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SUPPORTING REFERENCES

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CONSULTATION

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1. INTRODUCTION

The importance of Infection Prevention and Control in the operating theatre cannot be overestimated. Compliance with infection prevention and control practice is vital to reduce the risk of post-operative infection in patients.

Surgical site infection

Surgical site infections have been shown to comprise up to 20% of all healthcare – associated infections and at least 5% of patients undergoing a surgical procedure nationally develop a surgical site infection. Post operative infection is often localised to the surgical site, sometimes extending into the deeper tissue. Infection may become systemic due to the potential for entry of micro-organisms into the patient's blood stream.

Post operative infection can have a devastating effect on patients resulting in extended recovery time, long hospitalisation, discomfort, disability or even death.

People having an operation must be cared for by healthcare services that monitor surgical site infection rates, share this information with patients and relevant staff, and use it to help improve services and minimise future infection rates.

This policy deals with operating theatre procedures for the prevention of infection of patients and staff. All personnel entering restricted areas of the operating department should wear designated theatre attire. The National Institute for Health and Clinical Excellence (NICE 2008) concluded that all staff should wear specific non-sterile theatre wear in all areas where operations are undertaken.

Managers and individual employees working within the Operating Theatre Suites must accept responsibility to ensure the implementation of this Policy. All departments must have written procedures stating the correct preparation for staff and visitors entering and leaving all areas of the perioperative environment. Staff must be made aware of these policies and procedures (DH 2010).

2. GENERAL THEATRE RULES (to be followed by all Operating Department Personnel and Enforced by Department Managers)

- a) Excessive numbers of people must be avoided in the operating theatre during surgery. Persons should not enter/exit the theatre unnecessarily during the surgery.
- b) Doors to operating theatre should remain closed during surgery to optimise the efficiency of the ventilation system. This includes the doors between the anaesthetic room and theatre.
- c) All the personnel working or observing in theatre must be aware of the infection prevention & control procedures, including those not working directly within the operating theatre i.e. recovery staff.
- d) Theatre must be kept clear of unnecessary equipment and furnishings. All equipment must be stored clean and dry in the appropriate place
- f) Staff must wear appropriate clothing in accordance with this policy. This includes being “bare below the elbow” whilst in the theatre environment. Staff

must adhere to the uniform and hand hygiene policies. No jewelry to be worn on duty when wearing scrubs or staff uniform with the exception of plain band wedding rings and solid plain stud earrings. False finger nails, including acrylic or gel-coated nails must not be worn. These have been shown to harbour micro-organisms such as fungi and Gram-negative bacteria even after hand washing.

- g) Inoculation incidents or injuries to staff must be reported promptly and dealt with as per ELHT Policy & Code of Practice for the Prevention and Management of Inoculation/Sharps Injuries. (ELHT/CP 02)
- h) All clinical waste must be disposed of in accordance with Trust clinical and non-clinical waste management policy (ELHT/C71 V3.1)
- i) Adults having an operation under a general anaesthetic or a local anaesthetic (which affects a large part of the body, such as a limb or lower half of the body) are kept comfortably warm at normal body temperature before, during and after the operation to help reduce the risk of infection.

Antibiotic Therapy

People having certain types of operation for which there is a higher risk of infection are given prophylactic antibiotics before surgery to help prevent infection as per antimicrobial formulary.

3. GENERAL ENVIRONMENT

The General Operating Department is categorised as very high risk as such must have consistently high levels of cleaning (see section 12). The general environment of the department should be clean, clutter free, washable and damage free (intact). Any defects must be addressed immediately. General maintenance must be carried out on a regular basis at least annually.

Food must not be consumed within theatre, eating must be confined to the staff room. It is however important for staff to be well hydrated at work. To facilitate this staff will have access to fluids with the following provisos. They will use clear bottles labelled with staff name and date of use. They should be stored away from areas where direct clinical care is being provided (ideally in a cupboard) at a designated 'hydration station'. Staff should take their bottles home with them at the end of every shift to facilitate cleaning. Staff should not drink within sight of patients. In the event that there is an incident of diarrhoea and/or vomiting in the vicinity then the bottles must be discarded in to the infectious (orange) waste stream.

