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Author/Contact: (Asset Administrator)	Julie E Slater, Theatre Sister (Governance)		
Hospital Sites: (tick appropriate box/es to indicate status of policy review i.e. joint/ independent)	✓MEHT □ BTUH □ SUH		
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Approval Group / Committee(s):	n/a	**Date:**	n/a
Professionally Approved by: (Asset Owner)	Tom Gudde, Service Manager Theatres	**Date:**	3rd July 2019
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Executive and Clinical Directors (Communication of minutes from Document Ratification Group	**Date:** July 2019	**Distribution Method:**	Intranet & Website

Consulted With:	Post/ Approval Committee/ Group:	Date:
Wendy Matthews	Director of Nursing	18th June 2019
Deborah Lepley	Warner Library	19th June 2019

Related Trust Policies (to be read in conjunction with)	Infection Prevention Policy Theatre Policies Sharps Policy Waste Management Policy Safe Handling of Specimens in Theatre Policy

Document Review History:			
Version No:	**Authored/Reviewer:**	**Summary of amendments/ Record documents superseded by:**	**Issue Date:**
1.0	Julie Slater		2010
2.0	Julie Slater		Sept 2013
2.1	Julie Slater	Paragraph 8.2	February 2015
2.2	Julie Slater	Paragraph 8.6 and 9.1	May 2015
3.0	Julie Slater		26 July 2016
3.1	Julie Slater	Amendments to 9.1, 11.3 and App added	May 2017
3.2	Julie Slater	Amendments to 7.4, 7.5, 8.3 App 2 added	26 Sept 2017
3.3	Julie Slater	Amendments to 7.3 and App 3 added J Slater	7 July 2018
4.0	Julie Slater	Full Review	12th July 2019
4.1	Julie Slater	Additional Appendix 6 & 7; referenced in point 8.4 & 9.0	8th October 2019
4.2	Julie Slater	Addition to point 7.5; bullet point 3 & Appendix 8	9th December 2019
4.3	Julie Slater	Addition to point 8.3.2	17th December 2019
4.4	Julie Slater	Amendment to points 8.6 & 8.7	21st February 2020

Index

1.0 Purpose

1.1 To provide guidance and recommendations of practice to ensure competence as a skilled and trained scrub practitioner.

2.0 Aims

2.1 To ensure that the scrub practitioner maintains control of the sterile field.

2.2 To ensure the patient is safe during the operative procedure.

2.3 To ensure that the equipment and supplementaries are managed safely.

2.4 To anticipate the needs of the surgeon and have knowledge of the procedure that is being performed.

2.5 To manage the safe care and transfer of the patient into and out of the Operating theatre.

2.6 To ensure that the equipment required is managed safely.

2.7 To ensure that all patients care is accurately documented.

2.8 To ensure that any specimens taken are accurately documented and all paperwork and signatures are completed.

3.0 Scope

3.1 This policy applies to all staff that provide skilled assistance as a scrub practitioner throughout the preoperative and operative stage of the operative procedure.

4.0 Scrub Practitioner Role

4.1 The role of a Scrub Practitioner is to ensure that each patient receives individualised patient care and perform as an assistant to the Operating surgeon by providing the necessary skill to anticipate the surgeon’s specific needs.

5.0 Staff and Training

5.1 Staff who perform in the role of the scrub practitioner must achieve the competencies defined by the Association of Perioperative Practitioners (2016).

5.2 Staff will be accompanied by a mentor until they have provided documented evidence of competence.

5.3 All staff are required to have signed off competencies and be assessed at annual appraisal. ISS0 9001:2008 regulates staff competence.

6.0 Duties and Responsibilities

6.1 The scrub practitioner is responsible for the care of the patient during the operative procedure.

6.2 Duties are:

- To perform the swab, needle and instrument checks as per policy;
- To manage the safe handling and recording of all specimens according to the surgeons specification;
- To ensure the safe disposal of all sharps as per Trust policy;
- To ensure the safe management of all equipment;
- To ensure the safe disposal of all clinical waste as per Trust policy;
- To accurately record the operative procedure according to the direction of the operating surgeon;
- To ensure the patient is managed safely whilst in the Theatre Department;
- To ensure the privacy and dignity of patients is maintained at all times.

7.0 Before Procedure

7.1 Theatres must be checked and all equipment that is required for the operative procedure must be available.

7.2 Theatre scrub personnel must scrub, gown, and glove as per Association of Perioperative practitioners guidelines that are used within this department.

