guidance?	N/A

If you have identified a potential discriminatory impact of this procedural document, please refer it to the director of corporate governance, or the human resources department, together with any suggestions as to the action required to avoid/reduce this impact.

For advice in respect of answering the above questions, please contact the director of corporate governance (ext. 2306)

Please ensure that the completed EIA is appended to the final version of the document, so that it is available for consultation when the document is being approved and ratified, and subsequently published.

Checklist for the Review and Approval of Documents

To be completed (electronically) and attached to any document which guides practice when submitted to the appropriate committee for approval or ratification.

Title of the document: **City Road Theatres Operational Policy**

Policy (document) Author: **Theatre Manager**

Policy (document) Owner: **Theatre Manager**

		Yes/No/ Unsure/ NA	Comments
1.	**Title**		
	Is the title clear and unambiguous?	Yes	
	Is it clear whether the document is a guideline, policy, protocol or standard?	Yes	
2.	**Scope/Purpose**		
	Is the target population clear and unambiguous?	Yes	
	Is the purpose of the document clear?	Yes	
	Are the intended outcomes described?	Yes	
	Are the statements clear and unambiguous?	Yes	
3.	**Development Process**		
	Is there evidence of engagement with stakeholders and users?	Yes	
	Who was engaged in a review of the document (list committees/ individuals)?		
	Has the policy template been followed (i.e. is the format correct)?	Yes	
4.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?	Yes	
	Are local/organisational supporting documents referenced?	Yes	
5.	**Approval**		

	Does the document identify which committee/group will approve/ratify it?	Yes	
	If appropriate, have the joint human resources/staff side committee (or equivalent) approved the document?		
6.	**Dissemination and Implementation**		
	Is there an outline/plan to identify how this will be done?	Yes	
	Does the plan include the necessary training/support to ensure compliance?	Yes	
7.	**Process for Monitoring Compliance**		
	Are there measurable standards or KPIs to support monitoring compliance of the document?	Yes	
8.	**Review Date**		
	Is the review date identified and is this acceptable?	Yes	
9.	**Overall Responsibility for the Document**		
	Is it clear who will be responsible for coordinating the dissemination, implementation and review of the documentation?	Yes	
10.	**Equality Impact Assessment (EIA)**		
	Has a suitable EIA been completed?	Yes	

Committee Approval (Clinical Governance)			
If the committee is happy to approve this document, please complete the section below, date it and return it to the Policy (document) Owner			
Name of Chair	Declan Flanagan	Date	22 April 2016
Ratification by Trust Management Board (if appropriate)			
If the TMB is happy to ratify this document, please complete the date of ratification below and advise the Policy (document) Owner			
Date: 26 April 2016			