The layout of the department is designed to minimise, restrict or contain micro-organisms. Traffic must be controlled to minimise the movement of bacteria from the theatre environment itself, theatre personnel and patients. All areas within the theatre department e.g. corridors, anaesthetic rooms, stock rooms and the theatre itself must be considered restricted zones.

Staff rooms and waste collection areas are considered to be unrestricted areas.

Patients may be accompanied to theatre with one nurse and one relative. These people must go directly to the reception, recovery or the anaesthetic room as appropriate and leave the department immediately their presence is no longer

required. They are not required to wear protective clothing, but must decontaminate their hands on entry/exit of the department.

Order of patients on operating list

Surface contamination is more likely to pose a risk of transmission of micro-organisms than air. Surfaces such as operating tables, equipment and instruments that make direct contact with more than one patient have potential for transmission between “dirty” and subsequent cases.

4. BLOOD AND BODY FLUID PRECAUTIONS

It is essential that all operating theatre staff practice universal 'blood and body fluid precautions' i.e. the wearing of disposable plastic apron, gloves, masks and eye protection when handling blood, body fluids, soiled linen or instruments that may be contaminated (see ELHT/IC 18 Standard Universal Infection Control Precautions policy). This means that care is taken to prevent splashing and inoculation injuries, whether or not the patient is known to have an infectious disease, since many cases of infection will be unknown to either patient or staff. Needles must not be re-sheathed. (See Appendix 1 for further details).

5. THEATRE CLOTHING

Theatre staff are able to influence the environment by maintaining personal hygiene, wearing theatre attire correctly, reporting health problems, reducing unnecessary visitors and maintaining a clean environment. Theatre attire is designed to minimise the transfer of micro-organisms from the mucus membranes, skin and hair of the surgical team to the patient. It also provides the surgical team with some protection from the patient. Theatre scrubs and shoes must be worn in the theatre complex, outside attire may be acceptable for staff visiting the theatre however any members of staff visiting theatre must report to reception or the person in charge prior to entering the theatre complex. Theatre staff will advise on the appropriate dress code required for the individuals visit. Visiting staff entering the operating theatre including the anaesthetic room, scrub room, clean and dirty utility must cover all of their hair with a hat and wear clean scrubs and theatre shoes.

Uniforms

All theatre staff must wear a clean scrub uniform every day - either theatre uniform trousers and tunic or dress. All personal property (bags, etc) must be kept in the locker rooms and not taken into theatre.

All theatre attire must be changed when soiled and must be sent to the hospital laundry.

Scrub Team

The operating team must wear a sterile gown over standard theatre clothing.

Anaesthetists and recovery room staff must wear gloves whilst attending patients and must wear a mask and eye protection if splashes are anticipated.

Dress when leaving the theatre

When staff are required to leave the theatre for essential visits to other areas such as wards or other theatre units scrub uniforms must be clean. Hats and masks must be

removed prior and shoes removed if visibly stained. Theatre attire must not be worn when visiting the restaurant or shops

Gowns

Sterile reusable, liquid repellent surgical gowns. However in Orthopedics and some urology cases single use fluid repellent gowns are used routinely. If a fluid repellent gown is not used then a plastic apron should be worn underneath the gown.

Hats

A clean theatre hat must cover all hair when entering the operating theatre at all times. Beards/moustaches must be covered with balaclava style hats. Headwear should be donned before donning the scrub suit to eliminate hair and dandruff being shed onto the scrub suit. Religious head coverings (scarves, turbans) must be clean everyday and have no dangling ends.

Eye Protection

Full face visors or protective goggles/glasses must be available for all staff. These must be worn during invasive procedures when appropriate. Ordinary prescription spectacles do not provide sufficient protection from splashes at the sides.

Masks

These have been shown to be unnecessary for most urological and general surgical procedures, but provide a degree of protection from splashing and so may be worn by the operating team or those close to the table. Where there is a risk of facial splashing of body fluids, goggles or a visor provide better protection than a mask alone. Masks must be changed after each patient or if they become contaminated or damp. Remove by handling the ties never the filter and do not scrunch up. These must be disposed of in a clinical waste bag. Hands must be decontaminated after disposal of the mask, do not remove or change whilst wearing gloves. They must never be worn dangling around the neck

FOR ORTHOPAEDIC OPERATIONS, MASKS MUST CONTINUE TO BE WORN BY ALL STAFF IN THE OPERATING THEATRE.

