Cleaning and Decontamination of Reusable Surgical Instruments Trustwide Policy

<table>
<thead>
<tr>
<th>Document No</th>
<th>IP&amp;C - 00010</th>
<th>Version No</th>
<th>1.0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Approved by</td>
<td>Policy Governance Group</td>
<td>Date Approved</td>
<td>17.05.17</td>
</tr>
<tr>
<td>Ratified by</td>
<td>Infection Control Committee</td>
<td>Date Ratified</td>
<td>26.09.17</td>
</tr>
<tr>
<td>Date implemented (made live for use)</td>
<td>05.10.17</td>
<td>Next Review Date</td>
<td>26.09.20</td>
</tr>
<tr>
<td>Status</td>
<td>LIVE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Target Audience</td>
<td>All employees directly employed by the Trust, whether permanent, part-time or temporary (including fixed-term contract). It applies equally to all others working for the Trust, including private-sector, voluntary-sector, bank, agency, locum, and secondees. For simplicity, they are referred to as ‘employees’ throughout this policy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accountable Director</td>
<td>Medical Director</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Author/originator</td>
<td>Hospital Sterilisation and Decontamination Unit (HSDU) Sterile Services Manager</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Division and Department</td>
<td>Planned Care, HSDU</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Implementation Lead</td>
<td>Decontamination Lead Advisor/IP&amp;C Lead Nurse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If developed in partnership with another agency ratification details of the relevant agency</td>
<td>None</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Equality Impact
Great Western Hospitals NHS Foundation Trust strives to ensure equality of opportunity for all service users, local people and the workforce. As an employer and a provider of healthcare, the Trust aims to ensure that none are placed at a disadvantage as a result of its policies and procedures. This document has therefore been equality impact assessed in line with current legislation to ensure fairness and consistency for all those covered by it regardless of their individuality. This means all our services are accessible, appropriate and sensitive to the needs of the individual.

Special Cases
The Policy relates solely to the microbiological decontamination of surgical instruments including flexible endoscopes. The policy does not relate to items which may be contaminated with chemicals that are corrosive, irritant, toxic, catatonic or radioactive. The latter information can be located with the Control of Substances Hazardous to Health (COSHH) (Ref 1)
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Version 1.0

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1. Instant Information - The Reusable Medical Devices Life Cycle

**NB** Any device which is marked with the following symbol MUST NOT be reused as it is designated as single use.

Single use symbol as per European and International Standard (EN ISO) 15223 (Ref 2)
2 Instant Information: The Spaulding Classification for Medical Devices and Levels of Disinfection (Ref 3)

- **Critical**
  A device that enters normally sterile tissue or the vascular system or through which blood flows should be sterile. Such devices should be sterilised, which is defined as the destruction of all microbial life.

- **Semi-critical**
  A device that comes into contact with intact mucous membranes and does not ordinarily penetrate sterile tissue. These devices should receive at least high-level disinfection, which is defined as the destruction of all vegetative microorganisms, mycobacterium, small or non-lipid viruses, medium or lipid viruses, fungal spores, and some bacterial spores.

- **Noncritical**
  Devices that do not ordinarily touch the patient or touch only intact skin. These devices should be cleaned by low-level disinfection.
2. Document Details

2.1 Introduction and Purpose of the Document

Decontamination of reusable medical devices and equipment is a priority for the Trust and is essential to ensure the delivery of safe services to patients, staff and other service users, the management and In order to be registered with the Care Quality Commission (CQC), the Trust is required to maintain appropriate levels of cleanliness and hygiene in relation to reusable medical devices set out in the Health and Social Care Act 2008, and The code of practice on the prevention and control of infections and related guidance (July 2015) (Ref 4). The Code of Practice provides guidance on how providers can meet this registration requirement, including key recommendations on the provision of a safe decontamination service that generates a clean and sterile product. The Trust has a responsibility to systematically identify, assess and monitor all decontamination processes relating to reusable medical devices, ensuring that they are compliant with required standards and processes. This policy covers the decontamination of reusable medical devices such as surgical instruments and flexible endoscopes and does not address issues of environmental cleanliness or the decontamination of other ‘near-patient’ reusable devices. For further advice refer to The Infection Prevention and Control Team Documents, Infection Prevention & Control This policy promotes a consistent and standardised approach and focuses on embedding and sustaining a culture of best practice across the organisation. Through this the Trust will ensure that a robust programme of audit and review is in place, in order to provide assurance that the required standards are being met. When any deficiencies are identified, immediate remedial action will be taken and robust action plan will be developed and implemented

