University Hospitals of Morecambe Bay NHS Foundation Trust

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Document Title: **Local Safety Standards for Invasive Procedures (LocSsips) for:** **4 Steps For Patient Safety for Cardiac Catheter Lab**	**Version Number:** 1 **Status:** Ratified
Scope: Multi-Disciplinary Teams that are involved in the patients' interventional procedure episode	**Classification:** Departmental
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Replaces: New	**Head of Department:** Sarah Hunter Ward Manager MBCC
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Which Principles of the NHS Constitution Apply? 1,2,3,4	**Which Staff Pledges of the NHS Constitution Apply?** 1,2,3
Does this document meet the requirements of the Equality Act 2010 in relation to Race, Religion and Belief, Age, Disability, Gender, Sexual Orientation, Gender Identity, Pregnancy & Maternity, Marriage and Civil Partnership, Carers, Human Rights and Social Economic Deprivation discrimination? **Yes**	
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Reference Check Not applicable. Joanne Shawcross 12/8/16 **To be completed by Library and Knowledge Services Staff**	

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1. SUMMARY

Delivering patient care through a process of logical, timed and co-ordinated safety standards provides a quality framework for all patients who undergo interventional procedures at UHMB. The safety standards in this LocSsip (Local Standards Safety for Interventional Procedures) document are for teams to apply and use with the safety checklist/s when undertaking interventional procedures. When used together the LocSsip and Checklist provide a quality framework of safety standards for interventional procedures which work towards eliminating '**never events'**.

Harm free and compassionate care is a fundamental element of the University Hospital Morecambe Bay (UHMB) vision. All healthcare staff who participates in a patients' journey have a common goal which is to prevent harm and deliver safe patient care to the highest standards.
A wrong interventional procedure, or the incorrect patient, or the wrong anatomical site is rare. However, should any of these untoward events occur, experience has shown that they have a devastating impact on both patient and staff, which could affect the patient outcome.

The standards within this document have been developed to reduce the likelihood of these occurrences known as '**never events'**. Working in harmony with the principles of the World Health Organisation (W.H.O.) checklist they facilitate teams in delivering consistently high safe standards of patient care.
Further benefits of delivering care through these standards and the checklist process supports:

- Effective team communication and team harmony,
- A Systematic process for verification of the correct patient,
- An assurance that the correct procedure is consented for ,
- An assurance that (if applicable) that the correct site procedure occurs,
- Correct insertion of the right implant or device occurs,
- Specimens are verified, which ensures correct patient diagnosis.
- An opportunity to reflect and continuously improve at local level.

Audit, benchmarking, feedback and an open learning culture are crucial elements to successful and effective procedural teams. Procedural teams at UHMB through undertaking qualitative and quality audits will provide a mechanism to measure, benchmark, learn and improve from.

2. PURPOSE

The purpose of the UHMB Safe Standards for Interventional Procedures is to foster a Safety Culture by ensuring patient safety through universal best practice The 'LocSsips' in this document with robust use and adherence to the 'Time Out' Checklist ensures consistent, safe, and effective care for all patients undergoing an interventional procedure.

3. SCOPE

LocSsips are to be embedded in the culture and are crucial standards that must be applied consistently for all patients who attend for an interventional procedure across all the Trusts hospital sites. UHMB requires that **all staff** who are involved in the clinical interventional pathway embrace and participate in :-

- Safety Briefings
- Sign in
- Time out
- Sign out
- Debriefs

.

The Procedural team leader for the list should ensure a hard paper copy of the checklist is completed and retained in the patient notes as a mandatory standard of record keeping and to ensure it is available for audit.