Gloves

Scrub team - sterile gloves. A fresh pair of sterile gloves must be worn for each procedure. Double gloving is recommended wearing two pairs of sterile gloves when there is a high risk of glove perforation and the consequences of contamination may be serious.

Circulating team should wear non-sterile gloves and apron if dealing with used swabs or contaminated material.

Shoes

Standard closed toe non-slip theatre shoes with heel support must be worn and should be fully enclosed to provide protection from spillages and accidentally dropped equipment.

Footwear should be antistatic and washable. Shoes must be cleaned at the end of each day to remove splashes of blood and body fluids or in the event of heavy contamination on completion of that case.

Footwear should be cleaned regularly or when visibly soiled (using appropriate PPE) to remove any contaminants

Parents who are only entering the anaesthetic/ recovery room may continue to wear their own clothing and footwear.

Birthing partners who require entry into the operating theatre for maternity cases should change into theatre shoes and scrubs.

6. HAND DISINFECTION

Cuts

A waterproof occlusive dressing must cover fresh cuts, i.e. less than 24 hours old. Theatre personnel with septic or inflamed lesions must not work in the theatre suite pending an opinion from Occupational Health and Infection Prevention & Control Team. See section under Staff Health.

All staff working within the department must adhere to the Trust Hand Hygiene Policy Ref ELHT IC1

7. SURGICAL HAND ANTISEPSIS

The operating team must carry out a standard hand and arm wash (to the elbow) skin disinfecting procedure before putting on sterile surgical gloves and gowns. This must be carried out in a method to avoid splashing and contamination of clothing.

Fingernails must be cleaned with a sterile single use nailbrush at the beginning of the list/session. The operating team should wash their hands prior to the first operation on the list using an aqueous antiseptic surgical solution, with a single-use brush or pick for the nails only, and ensure that hands and nails are visibly clean.

Any agent or method of skin decontamination, which causes skin abrasions, is best avoided and using a nailbrush on the skin is not recommended.

Alcohol hand gel is an acceptable alternative to repeated washing between cases where the surgeon's hands are clean and have initially been decontaminated by conventional preoperative wash or "surgical scrub". Repeat surgical scrub in case of contamination.

Surgeons may be advised to remove wedding rings particularly if working with metal prostheses as this can lead to perforation of gloves.

Remove debris from underneath fingernails using a nail cleaner under running water. This should normally be necessary only for the first scrub of the list/session.

Use either an antimicrobial soap or an alcohol-based hand rub with persistent activity.

If using an antimicrobial soap (aqueous Chlorhexidine or Betadine antiseptic scrub):

1. Thoroughly wash hands and forearms to the elbow for the length of time recommended by the manufacturer, at least 2 minutes; however there is no evidence that more than 2 minutes washing is required. Do not use a technique liable to cause abrasions. When rinsing and removing the soap, ensure the hands are upper most so that the water runs away at the elbows

to avoid contamination of the hands and wrist. Always dry fingertips/ hands to elbow never return back to hands once the disposable towel has moved along the arm.

If using an alcohol-based surgical hand rub with persistent activity:

1. Follow the manufacturer's instructions. Before applying the alcohol solution pre-wash hands and forearms, to the elbow, with soap, rinse and dry hands and forearms completely. After application of the alcohol-based product to the hands and up to the elbow, allow to dry thoroughly before putting on sterile gloves.

If skin irritation, dermatitis or sensitivity occurs then advice from Occupational Health Department must be sought.

Gloves damaged during surgery

When gloves require changing intra-operatively due to a puncture or inadvertent contamination, the glove must be removed in a way that avoids further contamination. This can be achieved by pulling the gloves downwards by the fingers and palms (whilst also grasping the cuff of the gown), until the glove comes over the end of the hands / fingers. The glove may then be discarded into the appropriate receptacle. Hands must remain inside the sleeves of the gown and the closed glove technique is used to don a new glove as described in the gloving procedure.

On occasions it may be preferable to don a second pair of gloves taking care not to contaminate them during the gloving procedure. Alternatively a new glove may be donned with the assistance of another member of the surgical team.