2.2 Glossary/Definitions

The following terms and acronyms are used within the document:

<table>
<thead>
<tr>
<th>AE(D)</th>
<th>Authorised Engineer Decontamination</th>
</tr>
</thead>
<tbody>
<tr>
<td>AP(D)</td>
<td>Authorised Person Decontamination</td>
</tr>
<tr>
<td>BE ISO</td>
<td>British and European International Standard</td>
</tr>
<tr>
<td>CQC</td>
<td>Care Quality Commission</td>
</tr>
<tr>
<td>EN</td>
<td>European Standard</td>
</tr>
<tr>
<td>HCAI</td>
<td>Healthcare-associated infection</td>
</tr>
<tr>
<td>HSDU</td>
<td>Hospital Sterilisation and Decontamination Unit</td>
</tr>
<tr>
<td>HTM</td>
<td>Health Technical Memorandum</td>
</tr>
<tr>
<td>IP&amp;C</td>
<td>Infection Prevention and Control</td>
</tr>
<tr>
<td>MHRA</td>
<td>Medicines and Healthcare products Regulatory Agency</td>
</tr>
<tr>
<td>NHS</td>
<td>National Health Service</td>
</tr>
</tbody>
</table>
3. Main Policy Content Details

3.1 Duties (Roles and responsibilities)

The Health Technical Memorandum 01-01 (Ref 5), 01-05 (Ref 6) and 01-06 (Ref 7), provide guidance on management and decontamination of reusable medical devices. The reporting structure within the Trust, for decontamination, is outlined in Appendix C. The roles and responsibilities for a range of key officers with responsibility for aspects of decontamination are clearly defined and outlined below:

3.2 Chief Executive

The Chief Executive is the Executive Manager with roles and responsibilities as defined in HTM 01-01, and has ultimate management responsibility for allocation of resources and appointment of personnel for the organisation in which the decontamination equipment is installed.

3.3 Director of Infection Prevention & Control (DIPC) (designated person)

The DIPC is nominated as Decontamination Lead, with roles and responsibilities as defined in HTM 01-01, and has responsibility for decontamination at Board level and reports directly to the Chief Executive. This person is responsible for the effective and technically compliant provision of decontamination services, implementing and monitoring operational policy for decontamination and is responsible for clearly defining the roles and responsibilities of all personnel involved in the use, installation and maintenance of decontamination equipment. The DIPC also has responsibility for chairing the Trust’s Infection Prevention & Control Committee, which oversees the work of the Decontamination Risk Group.

3.4 Hospital Sterilisation and Decontamination Unit/Sterile Services Manager

The Hospital Sterilisation and Decontamination Unit/Sterile Services Manager is the lead for the safe decontamination and management of reusable surgical instruments and is termed the ‘user’ as defined in HTM 01-01.

Associated Decontamination Specialist Policies and Standard Operating Procedures’ are as follows:

- Decontamination of Flexible Endoscopes Policy (Ref 8)
- Quality Management System ISO: 13485 (Ref 9) and associated standard operating procedure/flow charts to demonstrate compliance.

3.5 Trust Equipment Manager

The Trust Equipment Manager is the Specialist Lead for Trust-wide procurement and management of medical devices.

3.6 Lead Nurse Practitioner for Infection Prevention and Control (Including Community Services)

The Lead Nurse Practitioner for Infection Prevention and Control is the Trust wide lead for the monitoring and control of transmissible infections
3.7 Divisional Directors of Nursing /Midwifery/Matrons

Directorate Directors of Nursing /Midwifery Matrons are the Specialist Leads for monitoring cleanliness of environment and medical equipment used at point of care.