7.3 After each case the Scrub Nurse is required to follow the recommended guidelines for scrubbing and gowning. It is not accepted practice to use alcohol solution alone to decontaminate the hands between procedures once the initial 5 minute scrub has taken place at the commencement of the list .Staff training supports that further hand washing following AFPPGuidelines must take place.(appendix 3)

74 Equipment and trolleys must be prepared maintaining aseptic technique.

7.5 Prior to the start of the Operating Theatre List all staff concerned with the list are required to be present in the allocated theatre for a team brief (WHO Safe Surgery Checklist 2018). At this time the staff discusses as a team and agrees the requirements for the surgical list. At this point any concerns from the team re the Proposed surgical list may be discussed. Any prosthesis that have been identified as required are agreed prior to the commencement of the procedure:

- All staff must undertake the trusts mandatory training for orthopaedic implant checks.
- An implant check sheet must be completed for each procedure. (Refer to Appendix 4)
- Where skin grafting and meshing is required as part of the operative procedure staff must have the skills required (See Appendix 8).

7.6 Side and site of surgery to be clearly marked and agreed before commencement of surgery.

7.7 Swabs, needles and accessories must be counted and documented as per Trust procedure.

7.8 Consent form and care plan must be checked and the WHO Safe Surgery Checklist (2018)adhered to.

7.9 Patients must be transferred and positioned on the operating table and the Risk assessment tool used to identify that patients are positioned correctly.

7.10 Positioning of the diathermy plate must be checked by the scrub practitioner as being correctly and safely positioned.

7.11 Time Out (WHO Safe Surgery Checklist 2018) is undertaken before commencing the procedure for which you are scrubbed. At this point there is a pause before surgery is commenced so that staff present can confirm with the surgical team and the Anaesthetist the surgery that is to be undertaken.(This happens for each individual patient). The scrub practitioner must not hand any instruments to the surgeon until this has been agreed.

7.11 All staff agree with the operating team the patient's operative procedure is correct and that the site for surgery is correct. The Scrub Practioner must not hand any instruments to the surgeon until this has been agreed. (WHO Safe Surgery Checklist 2018)

8.0 During Procedure

8.1 Maintain control of sterile blades and all needles, swabs and instruments throughout the operation.

8.2 The scrubbed practitioner must ensure that all swabs, needles, blades and any other supplementary that may be requested is accurately recorded on the Theatre White Board.

8.3 Ensure that any additional prosthesis including all implants and mesh are checked with the operating surgeon prior to being opened. The team that are involved with the operative procedure must pause whilst this is done. At this time the scrub nurse confirms the item requested as well as the sterility. The Operating surgeon must then agree the implant with the scrub practitioner before the pack is opened. This must be checked against the patients notes. To include name , date of birth and hospital number.

8.3.1 The operating surgeon must pause and check the specifications that are written on the outside packaging and confirm the prosthesis is correct before proceeding.

8.3.2 If any additional packs are required that are relevant to the speciality then the operating surgeon is responsible for ensuring that they check the packs that are required. The specifications are agreed by the surgeon. The size is verbalised with

the circulating practitioner (including the width and length) and that the details are then documented in the patient's notes.

8.4 Pass any specimens to the circulating nurse and check that they are placed in the correct containers and labelled correctly. All details of the specimen to be checked with the Operating Surgeon. Patients details to be agreed. Patient's details are to be documented onto the specimen form and the label using the patient's notes for verification.
(Refer to Appendix 6)

8.5 It is mandatory that a two way count is carried out with the circulating practitioner. Counts must be audible between the scrubbed practitioner and the circulating practitioner. Before the operation closure of the layers (peritoneum, fascia, skin).

8.6 Throughout the operation regular swab counts are advisable. Once the final count has been agreed as accurate and confirmed with the operating surgeon the scrub practitioner is responsible for ensuring that all swabs are then counted into a plastic bag (this additional count is to ensure that nothing has been removed following the agreed final count) the swabs are then placed in the clinical waste for disposal.

8.7 The instrument trolley is then removed from the operative area. It is the scrubbed practitioner's responsibility to ensure that the set is correctly prepared for safe transfer to Sterile Services.

8.8 If there is an item missing from the scrub practitioner's count then they must stop the operation and report to the surgeon and follow protocol for incorrect count.