Damaged gloves which show puncture through to the skin must be replaced after disinfection of hands with alcohol hand rub. Apply about 3ml of alcoholic hand rub and rub hands together until dry, ensuring all surfaces are covered before putting on new pair of gloves.

If inoculation or sharps injury has occurred, give first aid and follow Policy & Code of Practice for the Prevention and Management of Inoculation/Sharps Injuries. (ELHT/CP 02).

8. SKIN DISINFECTION

Skin

Standard disinfection of operating site consists of chlorhexidine 0.5% in 70% alcohol or alcoholic Betadine antiseptic. Alcohol solutions are deemed to be more efficient than aqueous solutions (Hospital Infection Society, 2005). The alcohol solution must be allowed to dry thoroughly before diathermy or other electrical operative equipment is used. Single use bottles are preferable to multi use bottles as these could become contaminated. However, if multi-use bottles are used they must be dated and used within 30 days and not be refilled. With the exception of Ophthalmology who will use single use iodine minims.

Mucous membranes

Rectum or vagina - Betadine or Chlorhexidine aqueous antiseptic.

Mouth - no preoperative disinfection required.

Shaving

Shaving must be avoided. A depilatory cream can be used the day before operation (a test patch will need to be done initially). If this is not possible then hair removal, using single use clippers rather than a razor may be undertaken, this should be carried out in the anaesthetic room as close to the time of the operation as possible. It is done as close to the time of operation as possible because of the risk of causing small abrasions, which may become colonised with bacteria. Where a painful area is recognised, hair removal may be left until the patient is anaesthetised, however hair removal must be undertaken whilst still in the anaesthetic room area before the patient is transferred onto the operating table, to prevent potential contamination of the operation site. Shaving should only be performed if other options are not possible. If it is necessary to shave the operation site, only the area to be incised needs to be shaved and should be carried out just prior to the skin prep and avoiding hair contamination of the local area.

If patients have skin lesions these must be covered prior to going to theatre. Dressing to leg ulcers and pressure sores should be changed prior to surgery if not part of the procedure to be performed and there should be no strikethrough.

If patients are taken to theatre on their own bed it is advisable to change the bed linen on the ward prior to transfer and ensure the bed is clean and dust free. Prior to patients returning from theatre on their own bed the linen must be changed before use.

9. DISPOSAL OF WASTE (as per Healthcare Waste Policy ELHT/ C71)

Sharps use and disposal: - these are for the disposal of ALL SHARPS (e.g. needles and syringes, ampoules, scalpel blades and any disposable sharp instruments used for invasive procedures) Giving set's containing medicinal waste should be disposed as a full unit in to pharmaceutical waste. Where blood and blood products are administered the giving set, including the sharp ends, must be disposed of in its entirety.

Sharps containers must not be filled to more than 3/4 capacity. After ensuring the lid is closed they must be labelled with the correct waste identification number, and left to be collected in a secure collection area.

Suction Jar Liners: - solidifying gel can be used in the bottom of liners and then the liner and its contents double bagged and disposed of as per waste policy. There are also dedicated incineration boxes that can be used if large numbers of suction jar liners are to be disposed of. The liners are placed in the box and then the box, once sealed, must be left in a secure area for collection.

Clinical waste

All staff handling or transporting clinical waste must receive training. This training must cover the following points: -

- i) Check that the storage bags are effectively sealed and correctly labelled.
- ii) Handle the bags by the neck only
- iii) Know the procedure in the case of accidental spillage of blood or body fluids

- iv) Understand the special problems relating to clinical waste and sharps disposal and know the procedure for accidental inoculation or contamination injuries

10. NON-DISPOSABLE LINEN AND THEATRE CLOTHES

Red linen bag (with alginate bag liner): - used for all theatre linen and contaminated theatre clothing. Linen is placed in an alginate bag, securely tied then placed in a red linen bag with green stripe, which is then securely tied. The bags must be secured when 2/3 full. Surgical gowns and wrap must be bagged separately from bed linen and scrubs due to separate wash lines. Refer to Infection Control Linen Policy (ELHT/IC11).

White linen bag: - all theatre staff uniforms, unless contaminated. (Bags are situated in changing rooms).