3.8 Authorised Person (Decontamination) (AP(D))

A Decontamination Equipment Specialist with adequate technical knowledge and relevant training will be appointed, in writing, as an Authorised Person (Decontamination) (AP (D)) as per HTM 01-01 with responsibilities as set down in HTM 01-01

3.9 Trust Decontamination Equipment Specialists

Trust Decontamination Equipment Specialists have adequate technical knowledge and relevant training and work under the (AP(D))

3.10 External Independent Authorising Engineer (Decontamination) (AE(D))

The AE(D) is designated by management to provide independent auditing, validating and professional advice on all decontamination procedures, washer disinfectors, sterilisers and sterilisation and to review and witness documentation on validation. The AE(D) will assist in the appointment of AP(D)s and their consequent annual assessments.

3.11 Operators

Staff who operate decontamination equipment are nominated as Operators, with roles and responsibilities as defined in HTM 01-01. They must be adequately trained and competent to carry out the task, under the management and supervision of the ‘User’.

3.12 Employees

Employees using Clinical facilities and medical equipment including surgical instruments are responsible for complying with all Trust policy and procedures relating to the management of decontamination and reporting to their line managers any shortfalls that they have identified.

3.13 Target Audience – As indicated on the Cover Page of this Document

The target audience has the responsibility to ensure their compliance with this document by:

- Ensuring any training required is attended and kept up to date.
- Ensuring any competencies required are maintained.
- Co-operating with the development and implementation of policies as part of their normal duties and responsibilities.


There are no special measures required for the purpose of this document.
5. Monitoring Compliance and Effectiveness of Implementation

The arrangements for monitoring compliance are outlined in the table below:

<table>
<thead>
<tr>
<th>Measurable policy objectives</th>
<th>Monitoring audit method</th>
<th>Monitoring responsibility (individual / group /committee)</th>
<th>Frequency of monitoring</th>
<th>Reporting arrangements (committee / group to which monitoring results are presented)</th>
<th>What action will be taken if gaps are identified?</th>
</tr>
</thead>
</table>
| Compliance with the health and social Care Act criterion 1, 2, 6, 9, 10 | This policy | • The Author  
• Infection control forum  
• Infection control committee  
• Decontamination review group (DRGM) meeting | 3 years or sooner if changes are required  
Monthly  
Twice yearly  
Quarterly | Governance Officer Infection Control Committee  
Trust Board Infection Control Committee and Infection Control Forum | Policy review and update by the author |
| HSDU Compliance with ISO13485 MDD 93/42 EEC | Systematic Internal audit against all key components | HSDU quality representative | Annual progress reports via quality report | Monthly progress reported at the internal performance board. | Corrective action plan against any non-conformance identified |
| HSDU Compliance with ISO13485 MDD 93/42 EEC | Systematic External audit against all key components | by SGS UK ltd. | Compliance assessments yearly. Re-certification every 3 years | Quality Governance meeting | Corrective action plan against any non-conformance identified |
| Equipment Management compliance with ISO 9001 | Systematic internal and external audit against relevant components | Trust Equipment team | Rolling programme of audits and annual surveillance | Trust Equipment Group by exception | Corrective action plan against any non-conformance identified |

7 Key Factors for Consideration when Assessing Decontamination Risks

7.1 Definition of a Medical Device

The Department of Health Managing Medical Devices (guidance for Healthcare and Social Services organisations) April 2014 (Ref 10) defines a medical device as “any instrument, apparatus, appliance, material or other article whether used alone or in combination, intended by the manufacturer to be used for human beings for the purpose of: control of conception, diagnosis, prevention, monitoring, treatment or alleviation of disease; diagnosis, monitoring, treatment, alleviation of or compensation for an injury or handicap; investigation, replacement or modification of the anatomy or physiological process'.