8.9 If there is a need for the scrub practitioner to change over during a procedure then the following instructions must be undertaken.

- The operating surgeon must be informed that this is about to happen.
- The WHO Check from Time Out is implemented and includes the whole team in Theatre.
- The scrub practitioner ensures that all of her swab, needle and instrument counts are completed with the person taking over. The circulating nurse must be part of this to ensure that the whole team responsible for the swab, needle and instrument count are included.
- This count must include all supplementaries and any additional single use items. These should all be recorded on the white theatre board.

9.0 After Procedure

9.1 At the end of the operative procedure the scrub nurse is responsible for:

- Discarding all clinical waste including sharps, swabs and all single use items from their trolley, ensuring that all instruments are accounted for ready for safe wrapping and transfer to the sterile services department;
- Ensuring that the patient's wound is dressed using aseptic technique to clean wound and apply dressing;

- Ensuring that the patient is transferred safely from the operating table to the patients bed and through to the Recovery area;
- Ensuring that all details of the patient's procedure and post care management is handed over to the Recovery person;
- Recording the patients operation formally onto the operating register
- Completing records onto Theatreman;
- Ensuring that the all specimens are accurately managed and recorded as per 09092 Safe Handling of Specimens in Theatre Policy;
- Ensure that all scantrack labels are present for Sets used;
- Ensure that all prosthesis and implants are accurately recorded in the patient's notes. A copy of the sticker identifying the prosthesis/implant must be recorded on the Theatre Care Plan and this must be handed over to Recovery on transfer of the patients care.
- Ensure that all dressings and packs are recorded on the Theatre Care Plan and form part of the handover to recovery.If a pack is put in at the end of the procedure then these must be accurately documented.
  (Refer to Appendix 7)

9.2 Before the patient leaves the operating theatre a debrief must be undertaken with the theatre team (WHO Safe Surgery Checklist 2018). This is to ensure that those staff present agrees the procedure that has been undertaken and that all the relevant care is accurately documented for handover to the recovery and ward staff. Any specimens that have been taken are agreed and the specimens are accurately managed and recorded. The specimen forms are signed by the operating surgeon as per 09092 Safe handling of Specimens in Theatre Policy.

10.0 Breach Reporting

10.1 Where an adverse incident occurs, this must be reported as per the Trust's Incident Policy. All adverse incidents that harm, or have potential to harm patients or staff, must be reported on a risk event form.

11.0 Audit and Monitoring

11.1 Completion of WHO checks within Theatreman are audited regularly for Theatres to ensure they have been documented. Where this has not been completed, staffs concerned are notified. WHO Audits are carried out in Theatres; reports are compiled, and reported to senior management.

11.2 Internal ISO quality audits identify where deviation from internal policies and procedures occur so these can be addressed. Internal audits are managed by an ISO Manager to ensure that the Theatre department is compliant.

11.3 A monthly Audit is undertaken in Orthopaedic Theatres for Prosthetics
(Refer to Appendix 1)

11.4 External auditors will be monitoring Theatres standards against ISO 9001:2008

11.5 Trust CQC Checks are carried out by a nominated Trust lead nurse or equivalent and these are reported back via the Trust Monitoring standards. Any failures are reported and must be addressed with immediate effect.

11.6 Monthly governance meetings are held for this directorate and attended by Trust governance representatives.

12.0 Implementation and Communication

12.1 Governance will upload the ratified policy to the website and the intranet and notify all staff in Focus.

12.2 The document author is responsible for ensuring that locally within Theatres, all staff are notified of this document.

2.0 Equality Impact Assessment

2.1 Mid Essex Hospital Services NHS Trust is committed to the provision of a service that is fair, accessible and meets the needs of all individuals.
(Refer to Appendix 5)

13.0 References

NICE Clinical Guidelines 2008. Nice Clinical Guideline 74 Guidance.nice.org.uk/74.

WHO Safe Surgery Guidelines. (2018)

AFPP Guidelines: Surgical Handwashing Gowning and Gloving.