11. HSDU EQUIPMENT AND INSTRUMENTS

Instruments to be returned to HSDU should be re-wrapped in their outer wrap and transported to HSDU in the trolley provided. All supplementary instruments are to be returned in their see-through pouch containing their unique identification label and then placed in a rigid container, which is available on each dirty trolley.

All reusable medical devices and other devices should be decontaminated in accordance with manufacturer's instructions and the Decontamination Policy (ELHT/IC20).

Systems must be in place to ensure that all reusable medical devices (including instruments) are tracked through the decontamination process and that it is able to identify patients on whom the medical devices have been used.

12. DISINFECTION AND STERILISATION OF EQUIPMENT

Heat-sensitive equipment

E.g. flexible endoscopes/bronchoscopes see Decontamination Policy (ELHT/IC20).

Other equipment

Visors, goggles and boots: - when visibly splashed with blood or body fluids these must be cleaned by using paper towels soaked in hypochlorite solution 1% (10,000 ppm available chlorine). If goggles are heavily contaminated send to HSDU.

Anaesthetic Equipment

A separate bacterial breathing filter must be used for each patient. It must be placed on the anaesthetic circuit in the anaesthetic room and be transferred with the patient into theatre and where necessary follow the patient into the recovery area. The filter protecting the machine must be changed at the end of each session or as per manufacturer's guidelines. See Cleaning & Disinfection of Equipment policy (ELHT/IC3).

Syringes and needles are sterile, single use items. A syringe must not be used for multiple patients, even if the needle is changed. ANTT should be followed for the preparation, and giving of all medicines and insertion of IV access devices. Syringes prepared in advance of the procedure must be stored in a clean container (blue ANTT tray) protecting the key parts following the principles of ANTT and the Micro critical

aseptic field and not left on work surfaces. Drugs prepared in advance must have identification labels attached to the syringe at the time of preparation.

13. FLOOR, FURNITURE AND FITTINGS

Theatre

The operating table, equipment and other furniture which may come into contact with the patient must be cleaned between each patient.

The floor

The operating theatre floor must be cleaned between cases and at the end of each list by theatre personnel. Mop the floor of the operating theatre with a fresh solution of neutral detergent and warm water (e.g. Hospec 5ml to 5L) and a clean mop. Staff must wear disposable gloves and plastic aprons. Domestic services must ensure that each evening all the equipment, in all areas of the theatre suite should be taken out and must be cleaned thoroughly with neutral detergent and warm water and left dry. All areas of the theatre suite must be mopped including the prep anaesthetic and scrub rooms. Specific spillages of blood or body fluids must be dealt with immediately after the case by using hypochlorite solution 1% (10,000ppm available chlorine) or hypochlorite granules before thorough cleaning (see Spillage Policy ELHT/IC2). ELHT/IC2). Disposable lint free cleaning cloths and disposable mop heads must be used. Floors of the operating suite should also be scrubbed on a weekly basis by domestic services staff. Cleaning schedules must be agreed with the Dept. Manager, they must be clear and be well publicised. The Domestic Supervisors will monitor the cleaning and ensure high standards are maintained.

For other surfaces

Normal housekeeping methods are adequate e.g. daily damp cleaning of ledges, shelves and all furniture including theatre patient trolleys and fittings with detergent and hot water at the end of each session. Domestic services will undertake this cleaning.

Anaesthetic machines/ monitors and leads must be cleaned following spillage and at the end of a list as per "Cleaning & Disinfection of Equipment" policy (ELHT/IC3) by theatre personnel.

Reception and Recovery areas

These must be cleaned on a daily basis including equipment, floor, furniture and fittings by domestic services.

Walls

Walls with intact surfaces acquire very few bacteria even if left unwashed for long periods; however they must not be allowed to become visibly dirty. The walls must be washed at least every 6 months and times/dates documented. This must be scheduled in advance and the Theatre Manager must maintain records.

If areas of paint peel off, the wall must be repainted or covered with a new wall finish.

The operating lamp

This must be cleaned daily with detergent and hot water at the end of the day.

14. AIR SAMPLING

All ventilation systems should be inspected quarterly & verified at least annually to ensure that the system achieves the minimum standards as per Health Technical Memorandum 03-01 and records kept.