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Decontamination of ‘near patient’ medical devices for example, commode chairs, drip stands, dressing trolleys, Blood Pressure cuffs, bedpans are not covered in this policy.

7.2 The Medical Device Decontamination Cycle

The decontamination of reusable medical devices is the combination of processes, which if not correctly undertaken, individually or collectively, may increase the likelihood of micro-organisms being transferred to patients, staff or visitors.

The manufacturers of medical devices give clear instructions on how the reusable product can be safely decontaminated between uses. The users must be able to demonstrate that local cleaning and decontamination procedures comply with this advice and that regular audit of user’s compliance is evident.

**NB** Additional procedures are required for equipment which has been used on patients who have known Creutzfeldt-Jakob disease or Variant Creutzfeldt-Jakob disease Refer to Protection against Infection with Transmissible Spongiform Encephalopathy Agents Policy (Ref 11).

7.1 Level of Decontamination

The level of decontamination required directly relates to the level of risk posed i.e. the degree of contamination, the purpose for which the equipment is to be used and the vulnerability of the patient. The appropriate level and method of decontamination identified by risk assessment will always be supported by the manufacturers’ recommendations for their product.

7.2 Cleaning

This may be done immediately after use with Flexible Endoscopes or within HSDU via manual wash, ultrasonic process or the washer disinfector machine.

It is a process designed to physically remove contamination but does not necessarily destroy microorganisms. The reduction of microbial contamination is not routinely measured and will depend upon many factors, including the efficiency of the cleaning process and the initial bio-burden. Cleaning removes micro-organisms and the organic material on which they thrive

7.3 Disinfection

A process used to reduce the number of viable microorganisms but which may not necessarily inactivate some microbial agents, such as certain viruses and bacterial spores. Disinfection may not achieve the same reduction in microbial contamination levels as sterilisation.

7.4 Sterilisation

Sterilisation - A process used to render an object free from microorganisms including viruses and bacterial spores. Normal sterilisation methods will not destroy prions.

**NB** If there are any queries about either the level of decontamination required or which method is most appropriate it is essential to contact the HSDU Manager.
8. **Equipment Track and Traceability**

8.1 **Surgical Instruments**

There is a need to track and trace reusable surgical instruments throughout their use and reprocessing. This is to avoid instrument migration and is an essential requirement of the HTM 01-01. Records should be maintained for a nationally recognised time frame for all surgical instrument sets (and supplementaries for high-risk procedures) identifying the following:

- The cleaning and sterilization method used
- A record of the decontamination equipment and cycle
- The identity of the person(s) undertaking decontamination at each stage of the cycle
- The patients on whom they have been used and details of the procedures involved.

Each area that is using reusable instruments should have a local procedure available informing staff how to:

- Comply fully with monitoring condition and functionality of the instruments
- Report damaged instruments in need of replacement or repair
- Comply with track and trace of instruments
- Safely store before use and returned to HSDU for reprocessing.

8.2 **Equipment Requiring Inspection, Service or Repair**

Equipment that is sent to the manufacturer for service/repair requires a certificate to confirm whether it has been decontaminated. A decontamination certificate will be provided by HSDU equipment. If a full decontamination procedure has not been carried out, this must be clearly stated on the outer wrapper.

External contractors will have completed a permit to work and a local induction prior to carrying out any work; they will have supplied a ‘method statement’ which will include the decontamination responsibilities for equipment being used.

Ultimately it is the responsibility of users to present equipment to repairers that has been decontaminated, and affixes appropriate labels (this applies internally and externally).

Recipients of equipment for inspection, service or repair which does not have a decontamination certificate attached MUST NOT handle the equipment until the ward/department staff have been contacted to clarify whether the equipment has been decontaminated.