4. PROCEDURE

4.1 4 Steps For Patient Safety for Cardiac Catheter Lab

4.1 <u>STEP 1</u> List Safety Briefing

- Prior to commencement of any elective, procedural list a ‘Safety Briefing’ which involves key members of the team as a minimum (ideally all the team) must take place.
- The purpose of the brief is to discuss the sessions’ list schedule of planned interventional procedures.
- The area used should be quiet and free from interruptions.
- The brief may be led by any designated member of the team
- All staff members of the procedural team are named for the session and roles identified.
- The procedural list must be visible throughout the session for staff in all areas involved in the procedural list. (This includes holding areas for patients)
- Any anticipated milestones or challenges must be considered, and plans put in place if necessary.
- Equipment checks should have already been performed and any issues highlighted, and actions put in place to address if required.
- Procedures involving implantation of devices must be discussed and availability of devices verified for the list, the list operator must confirm that they approve the device availability.
- If it is necessary to change the list order, a new printable list must be produced and communicated. (All staff should be familiar with the List Change LocSsip and follow the safety steps outlined in the LocSsip for doing so.)
- In the event of staggered admission times, a safety briefing must be undertaken for each successive list of patients for each discrete admission time

4.1.2 STEP 2 Procedural Sign In (2A) and 'Time Out' (2B)

Sign in and Time Out are safety processes whereby the prompts on the checklist ensure verification of the correct patient, procedure, which side and which implants/devices will be required.
Conscious and coherent patients should actively be encouraged to participate in these processes.

Sign In 2A

- The Sign in verification process must be performed by two team members, one will be the Operator and the other will also be involved in the procedure.
- The questions will be undertaken verbally in a clear, precise and audible tone, with the patient, their family or carer.
- The process must have both the two's checkers full attention to confirm sign in. No other task should be undertaken until this is completed.

Time Out 2B

Time out must be undertaken with all the team present and everyone must engage and give their full attention

- The steps on the checklist must be led by a trained Healthcare professional in a clear and audible manner.
- All Team members must 'stop and pause' whilst the checklist questions are asked and responded to, hence this part of the safety process is known as 'time out'.
- If there is an interruption, the 'time out' must be suspended and recommenced.
- Every team member is valuable and should feel comfortable and at ease to raise any questions or concerns they have relating to the case at this time.
- The patient should once again be included where possible in the time out.
- Team members must not enter or leave the procedural room during this time.

4.1.3 STEP 3 Sign Out

Sign Out when the procedure is completed

All patients who have undergone an interventional procedure must undergo safety checks at the end of the procedure before leaving the procedural room.
Any team member who has been involved in the procedure should not leave the room until this is completed and verified as correct

- The nominated Healthcare professional leading time out will request that all the team is present and ask the team to 'stop and pause'.
- The set questions on the designated section of the Checklist are then directed to the appropriate team member/s, who will verbally respond to the questions being asked.
- Any specimen taken must be confirmed visually that it is labelled correctly.
- Implant/device insertion logs and securing of stickers must be confirmed.

- Finally prior to transfer to the recovery/discharge area the team will review any key plans or concerns for the handover.
- **A member of the procedural team must participate in the patient handover to the recovery/discharge area**
- The 'Time Out' sheet is then signed by a registered healthcare professional and retained in the patient's notes as evidence.

4.1.4 STEP 4 List De Briefing

National Safety Standards of compliance with debriefing state this can only occur after the last patient on the list has been transferred out of the procedural room to the recovery/discharge area.
There are also some mandatory requirements of which specific team members must be present at a debrief:

- The Operator, (this is staff member who has undertaken the procedural interventions on the list).
- The debrief may be led by any confident team member.
- All members of the procedural team should have noted any key points for consideration at the debrief that arose throughout the list; should be presented for consideration at the debrief.