Ultra clean theatres need theatre air sampling as per Health Technical Memorandum 03-01 by means of in-use microbiological testing on an annual basis. There is currently no requirement for physical testing in theatres with conventional ventilation.

Theatres need to be revalidated as part of the planned preventative maintenance schedule

a) for estate staff to demonstrate that they have handed the theatre back in good working order and

b) to put down a marker (in case of future litigation) that theatres can be demonstrated to have been working as expected. Theatre staff must make a daily record of the warning and indicator lights within the theatre as an indication that the system was operating as expected on any given day. This record must be kept within Theatre for inspection.

The Infection Prevention & Control Team must be included in the circulation of monitoring reports.

15. LABORATORY SPECIMENS

All biological samples, cultures and other materials must be transported in a manner that ensures they do not leak in transit.

16. STAFF HEALTH

Staff with a boil/septic lesion of the skin or exacerbation of eczema are advised not to work in the operating theatre. Protection cannot be achieved by covering the lesion with an adhesive dressing. Staff must report to Occupational Health Department for advice.

Staff infected with *Strep. pyogenes* (e.g. skin infection, streptococcal tonsillitis) must not work in the operating suite.

Respiratory infections in the team may cause respiratory infection in the patient at a time when they are particularly susceptible and it is preferable for persons with such infection to be excluded from the team; the hazard from respiratory infection applies especially to anaesthetic staff.

All members of staff working within the theatre must avail themselves of Hepatitis B vaccinations, boosters and antibody checks with the Occupational Health Department.

Refer to Policy and Code of Practice: the screening for and prevention of Hepatitis B Infection in Health Care Workers ELHT/ HR 40

17. PATIENT INFORMATION

People having an operation and their carers should be given information and advice about how to look after the wound when they go home, how to recognize problems with the wound and who to contact if they are concerned about it.

18. MONITORING THE EFFECTIVENESS OF THE POLICY

Sections of this policy will be monitored and audited by the Patient Environment Audits and High Impact Interventions. Information will be reported to Infection Prevention Committee via the Divisional Performance Reports.

APPENDIX 1

Blood and body fluid precautions

Despite the recent concerns regarding the infection status of patients presenting for surgery, the suggestion that all patients should be tested pre-operatively is neither practical nor financially viable. For example, the demands of emergency surgery can result in specific tests not being carried out. In addition, clinical testing for HIV infection can be inconclusive and less scientific methods of categorising patients, which are questionable on moral grounds, are often inaccurate in the extreme. It is therefore essential that sound infection control measures and the principles of good hygiene, including blood and body fluid precautions are an everyday practice for all staff in the clinical setting.

In the past, attempts were made to identify individuals who were more likely to harbour these viruses and use special precautions when treating them. Since it is impossible to identify many virus carriers on the basis of clinical enquiries and as it is unethical to screen all patients for carriage of viruses purely for infection control reasons, a system of universal precautions must be established when dealing with blood and body fluids. This involves the identification of high-risk procedures rather than high-risk individuals. The precautions are designed to protect staff from risks such as sharps injuries and body fluid spillages and to protect patients from cross infection. They also help to avoid discriminatory practices, which might otherwise arise during patient care.

It is essential that all operating theatre staff at all times practice 'blood and body fluid precautions' when handling blood and body fluids or instruments which may be contaminated. Care must be taken to prevent splashing and inoculation injuries whether or not the patient is known to have an infectious disease since many cases of infection will be unknown to either patient or staff.

APPENDIX 2

Theatre Protocol for Colonised/Infected Cases

1. Introduction

This protocol relates to those patients prior to surgery who are **known** to be carriers or infected with multiple drug-resistant bacteria (e.g. MRSA/ CPE) or infectious diseases. In practice, it refers to anyone in Source Isolation on the ward.

In addition to Standard (Universal) Infection Control Precautions (see policy ELHT/IC 18) that should be employed with **all** patients, the following must also be observed for these colonised/infected patients.

The **surgical team** booking in patients for theatre must notify theatres **in advance** of any organisms or infectious diseases that patient may have e.g. MRSA, TB, multi drug organisms or chickenpox etc.

Ward **nursing staff** must also notify theatres **in advance** as to whether or not the patient is being nursed on the wards in Source Isolation.