8.3 **Upgrade or Replacement of Medical Equipment**

Equipment management also requires that programmes are developed to upgrade and/or replace any equipment decontamination facilities that do not meet the requirements of current standards and test methods. Any medical device that does not meet best practice decontamination standards must be highlighted on the directorate risk register and an action plan developed to move to best practice if appropriate. Any medical device that does not meet essential decontamination quality requirements must be removed from use.
8.4 Procurement

Before any new reusable medical device is purchased the manufacturer decontamination instructions must be reviewed by the HSDU manager to ensure that it is possible to reprocess: this must be documented, signed and dated on the relevant paperwork.

The Supplies Department, in supporting procurement of instrumentation, will ensure that purchasers are aware of the requirement to check manufacturer’s instructions to enable the product to be processed as required i.e. by sterilisation or disinfection and HSDU are required to approve.

9. Monitoring and Audit

9.1 Surveillance of Healthcare Associated Infection

The lead nurse practitioner for infection prevention and control will ensure that there is a robust structure in place for Surveillance of Healthcare Associated Infection and monitor compliance against agreed targets. Outcomes of this surveillance are discussed at the monthly Infection Prevention and Control (IP&C) meeting where suitable action plans are agreed and progress towards improved practice monitored.

Managers of departments and units will add any significant infection prevention and control risks to the directorate risk registers. Any significant ongoing unresolved risks will be identified and discussed at the Infection Control Committee.

9.2 Audit of Regulatory Requirements in HSDU

HSDU is registered with the Medical Devices Directive 93/42 EEC (Ref 12) and runs a validated quality management system to ISO EN 13485. The Quality Assurance Management System and Operational Policies detail the department’s ability to provide a consistent service that meets the regulatory requirements. The department is also responsible for the repair and maintenance of all surgical instruments (excluding flexible endoscopes) via nominated third party contractors. The department has a robust internal quality management system and is also independently audited once a year by a ‘Notified Body’, SGS UK Ltd, who is appointed by the MHRA. Audit reports identifying non conformity from both internal and external audits and actions taken to improve quality are reported to the HSDU Manager monthly.
10. Review Date, Arrangements and Other Document Details

10.1 Review Date

This document will be fully reviewed every three years in accordance with the Trust’s agreed process for reviewing Trust-wide documents. Changes in practice, to statutory requirements, revised professional or clinical standards and/or local/national directives are to be made as and when the change is identified.

10.2 Regulatory Position

The Health and Social Care Act 2008.
The Code of Practice on the prevention and control of infections and related guidance (July 2015) CQC (Care Quality Commission) regulate the Trusts activity and its right to provide services.
HTM 01-01
HTM 01-05
HTM 01-06
ISO: 13485
MDD 93/42 EEC
Managing Medical Devices (guidance for Healthcare and Social Services organisations) April 2014
European and International Standard (EN ISO) 15223

10.3 References, Further Reading and Links to Other Policies

The following is a list of other policies, procedural documents or guidance documents (internal or external) which employees should refer to for further details:

<table>
<thead>
<tr>
<th>Ref. No.</th>
<th>Document Title</th>
<th>Document Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>European and International Standard (EN ISO) 15223</td>
<td>Available in HSDU</td>
</tr>
<tr>
<td>3</td>
<td>Spaulding scale of classification</td>
<td>Available in HSDU</td>
</tr>
<tr>
<td>5</td>
<td>Department of Health HTM 01-01 management and decontamination of surgical instruments (medical devices) used in acute care.</td>
<td><a href="http://www.gov.uk/dh">www.gov.uk/dh</a></td>
</tr>
<tr>
<td>6</td>
<td>HTM 01-06 Decontamination of Flexible Endoscopes</td>
<td><a href="http://www.gov.uk/dh">www.gov.uk/dh</a></td>
</tr>
<tr>
<td>7</td>
<td>HTM 01-05 Decontamination in primary care dental practices</td>
<td><a href="http://www.gov.uk/dh">www.gov.uk/dh</a></td>
</tr>
<tr>
<td>8</td>
<td>Decontamination of Flexible Endoscopes Policy</td>
<td>Decontamination of Flexible Endoscopes Policy.docx</td>
</tr>
<tr>
<td>9</td>
<td>Quality Management System ISO: 13485</td>
<td>Available in HSDU</td>
</tr>
<tr>
<td>10</td>
<td>Managing Medical Devices (guidance for Healthcare and Social Services organisations) April 2014</td>
<td><a href="http://www.mhra.gov.uk">www.mhra.gov.uk</a></td>
</tr>
<tr>
<td>11</td>
<td>Infection Prevention and Control of CJD and vCJD and other Human Prion Diseases.</td>
<td>Infection Prevention and Control of CJD - vCJD and other Human Prion Diseases</td>
</tr>
</tbody>
</table>
11.4 Consultation Process