All members of the team attending debrief should feel comfortable enough to contribute to the debrief discussion and raise any concerns or questions.
Any questions included in the debrief are professional and not personal and are to designed to facilitate reflection, share learning, and make improvements where appropriate.
The leader of the debrief should always ensure that what went well during the list is discussed at this feedback session.
Debrief templates are encouraged to be localised, however all debriefing templates must be approved in line with the Trust Governance Processes, for procedural documents.
Examples of questions for discussion and consideration should include:

- Communication – *any issues for* improvements*?*
- Team Harmony – *for example was the best use of skills utilised?*
- Planning - *were there any planning issues, i.e. list order, missing stock how can we improve?*
- Equipment failures *what were the issues? Has the problem been resolved? What action is required? Will it impact on a forthcoming list? Who is taking responsibility to ensure actions and relevant communication are followed through?* See section 4.2 of these standards.
- The need to raise a C.I. R. – *is there one?*
- Identification of training or development that could benefit the team

The above list is not inclusive and wider learning and sharing may be an outcome from any theatre debrief.

Debriefs should be retained for analysis by the audit team.

Monthly Audits will be undertaken in the work area to ensure Debrief actions:

- have been logged
- reviewed
- lessons learned have been shared with MDT team at Staff meetings

The Governance Lead in conjunction with the Matron will ensure that quarterly reports of any themes are produced and the learning outcomes are included in the Divisions' of learning lessons bulletin.

4.2 Non-routine issues with malfunctioning equipment

If medical equipment is thought to be the cause of an incident, it is important to follow these steps:

- Quarantine - The Medical Device and all associated equipment/consumables should be removed from service. The settings of the device should not be changed or adjusted.
- Record - One of the most important pieces of detail to include in the Trust incident report is the correct identification of the equipment through asset number, make, and model, type of equipment, site and location. Without this a technical investigation cannot commence.
- Evaluate - If a technical investigation or evaluation is required, then the originator or manager should request this through the Medical Engineering Department.

It is Trust policy that Medical Device Users should report incidents internally and any decision relating to reporting an incident to the MHRA will be approved by The Trust Medical Device Department with the Risk Office.

Radiology Equipment

- Quarantine-Radiology equipment and all associated equipment/consumables should be removed from service. The settings of the equipment should not be changed or adjusted. The equipment Preventative Maintenance provider should be informed and a date arranged for equipment review.

Record

- The Radiology equipment asset number, make, model, type of equipment, site and location must be logged, All exposure factors used and projections undertaken along with patient height and weight should be recorded. If there is reason to suspect that a patient has received a radiation dose much greater than intended, IRMER procedure for reporting a potential incident of over exposure to a patient should be followed

Evaluate

- Advice should be sought from the Preventative Maintenance provider as to the nature of the fault and recommendations. The incident should be reported also Radiation Protection Advisor to the Trust for their evaluation and

recommendations. The incident may require reporting to external agencies, HSE, CQC as part of these recommendations. Any recommendations must be shared with the Risk Office.

5 ATTACHMENTS	
Number	**Title**
1	Description of NatSsip
2	MBCC Cardiac Catheter Laboratory Safety Handover Information
3	MBCC Procedural Safety Standards Checklist
4	MBCC Cardiac Catheter Laboratory Safety Briefing
5	MBCC Cardiac Catheter Laboratory Safety Debrief
6	Equality & Diversity Impact Assessment tool

6 OTHER RELEVANT / ASSOCIATED DOCUMENTS	
Unique Identifier	**Title and web links from the document library**
Corp/Proc/022	Reporting and Management of Incidents including Serious Incidents http://uhmb/cs/tpdl/Documents/CORP-PROC-022.docx
Corp/Strat/001	Risk Management Strategy http://uhmb/cs/tpdl/Documents/CORP-STRAT-001.docx
Corp/Pol/089	Medical Devices Management http://uhmb/cs/tpdl/Documents/CORP-POL-089.docx
Corp/Proc/057	Policy for Consent to Examination or Treatment http://uhmb/cs/tpdl/Documents/CORP-PROC-057.docx
Z059	Elective Cardiac Catheterisation and Coronary Angiography – MBCC http://uhmb/cs/tpdl/Documents/Z059.pdf
Rad/SOP/001	MBCC - Radiographic Imaging for Elective Cardiac Catheterisation and Coronary Angiography http://uhmb/cs/tpdl/Documents/RAD-SOP-001.docx