5 Steps to Safer Surgery 2010 NHS National Patient Safety Agency (December 2010)

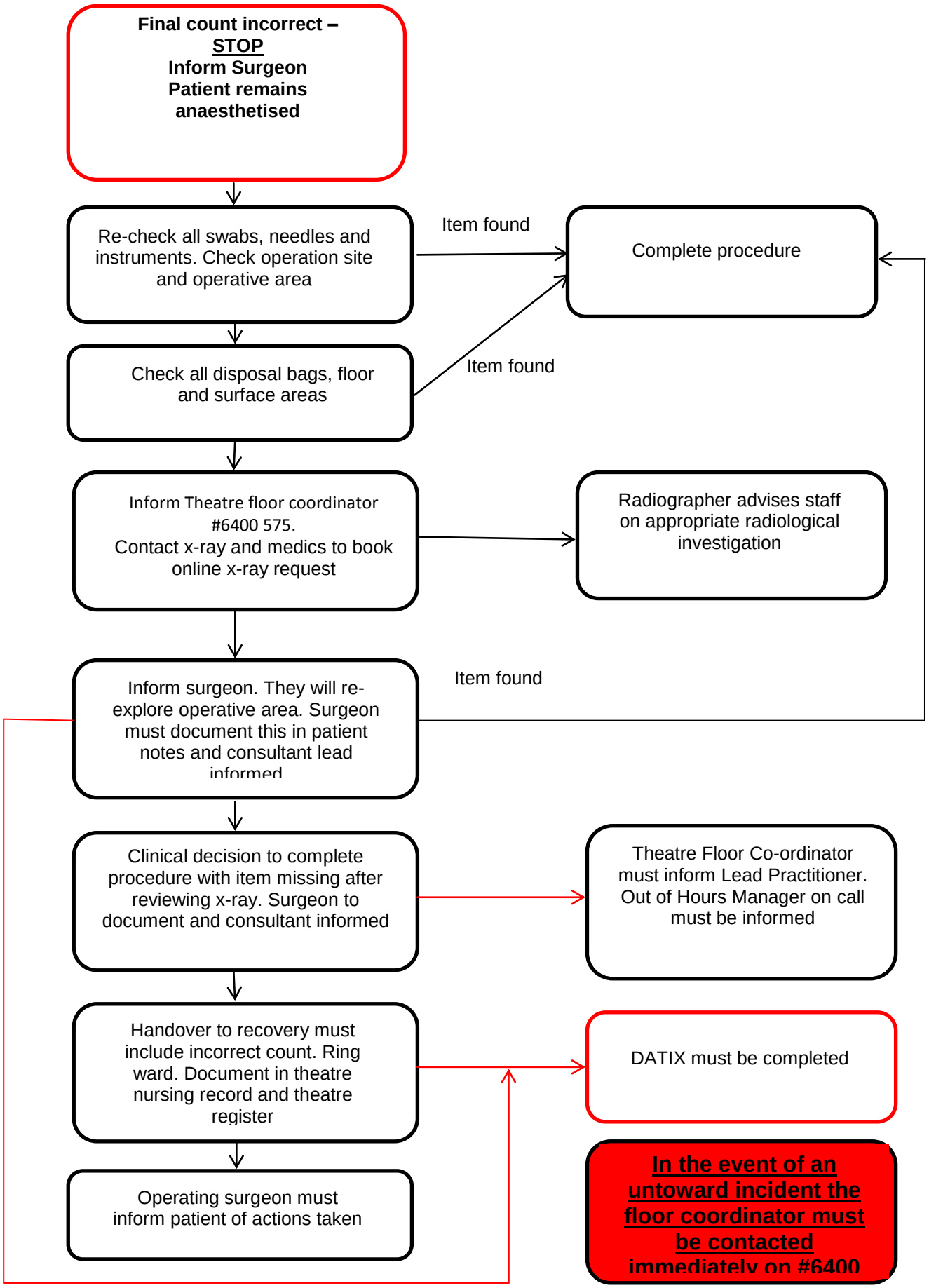
AFPP Standards: Recommendation for Safe Perioperative Practice (2016)

Appendix 1

Orthopaedic Audit

Date, Theatre and Case no.				
Surgical Pause				
Prosthesis check against side and consent				
All staff Agreed				
NJR checked by Surgeon post op				

Incorrect Swab/Sharps/Instrument Procedure



Appendix 3

Surgical Hand Antisepsis

References

AfPP 2007 **Standards and Recommendations for Safe Perioperative Practice** 2nd edn Association for Perioperative Practitioners, Harrogate

Al-Naami MY, Anjum MN, Afzal MF, Al-Yami MS, Al-Qahtani SM, Al-Dohayan AD, El-Tinay OFY, Karim AAA, Khairy GA, Al-Saif AA, Zubaidi AM, Al-Obaid OA, Al-Saif FA 2009 Alcohol-based hand-rub versus traditional surgical scrub and the risk of surgical site infection: a randomized controlled equivalent trial **EWMA Journal** 9 (3) 5-10