Appropriate antibiotic prophylaxis should be given, depending on the type of surgery and resistant bacteria/infection present.

Patients ideally should be placed last on the list to ensure that the theatre is scrupulously cleaned afterwards, however in an emergency situation this may not happen and the theatre must be cleaned thoroughly after the case. If a patient needs to be recovered in theatre because they have an **infectious respiratory disease**, they should be placed last on the session to cause least disruption.

Gloves and aprons must be worn by all staff when dealing with patients known to be carrying antibiotic resistant bacteria and when touching equipment attached to such patients.

2. Anaesthetic Room

Patients with resistant bacteria or infectious diseases may be anaesthetised in the anaesthetic room if all equipment used on them is decontaminated appropriately (see Cleaning and disinfection of equipment policy ELHT IC 3) before the next patient. If it is preferred that they go straight into theatre, then this is a satisfactory option.

Disposable anaesthetic machine circuits must be used and changed after an infectious case.

3. Theatre (operating room)

The minimum necessary number of people should be present.

In addition to the usual theatres clothing the **circulating nurse, anaesthetist and anaesthetic nurse/ODA** should wear plastic aprons, disposable gloves and other appropriate PPE as necessary.

It is **not** necessary for anyone entering the operating room that does not go to the immediate vicinity of the operating table, to take any special precautions.

Patients with infectious respiratory disease, such as **open pulmonary tuberculosis** or **chickenpox** must be recovered in theatre.

Patients with **open pulmonary multi-drug resistant tuberculosis** must not be taken to theatre without prior discussion with the relevant specialist physician and the Infection Prevention & Control Team (IPCT).

For patients with **CJD** or similar diseases refer to the CJD Policy. Prevention of Transmission of Creutzfeldt–Jakob Disease (CJD) and other Transmissible Spongiform Encephalopathies (TSE). ELHT/ IC19

After the operation, all surfaces which may have become contaminated should be cleaned with Actichlor Plus 1000ppm.

Surfaces contaminated with blood and blood stained body fluids should be cleaned, as per Spillage Policy ELHT/IC02, with 10,000ppm hypochlorite.

Protective clothing i.e. gloves and aprons (masks if worn) should be removed before leaving the operating room and disposed of in a clinical waste bag and hands washed.

All **linen** must be bagged in a red alginate bag and placed in a red laundry bag. Clinical waste for incineration must be put in orange bags. Fluid waste needs to go in Orange lidded rigid containers unless it is full blood then it should be an anatomical Red lidded container or treated with a solidifying gel. If waste has been solidified it can be bagged and put in an orange bag in small quantities due to the weight.

Instruments must be returned to HSDU in the normal way, or decontaminated using local procedures (except instruments used on known and suspected CJD patients – contact IPCT).

As soon as theatre cleaning is complete, it can be used again; no time period needs to elapse.

4. Recovery

Patients may be recovered in Recovery, unless they have an **infectious respiratory disease**. Source Isolation procedures must be adhered to, i.e.

Source Isolation sign to be displayed above bed/trolley (see Isolation Policy ELHT/IC05)

Gloves and aprons must be worn by all staff when attending to the patient and the patient's immediate environment and bed space.

Gloves and aprons must be changed **between dirty and clean tasks** and hands appropriately decontaminated (see Hand Hygiene Policy IC1)

Gloves and aprons must be changed **between patients** and hands appropriately decontaminated.

All equipment and bed space must be decontaminated using Actichlor Plus between patients.

Discuss with IPCT with regards to curtain changes.

If possible the patient should be nursed, in a designated area away from other patients, and near a clinical hand-washing sink.

APPENDIX 3

Potential or confirmed cases of Carbapenemase Producing Enterobacteriaceae (CPE)

- If the patient is at risk this must be identified on the theatre check list
- It is vital that the ward staff are efficient in informing the theatre staff of any risk
- Planned last on the list wherever possible
- Remove all non-essential equipment and stock from theatre
- Standard precautions should be adhered to and theatre doors kept closed, with minimal numbers of staff entering the theatre, so that the ventilation system can function efficiently and effectively
- Theatre personnel collecting/receiving a patient, and not in direct contact with the patient, need not wear protective clothing. Theatre personnel in close contact with the patient should wear a long sleeved gown and gloves
 - Bed/trolley linen should be changed outside the theatre and bagged accordingly. See Used Laundry Management Policy
 - The trolley/bed must be cleaned with 1,000 ppm of available chlorine once stripped
 - Soft materials, e.g. BP cuffs must be decontaminated with 1,000ppm available chlorine solution and dried. See Trust Decontamination of the Patient Environment including Terminal Cleaning and Deep Cleaning Policy Disposable tourniquets must be used
 - Theatre environment/equipment (unless contraindicated) should be decontaminated using a solution of 1,000ppm available chlorine.