7 SUPPORTING REFERENCES / EVIDENCE BASED DOCUMENTS	
References in full	
Number	**References**
1	WHO Surgical Safety Checklist (Patient Safety Alert Update 26 January 2009)
2	NatSsips National Safety Standards for Invasive Procedures NHS England September 2015

8 DEFINITIONS / GLOSSARY OF TERMS	
Abbreviation or Term	**Definition**
W.H.O	World Health Organisation
C.I.R.	Clinical Incident Report
N.B.	Note Well
M.B.H.T.	Morecambe Bay Hospital Trust
I.R.M.E.R	Ionising Radiation Medical Exposure Regulations 2000
H.S.E	Health and Safety Executive
C.Q.C	Care Quality Commission
M.H.R.A	Medicines and Healthcare products Regulatory Agency

9 CONSULTATION WITH STAFF AND PATIENTS	
Enter the names and job titles of staff and stakeholders that have contributed to the document	
Name	**Job Title**
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Suzanne Collett	Clinical Leader MBCC
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Gail Vickers	Deputy Lead Radiographer Cath lab
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Andrea Bateson	Heath Care Assistant
Julie Trusler	Heath Care Assistant

10 DISTRIBUTION PLAN	
Dissemination lead:	Alison Capps-Nevett
Previous document already being used?	No
If yes, in what format and where?	Trust Document Library
Proposed action to retrieve out-of-date copies of the document:	N/A
To be disseminated to:	
Document Library	
Proposed actions to communicate the document contents to staff:	o Include in the Divisional Monthly Newsletter o Table at local departmental meetings o Clinical leads to disseminate to Clinicians o New documents uploaded to the Document Library

11 TRAINING Is training required to be given due to the introduction of this procedural document? Yes		
Action by	**Action required**	**Implementation Date**
Alison Capps-Nevett MDT Cardiology Leads of Service	To present and discuss at Staff meetings to capture all MDT staff groups	December 2016

12 AMENDMENT HISTORY				
Revision No.	**Date of Issue**	**Page/Selection Changed**	**Description of Change**	**Review Date**
1		All	New	01/08/2019

Appendix 1: Description of NatSsip

Description of NatSsip which are mandatory inclusion in this LocSsip. The mandatory standards in this document are not all the standards required for prosthesis verification , the only inclusion is what is relevant to this particular standard	By Whom/How	Where identified	Inclusion achieved
Pre list Safety briefing for interventional procedures as identified by NatSsip NatSsip Standard 4.7	Procedural team plus other key members	Page 4	Yes
Sign in standards NatSsip Standard 4.8	Operator and 1 other plus patient.	Page 5	Yes
Time Out Standards NatSsip 4.9	Procedural team	Page 5	Yes
Sign Out Standards NatSsip 4.12	Procedural team to handover team	Page 6	Yes
Debriefing Standards (to include feedback mechanism for anyone not present to raise concerns) NatSsip 4.13	All	Page 6 & 7	Yes
Mechanism for communication , audit and learning NatSsip 4.13	All	Page 7	Yes

Appendix 2. MBCC CARDIAC CATHETER LABORATORY SAFETY HANDOVER INFORMATION

University Hospitals of Morecambe Bay NHS Foundation Trust

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PROCEDURE: CORONARY ANGIOGRAM / DEVICE IMPLANT Date__/__/__ ***(circle and specify procedure if Device***