Arrowsmith VA, Maunder JA, Taylor R, Sargent RJ 2001 Removal of nail polish and finger rings to prevent surgical infection **Cochrane Database of Systematic Reviews**

Ayliffe G, Lowbury E, Geddes A, Williams J 2000 **Control of Hospital Infection: A practical handbook** 4th edn Arnold, London

Centar for Disease Control 2002 **Guideline for Hand Hygiene in Health-Care Settings: Recommendations of the Healthcare Infection Control Practices Advisory Committee and the HICPAC/SHEA/APIC/IDSA Hand Hygiene Task Force Center for Disease Control and Prevention** Atlanta, Georgia

Marchand R, Thaoret S, Dion D, Pellerin M 2008 Clinical implementation of a scrubless chlorhexidine/ethanol pre-operative surgical hand rub **Canadian Operating Room Nursing Journal** 26 (2) 21-2, 26, 29-31

Paulson DS 2004 Hand scrub products - performance requirements versus clinical relevance **AORN Journal** 80 (2) 225-8, 230-1, 233-4

Patterwood J, Shridhar V 2009 Water conservation in surgery: a comparison of two surgical scrub techniques demonstrating the amount of water saved using a 'taps on/taps off' technique **Australian Journal of Rural Health** 17 (4) 214-7

Somner JEA, Stone N, Koukkoulli A, Scott KM, Field AR, Zygmunt J 2008 Surgical scrubbing: can we clean up our carbon footprints by washing our hands? **Journal of Hospital Infection** 70 (3) 212-215

Tanner J, Khan O, Walsh S, Chernova J, Lamont S, Laurant T 2009 Brushes and picks used on nails during the surgical scrub to reduce bacteria: a randomised trial **Journal of Hospital Infection** 71 (3) 234-238

Tanner J, Swarbrook S, Stuart J 2008 Surgical hand antisepsis to reduce surgical site infection **Cochrane Database of Systematic Reviews**

Surgical Hand Antisepsis

Hand washing and surgical hand antisepsis are two different activities. The distinction between hand washing and surgical hand antisepsis is defined as follows:

Hand washing is decontamination of the hands by one of two methods; hand washing with either an antimicrobial or plain soap and water, or use of an antiseptic hand rub (AORN 2008).

Surgical hand antisepsis is an extension of hand washing (AfPP 2007). It is also defined as: the antiseptic surgical scrub or antiseptic hand rubs performed before donning sterile attire preoperatively (AORN 2008). The aim is to both reduce the number of resident and transient flora to a minimum but also to inhibit their re-growth for as long as possible, not just on the hands but also on the wrists and forearms (AfPP 2007).

This poster presents a guide to surgical hand antisepsis.

The Association for Perioperative Practice acknowledges the contribution of Allyson Lipp, Principal Lecturer, University of Glamorgan, Pontypridd in formulating this guidance.

References

Association for Perioperative Practice 2007 **Standards and Recommendations for Safe Perioperative Practice** Harrogate, AFPP

Association of perriOperative Room Nurses 2008 **Perioperative Standards and Recommended Practices** Denver AORN

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Surgical Hand Antisepsis

Purpose

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

Preparation

Nail varnish, false nails, rings, watches and bracelets should be removed. Expert opinion proposes that this type of accessory is likely to harbour pathogenic organisms which could contaminate surgically scrubbed hands and arms. A systematic review by Arrowsmith et al (2001) found no randomised controlled trials (RCTs) that compared the wearing of rings versus no rings. They found one small RCT comparing the use of nail polish which measured the number of colony forming units (CFUs) of microorganisms following surgical scrub and found there was no significant difference between those wearing and not wearing nail polish.

Expert opinion asserts that hair, mask (if worn) and attire should be comfortable, safe and unlikely to need adjustment after the scrub procedure thus avoiding potential contamination.

Procedure

Nail picks are recommended in UK theatre practice but scrubbing brushes are no longer deemed to be necessary especially for use on skin (AfPP 2007). Until recently brushes were advocated to commence the procedure in US literature (CDC 2002); hence the outdated term of 'scrubbing' which lingers on. The use of nail picks and brushes have been called into question in a recent randomised controlled trial by Tanner et al (2009) which showed no difference in the amount of colony forming units in the glove juice between those practitioners who used chlorhexidine alone, chlorhexidine plus nail pick and chlorhexidine plus nail brush. The study was relatively small and despite a power calculation failed to demonstrate statistical significance. Therefore it would benefit from replication.