The following is a list of consultees in formulating this document and the date that they approved the document:

<table>
<thead>
<tr>
<th>Job Title / Department</th>
<th>Date Consultee Agreed Document Contents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Associate Director for Quality, Safety and Regulation</td>
<td></td>
</tr>
<tr>
<td>Sterile Services Manager – HSDU</td>
<td></td>
</tr>
<tr>
<td>Divisional Directors of Nursing /Midwifery</td>
<td></td>
</tr>
<tr>
<td>Divisional Director – Diagnostics and Outpatients Directorate</td>
<td></td>
</tr>
<tr>
<td>Divisional Director – Planned Care Directorate</td>
<td></td>
</tr>
<tr>
<td>Divisional Director – Unscheduled and Community Care Directorate</td>
<td></td>
</tr>
<tr>
<td>Divisional Director – Woman’s and Children’s Directorate</td>
<td></td>
</tr>
<tr>
<td>Lead Nurse Practitioner for Infection Prevention and Control – Infection Control</td>
<td></td>
</tr>
<tr>
<td>Medical Director and Director of Infection Prevention and Control (DIPC)</td>
<td></td>
</tr>
<tr>
<td>Trust Equipment Manager – Trust Equipment</td>
<td></td>
</tr>
</tbody>
</table>
Appendix A – Equality Impact Assessment
Equality Impact Assessment

Are we Treating Everyone Equally?

Define the document. What is the document about? What outcomes are expected?

Consider if your document/proposal affects any persons (Patients, Employees, Carers, Visitors, Volunteers and Members) with protected characteristics? Back up your considerations by local or national data, service information, audits, complaints and compliments, Friends & Family Test results, Staff Survey, etc.

If an adverse impact is identified what can be done to change this? Are there any barriers? Focus on outcomes and improvements. Plan and create actions that will mitigate against any identified inequalities.

If the document upon assessment is identified as having a positive impact, how can this be shared to maximise the benefits universally?

Our Vision

Working together with our partners in health and social care, we will deliver accessible, personalised and integrated services for local people whether at home, in the community or in hospital empowering people to lead independent and healthier lives.

Protected Characteristics

- Age
- Disability
- Sex
- Sexual Orientation
- Religion or Belief
- Race - including Nationality & Ethnicity
- Pregnancy & Maternity
- Gender Re-assignment
- Marriage & Civil Partnership

Trust Equality and Diversity Objectives

- Better health outcomes for all
- Improved patient access & experience
- Empowered engaged & included staff
- Inclusive leadership at all levels
## Appendix B – Quality Impact Assessment Tool

<table>
<thead>
<tr>
<th>Purpose</th>
<th>To assess the impact of individual policies and procedural documents on the quality of care provided to patients by the Trust both in acute settings and in the community.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Process</td>
<td>The impact assessment is to be completed by the document author. In the case of clinical policies and documents, this should be in consultation with Clinical Leads and other relevant clinician representatives. [Risks identified from the quality impact assessment must be specified on this form and the reasons for acceptance of those risks or mitigation measures explained.]</td>
</tr>
<tr>
<td>Monitoring the Level of Risk</td>
<td>The mitigating actions and level of risk should be monitored by the author of the policy or procedural document or such other specified person. [High Risks must be reported to the relevant Executive Lead.]</td>
</tr>
<tr>
<td>Impact Assessment</td>
<td>Please explain or describe as applicable.</td>
</tr>
</tbody>
</table>