Nursing Handover

Completed by…… NMC: If applicable

- **Patient identity** checked verbally / by wristband? **Y / N**
- **Consent** obtained? **Consent form completed**? **Y / N**
- **Operative site** confirmed**? Y / N** *details* ……
- **MRSA** status checked? **Y / N** Result Date**.../..../...**
- Any known **allergies**? **Y / N** *if Y details* ……
- **IV Access** established & checked? **Y / N**
- **Anti-coagulation** therapy **Y / N** *if Y*
  - **Warfarin / NOAC** *circle*
  - **Warfarin/ NOAC stopped? Y/N**
  - If **Warfarin INR**
  - **Date Warfarin stopped .../..../...**
  - Which **NOAC? Rivaroxaban Apixaban Dabigatran Other.....**
  - **Date NOAC stopped?** __|__|_
- Is Patient **diabetic**? **Y / N** *if Y*
  - **BM** checked? Time _____
  - **Metformin Y / N**
- Any **metal** plates/pins/ joint replacements if using diathermy? **Y / N** *If* **Y** *Site and side*…….
- **Hydration** status adequate? IV fluids required? **Y / N**
- **Antibiotic** prophylaxis given? **Y / N**

AFFIX PATIENT STICKER HERE

AHP/Other HCP Handover

Completed by…… RA/RCCP:

- **Blood** Results reviewed? **Y / N**

Hb	eGFR	Creat	INR	Date

- **Pregnancy Status** checked? **Y / N N/A**
  - Patient of appropriate age asked if pregnant
  - LMP/10 Day rule/ Pregnancy test
  - Patients >55 years not asked
- **Previous coronary angiogram? Y / N**
  - UHMBT
  - Blackpool
  - Other……
- Previous **contrast reaction? Y / N** *if Y details*
  - ……
- Has this been discussed with Operator? Can case safely continue with steroid/ chlorpheniramine prophylaxis? **Y / N**
- Any **allergies**? **Y / N** *if Y details* ……
- **Asthma**? **Y / N** *if Y details* ……
- Previous **PCI / CABG**? **Y / N**
  - Details.....
- Recent **Echo** available? **Y / N** Date**.../..../...**
- **Closure device** planned? *details*……
- **Height** & **Weight** recorded?
  - ……cm/ft. ……Kg/st
- If **Device**, has Device been discussed & identified with the Operator? **Y / N**
- High Risk patient? **Y / N** *if Y details*
  - ……
- Any **contraindications/comorbidities**? *if Y details*
  - ……

TEAM MEMBERS

Consultant……

Specialist Registrar……

Assigned Nurse……

Radiographer……

Cardiac Physiologist……..

HCA……

Other……..

Other……

Changeover of Staff should be avoided during a procedure.

If **staff handover is unavoidable**, a **cohesive handover must be undertaken** to ensure the safest patient care.

Member of staff leaving procedure……

Member of staff joining procedure……

Handover undertaken? **Y / N**

Completed by: Date: __|__|__

Completed by: Date: __|__|__

Appendix 3.
MBCC PROCEDURAL SAFETY STANDARDS CHECKLIST

FIRST EDITION MAY 2016

AFFIX PATIENT STICKER HERE

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PROCEDURE: CORONARY ANGIOGRAM / DEVICE IMPLANT Date__/__/__ ***(circle and specify procedure if Device Implant)……..***

►►►►►►SIGN IN

- ☐ Has the **patient/guardian confirmed his/her identity, procedure, site of surgery/procedure** and **consent**? **Y / N**
- ☐ Is the patient **pregnant? Y / N**
- ☐ Does the patient have any known **allergies**? **Y / N**
  If Y *document*……..
- ☐ Have **recent Bloods** been reviewed? **Y / N**
- ☐ **Anticoagulation** reviewed? **Y / N INR** ……..
- ☐ **12 Lead ECG** available? **Y / N**
- ☐ **NIBP Right** ……/…… **mm/Hg Left** …../……. **mm/Hg**
- ☐ **HR** …….**bpm**
- ☐ **SPO2** …….. **%** on air /Supplementary O^2 at … **L/min** *circle*
- ☐ **TEMP** …….^{0}**C**
- ☐ **Arterial** access route identified if angiogram? **Y / N**
- ☐ **Operative site** identified? **Y / N** *details*……..
- ☐ **Hair removal** at site required**? Y / N**
- ☐ **IV Access** obtained **Y / N Left or Right / Flushed** *circle*
- ☐ **Arterial closure** device planned if Angiogram? **Y / N**
  details ……

SIGN IN *Completed by*……..……&……..