Products

Any surgical antiseptic should have four main properties (CDC 2002):

1. *Antimicrobial activity* – this should include destruction of a broad spectrum of pathogenic organisms.
2. *Persistent activity* – the antimicrobial agent should be long lasting especially for longer cases.
3. *Safety* – the agent should be safe for the skin and eyes of the person using it, as well as being non-irritating and sensitising. The environment also needs to be considered as the agent may have long term harmful effects.
4. *Acceptance* – this is a more subtle characteristic which may include colour, smell and feel and is required for antiseptic uptake by the surgical team. Acceptance should not be underestimated.

Three types of antiseptic solutions are available (Tanner et al 2008):

1. *Aqueous scrubs* – usually contain chlorhexidine gluconate or povidone iodine. Using aqueous solutions require a surgical scrub (see 'process' section).
2. *Alcohol rubs* – three main types of alcohol ethanol, isopropanol and n-propanol. This involves rubbing the alcohol solution into the hands systematically following removal of visible soiling or a preliminary handwash.
3. *Alcohol rubs containing additional active ingredients* – these include chlorhexidine gluconate, iodophors, biguanides and phenolic compounds such as hexachlorophene and triclosan.

Proof (evidence)

Alcohol hand rubs are gaining popularity as surgical scrub replacement as they save time, water and money. Surgical site infections (SSI) in a Saudi randomised controlled equivalent trial of 500 patients undergoing clean and clean/contaminated surgery showed 8 (2.94%) patients in the traditional surgical scrub compared to 12 (5.3%) in the alcohol-based hand rub (following an initial scrub when commencing the surgical list) (Al-Naami et al 2009). The authors claimed that alcohol hand rub was as effective and was preferred by the surgeons. A one year retrospective analysis of cardiac surgery infection rates in a Canadian theatre showed comparable infection rates between the two methods (Marchand et al 2008). Sixty nine SSIs in 2,084 operations (3.31%) with standard scrub compared to 78 SSIs in 2,175 operations (3.59%). The study also showed high compliance, acceptability as well as cost savings.

The reader is directed to a paper on scrub products' performance requirements compared to their clinical relevance for more detail on the efficacy of surgical scrubs (Paulson 2004). In reality there will be a limited number of products available for surgical scrub from the hospital pharmacy. It is anticipated that the products will comply with safety requirements.

A systematic review that examined surgical hand antisepsis to reduce SSIs found only one RCT which compared a surgical scrub with an alcohol rub and this demonstrated equivalence in the number of SSIs between the groups (Tanner et al. 2008). The other nine trials included in the review measured hand contamination rather than SSI. Three RCTs which compared aqueous surgical scrubs showed that aqueous chlorhexidine gluconate is significantly more effective than povidone iodine in reducing CFUs, but this cannot be extrapolated into a reduction in SSIs (Tanner et al. 2008).

Duration of the scrub procedure was also included in the review. The evidence was based on CFUs not SSIs and centres around two to three minutes with AfPP recommending a timed two minute scrub (AfPP 2007).

Protecting the environment

Many theatres are now equipped with electronic sensors ensuring that water flows only when required. A study by Potterwood and Shridhar (2009) examined the amount of water used in a five minute 'taps on' scrub (15L) compared to a 'taps off' scrub (4.5L). Turning the taps off intermittently showed a saving of 11L or 71%. This study was undertaken in Australia where the drought imperative stimulated the research. It confirmed the findings of a similar study by Sommer et al (2008). The take home message is that expensive equipment is not necessary and the use of mixer taps with knee/foot controls will save money and help the environment.

Dispensers should be checked to ensure that they deliver the correct amount of the product according to the manufacturers' recommendations. Overuse of surgical scrub will not result in greater effectiveness and over time it may cause irritation and will be costly to the organisation and the environment. Partially empty dispensers should not be 'topped up' as contamination may occur (CDC 2002).

Process

Each step of surgical 'scrubbing' consists of five strokes rubbing backwards and forwards and adapts Ayliffe's six step technique (Ayliffe et al 2000) into eight steps. Sources of evidence drawn on include AfPP's Standards and Recommendations for Safe Perioperative Practice (AfPP 2007), AORN's recommended practices (Paulson 2004), and Ayliffe's six step hand washing technique (Ayliffe et al 2000).