As soon as theatre cleaning is complete, it can be used again; no time period needs to elapse.

Monitoring Mechanism:

Measuring and monitoring compliance with the effective implementation of this procedural document is best practice and a key strand of its successful delivery. Hence, the author(s) of this procedural document has/have clearly set out how compliance with its appropriate implementation will be measured or monitored. This also includes the timescale, tool(s)/methodology and frequency as well as the responsible committee/group for monitoring its compliance and gaining assurance.

Aspect of compliance being measured or monitored.	Individual responsible for the monitoring	Tool and method of monitoring	Frequency of monitoring	Responsible Group or Committee for monitoring
Compliance with Infection Prevention Protocol's within the Operating Theatre	Theatre Manager	High Impact Interventions	Monthly	Infection Prevention & Control Committee
Environmental decontamination and cleanliness	Theatre Manager Domestic Supervisor	NAPF Domestic walk rounds	Annual (minimum) Monthly	Nursing and midwifery Leaders Forum Infection Prevention & Control Committee

Equality Impact Assessment Screening Form

Department/Function	Infection Prevention & Control			
Lead Assessor	Kirsty Holt			
What is being assessed?	Theatre Infection Control Policy			
Date of assessment	27/09/2019			
What groups have you consulted with? Include details of involvement in the Equality Impact Assessment process.	Equality of Access to Health Group	<input type="checkbox"/>	Staff Side Colleagues	<input type="checkbox"/>
	Service Users	<input checked="" type="checkbox"/>	Staff Inclusion Network/s	<input type="checkbox"/>
	Personal Fair Diverse Champions	<input type="checkbox"/>	Other (Inc. external orgs)	<input type="checkbox"/>
	Please give details: Operating department staff			

1) What is the impact on the following equality groups?		
Positive:	Negative:	Neutral:
<ul style="list-style-type: none"> ➤ Advance Equality of opportunity ➤ Foster good relations between different groups ➤ Address explicit needs of Equality target groups 	<ul style="list-style-type: none"> ➤ Unlawful discrimination, harassment and victimisation ➤ Failure to address explicit needs of Equality target groups 	<ul style="list-style-type: none"> ➤ It is quite acceptable for the assessment to come out as Neutral Impact. ➤ Be sure you can justify this decision with clear reasons and evidence if you are challenged
Equality Groups	Impact <small>(Positive / Negative / Neutral)</small>	Comments
Race <small>(All ethnic groups)</small>	Neutral	<ul style="list-style-type: none"> ➤ Provide brief description of the positive / negative impact identified benefits to the equality group. ➤ Is any impact identified intended or legal?
Disability <small>(Including physical and mental impairments)</small>	Neutral	
Sex	Neutral	
Gender reassignment	Neutral	

Religion or Belief	Neutral	
Sexual orientation	Neutral	
Age	Neutral	
Marriage and Civil Partnership	Neutral	
Pregnancy and maternity	Neutral	
Other (e.g. caring, human rights)	Neutral	

2) In what ways does any impact identified contribute to or hinder promoting equality and diversity across the organisation?	No impact
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<p>3) If your assessment identifies a negative impact on Equality Groups you must develop an action plan to avoid discrimination and ensure opportunities for promoting equality diversity and inclusion are maximised.</p> <ul style="list-style-type: none"> ➤ This should include where it has been identified that further work will be undertaken to further explore ➤ the impact on equality groups ➤ This should be reviewed annually. 		
Action Plan Summary		
Action	Lead	Timescale

This form will be automatically be inserted as an appendix in all Policies and Procedures which are presented for ratification at the Policy Council. Please do not hesitate to contact the qualityandsafetyunit@elht.nhs.uk if you have any queries.