TIME OUT ►►►►►►STOP & PAUSE

- ☐ **Team members (& visitors); does everyone know each other's names? Y / N**
  (If not, introduce self and indicate for others to state name and role)
- ☐ **Confirm patient's name Y / N**
- ☐ **Team audibly confirm the planned procedure and side Y / N**
- ☐ **Does the patient have any allergies? Y / N**
- ☐ **Is the patient diabetic? Y / N**
- ☐ **Have bloods been reviewed? Y / N**
- ☐ **Anticoagulation therapy? Y / N**
- ☐ **Antibiotic prophylaxis** given? **Y / N**
- ☐ Can the Clinical Leader confirm that all **necessary equipment** is available and operative for the planned procedure? **Y / N**
- ☐ Can the Clinical Leader confirm that the **implant device** for the procedure is available? *Where applicable* **Y / N**
- ☐ Does **anyone** wish to raise **any concerns or risks** about this patient that have not yet been addressed? **Y / N** *if* ***Y*** *details*

  ……..
  ……..

TIME OUT *Completed by*……..……

SIGN OUT ►►►►►►

- ☐ Can the **Operator confirm the procedure** that has been undertaken**? Y / N**
- ☐ Have any **equipment issues** arisen that need to be addressed**? Y / N** *if* ***Y*** *to whom has this responsibility been allocated?*
- ☐ **Have any changes to the planned procedure** been documented on patient record? **Y / N /***No changes*
- ☐ Any **key concerns** for the **recovery or post procedure management** of the patient? **Y / N** if **Y** *have these been communicated and addressed?*
- ☐ Have any **Implant devices** been recorded? **Y / N**
- ☐ Have there been any untoward incidents with this patient? **Y / N** *if* ***Y*** *details*

  ……..
- ☐ Is it necessary to submit a **Clinical Incident report**? **Y / N** *if* ***Y*** *to whom has this responsibility been allocated?*

  ……..
- ☐ Is it necessary to implement **Duty of Candour** policy? **Y / N** *if* ***Y*** *to whom has this responsibility been allocated?*

  ……..
- ☐ Has an **Emergency transfer** procedure been necessary? **Y / N** *if* ***Y*** *details* ……..

SIGN OUT *Completed by*…….. & ……..

Appendix 4. MBCC CARDIAC CATHETER LABORATORY SAFETY BRIEFING

University Hospitals of Morecambe Bay NHS

Key team members as minimum must attend this meeting *prior to the start* of the list; ideally the entire team to attend

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Date …../…../……. am/pm **Consultant** …… **Angiogram List** **Pacing List** **Combined List**