Step 1 (pre-scrub/pre wash)

- Wash hands and arms with running water and an antimicrobial solution or plain soap
- Remove debris from under nails using a nail pick
- Rinse hands and arms
- During each of the following steps keep hands above elbows allowing water to drain away
- Avoid splashing surgical attire.

Step 2

Apply an amount of surgical scrub product recommended by the manufacturer. Work into hands palm to palm and continue with rotating action down opposing arms working to just below the elbows.

Step 3

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

Step 4

Rub palm to palm, fingers interlaced.

Step 5

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

Step 6

Rub left palm with clasped fingers of right hand and vice versa.

Step 7

Once more rotate down the arm with opposing hand working to just below the elbow.

Rinse and repeat steps 2-7 keeping hands above elbows at all times.

Step 8

Rinse hands under running water.

Dry thoroughly using one (or one side of a) sterile paper hand towel for each hand, rotating down hands to elbows before discarding.

Application of alcohol hand rub

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

Appendix 4 Orthopaedic Prosthesis Checklists

Total Knee Replacement / Partial knee

Patient name: Date :

Side:

Type: CR / PS / Oxinium / Partial Knee / PFJ / Legion Other

Femur:
Tibia:
Insert:
Patella:
THR
Patient name:
Date : Side:
Type: Cemented / hybrid / un-cemented Other:

Shell:
Liner:
Head:
Stem:
Screw:
Other:

Total Hip Replacement.

Patient name:

Date :

Side:

Type: Cemented / hybrid / un-cemented Other:

Shell:
Liner:
Head:
Stem:
Screw:
Other:

Total Shoulder Replacement.

Patient name:

Date:

Side:

Type: Reverse/Anatomical.

Stem:
Glenoid:
Glenoid Base Plate:
Glenosphere Head:
Insert:
Other:

Appendix 5: Preliminary Equality Analysis

This assessment relates to: Duties of a Scrub Practitioner (10032)

A change in a service to patients		A change to an existing policy	X	A change to the way staff work	
A new policy		Something else (please give details)			

Questions	Answers
1. What are you proposing to change?	Full Review
2. Why are you making this change? (What will the change achieve?)	3 year review
3. Who benefits from this change and how?	Patients and clinicians
4. **Is anyone likely to suffer any negative impact as a result of this change?** If **no**, please record reasons here and sign and date this assessment. If **yes**, please complete a full EIA.	No
5. a) Will you be undertaking any consultation as part of this change? **b) If so, with whom?**	Refer to pages 1 and 2

Preliminary analysis completed by:

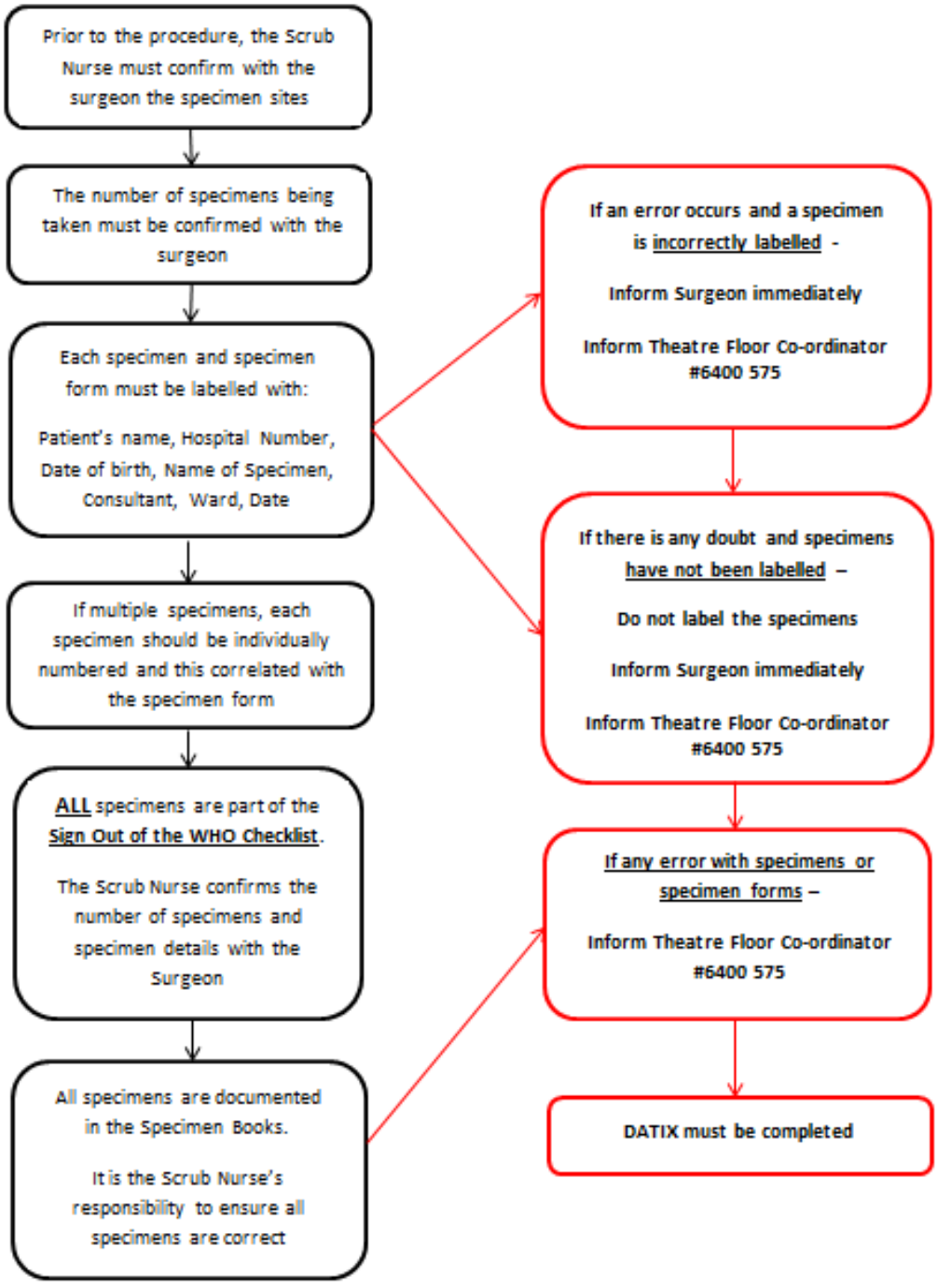
Name	Julie E Slater	**Job Title**	Theatre Sister (Governance)	**Date**	June 2019

Appendix 6: Specimen Handling Procedure

Band 7 Team 05/10/17

NHS Mid and South Essex University Hospitals Group

Specimen Handling Procedure



Appendix 7

Retained packs at the end of an operative Procedure

- If packs/Swabs are to be left inside the cavity for any reason the Surgeon must inform the scrub nurse before the closure. The scrub nurse must acknowledge that they have heard this and record this retained swab on the dry wipe board clearly stating the number and size of swab inside the patient separately to the main count.

- It is the responsibility of the named Scrub nurse/ surgeon to ensure that documentation after completion of the count is recorded accurately in the relevant documentation (Orange sticker, the op sheet, Theatre care plan, Theatre man comment box and the bracelet).

- Any intentionally retained packs should be clearly described and must be recorded in the relevant documentation .Explaining the number, size, type of swab and exact location. It must state when this pack should be removed. This is the responsibility of the surgeon making this decision.

-Safety alert label should be attached to the surgeon's operation notes and documented in red in the Theatre nursing care plan.

-Make sure the Bracelet are filled in CAPITAL, legible and all the counts are documented.

-Any retained items must be communicated when the patient is transferred and awake. The patient should be informed of any intentionally retained packs, the reason for the -retention and when to expect them to be removed.

-On removal the packs must be opened up fully to ensure they are complete and to confirm -the number retained. Preferably use packs with strings. This should tally the document and the orange sticker and the Bracelet. Bracelet must be removed and must be documented in operation notes and theatre care plan.

Appendix 8

Management of Skin Graft

Management of Skin Graft:

- Competency must be achieved in the following.
- Equipment that is required.
- Specific to split skin grafting. Large amounts of skin to be stored in the steel tray provided and labelled with mesh size as appropriate.
- Smaller amounts autograft, the wooden board must be used as a place of safety and
  this must be covered by a damp swab (in all cases where a damp swab is covering the wooden board, means there is a skin graft present).
- All skin grafts that are taken must be included on the white board and crossed through once used/discarded.