1. Consider the impact that your document will have on our ability to deliver high quality care. \[The policy will ensure that there is an agreed system in place to ensure reusable medical devices including patient equipment is decontaminated in line with the health and Social Care Act 2008 and associated guidance documents and relevant users of the equipment are aware of their responsibilities in the decontamination cycle.\]

2. The impact might be positive (an improvement) or negative (a risk to our ability to deliver high quality care). \[Areas associated with high risk equipment are audited internally and externally against a documented internal quality management system in line with ISO 13485. Any non-conformances identified have an appropriate associated corrective action plan in place.\]

3. Consider the overall service - for example: compromise in one area may be mitigated by higher standard of care overall. \[Where adequate decontamination cannot be provided at point of use the hospital provides a central decontamination service or will contract this service out to a third party provider if the central service is unable to support this.\]

4. Where you identify a risk, you must include identify the mitigating actions you will put in place. Specify who the lead for this risk is. \[Risks associated with equipment are also identified via the Trusts directorate risk registers. Designated leads are appointed by the directorate general managers\]

### Impact on Clinical Effectiveness & Patient Safety

5. Describe the impact of the document on clinical effectiveness. Consider issues such as our ability to deliver safe care; our ability to deliver effective care; and our ability to prevent avoidable harm. \[This policy will ensure there is guidance for managers to ensure systems are in place to monitor the prevention and control of infection. The systems use risk assessment and consider how susceptible service users are and any risk that their environment and other users may pose to them.\]

### Impact on Patient & Carer Experience

6. Describe the impact of the policy or procedural document on patient / carer experience. Consider issues such as our ability to treat patients with dignity and respect; our ability to deliver an efficient service; our ability to deliver personalised care; and our ability to care for patients in an appropriate physical environment. \[Ensuring there is adequate controls in place to minimise risks of infection being transmitted between patients and staff. \[Provision of services that are able to support the appropriate decontamination of medium and high risk medical equipment through automated processes and ensure equipment is available to clinical staff when needed without delay to the services provided.\]

### Impact on Inequalities

7. Describe the impact of the document on inequalities in our community. Consider whether the document will have a differential impact on certain groups of patients (such as those with a hearing impairment or those where English is not their first language). \[There are no know inequalities within this document\]

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Appendix C – Decontamination Responsibilities Structure

Chief Executive

Medical Director and Director of Infection Prevention and Control (Decontamination Lead)

Associate Medical Directors

Associate Director of Quality & Patient Safety

Director of Finance and Performance

Director of Estates and Facilities Responsible for Environmental Cleanliness

Directorate Heads of Nursing /Midwifery/DGM Responsible for Environmental Cleanliness

Associate Director of Quality & Patient Safety

General Manager for Directorate

Lead Nurse Practitioner for Infection Prevention and Control Responsible for Monitoring and controlling the transmission of infections affecting staff, patients, and visitors

Trust Equipment Management – Responsible for Management of medical devices

HSDU Manager Responsible for Decontamination and management of reusable surgical instruments. Ensuring all Trust automated decontamination equipment is compliant.

General Manager for Directorate

General Manager for Directorate

General Manager for Directorate

Deputy Director of Estates and Facilities

Deputy Director of Estates and Facilities

Deputy Director of Estates and Facilities

Ward/Department Managers

Service Department Leads

Matrons

All Medical, Nursing and Midwifery “users” are Responsible for Environmental Cleanliness in patient areas including medical equipment ensuring decontamination is in line with trust policy and manufacturer’s instructions.

Tasks Performed by Cleaning contractors and Trust cleaning staff

Cleaning contract with Carillion Trust staff

Policy Cleaning Strategy GWH Strategic Cleaning Plan Community (to be updated)
Update must identify audit process and compliance monitoring and reporting process

Policy Management of reusable surgical instruments policy (To be developed)
Accredited dep. Audited annually by external auditor

Policy Medical equipment management policies
Accredited dep. Audited annually by external auditor

Policy IP&C policies

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