please circle

SAFETY BRIEFING	TEAM MEMBERS PRESENT FOR BRIEFING	NOTES
☐ **Team members (& visitors);** does everyone know **each other's names and role? Y / N** ☐ Who has checked **Lab equipment? Have any issues** been addressed? **Y / N** *details* **.....** o **Defibrillator ……..** o **Imaging unit ……** o **Haemodynamic unit ……** o **Diathermy unit? ……** ☐ Who has checked that we have all **required equipment/devices for the list? ……**Can the **Operator confirm** that these are **correct? Y / N** ☐ Do we need to **fast track any items for this list o**r for **tomorrow's list? ……** ☐ Are there any **specific patient issues** that we should be aware of**? Y / N If Yes** are these addressed? **……..** ☐ Anything else that will **affect the list? Y / N If Yes** are these addressed? **……** ☐ Can we confirm the **list order? Y / N** Are there any **changes to the list *in line with LocSsips*? Y / N If Yes, has a new list been printed, displayed and communicated? Y / N** ☐ Any **issues troubling team members? Y / N If Yes** are these addressed?.....	**Consultant**…… **Specialist Registrar**…… **Nurse**…… **Radiographer**…….. **Cardiac Physiologist**…….. **HCA**…….. **HCA**…….... **Other**…… **Other**…… **The Cath Lab Team consists of a Consultant Cardiologist, a Specialist Registrar or Fellow in Cardiology, Registered Nurses, Assistant Practitioner, Health Care Assistants, Cardiac Physiologists and Cardiac Radiographers.** **There may also be in attendance; visiting Consultants, students on placement, UHMB staff on PDR visits, company engineers and company representatives or technical support teams who are required for their support during certain procedures. This list is not exhaustive.**	

Safety Briefing Completed by: **Date:** _ _ | _ _ | _ _ Professional ID Stamp

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Appendix 5. MBCC CARDIAC CATHETER LABORATORY SAFETY DEBRIEF

Team Debrief-the entire team should attend this meeting *at the end* of the list after the last patient has left the lab.

Date …../…../……. am/pm **Consultant** …… **Angiogram List** **Pacing List** **Combined List**
please circle

SAFETY DEBRIEF

☐ **What went well today? What was really good?**

…….. ……

☐ Did the **team communicate effectively?** Are there any issues for **improvements?**

…….. ……

☐ **Were there any equipment issues? Y / N**
details……

- o **Are these fully resolved? Y / N**
- o **Is further action required? Y / N**
- o **Will future lists be affected? Y / N**
- o **Who is responsible for ensuring actions and communication?.....**

☐ Did the team **harmonise well?** Were skills **best utilised? ……..**

☐ Were there any **planning issues?** Issues with **List order? Unavailable stock? ……**

☐ Is there a need to raise a **Clinical Incident? If so,** *details* **…….**
Submitted by…….

☐ If applicable has **Duty of Candour policy** been followed? If so**, by whom ……**

TEAM

As a *mandatory* requirement, the Cardiologist, as Operator, must be present at the debrief meeting.

Have all team members, including the Cardiologist as Operator, attended the debrief session? Y / N

If Not; who has been unable to attend and why?

…….. ……

All members of the team should feel comfortable and able to raise any concerns or questions in this session.

Any questions included in this debrief are professional, not personal and are to facilitate reflection, share learning and, where appropriate, make improvements.

☐ Does anyone have any **particular concerns** in relation to any of **today's list?**

……..

……..

☐ Have any **Training or Development** needs been identified?

- o **.....**
- o **……..**

☐ **……..**

……..

……..

☐ **……..**

……..

……..

☐ **……..**

……..

……..

- **Please tick appropriate boxes for any actions which are relevant for the next day procedural list. These will be added to the MBCC Daily Action Log and communicated at the start of the next day's Safety briefing.**
- **Have all actions been transferred to the MBCC Safety Briefing Action plan?**
- **Scanned for Audit? Y / N**

Debrief completed by **Date ….…../……** Professional ID Stamp

Appendix 6 - EQUALITY & DIVERSITY IMPACT ASSESSMENT TOOL

		Yes/No	Comments
1.	**Does the policy/guidance affect one group less or more favourably than another on the basis of:**		
	• Age	No	
	• Disability	No	
	• Race	No	
	• Sex	No	
	• Religious belief – including no belief	No	
	• Sexual Orientation	No	
	• Gender reassignment	No	
	• Marriage and civil partnership	No	
	• Pregnancy and maternity	No	
2.	**Is there any evidence that some groups are affected differently?**	No	
3.	**If you have identified potential discrimination are there any exceptions - valid, legal and/or justifiable?**	No	
4.	**Is the impact of the policy/guidance likely to be negative?**	No	
4a	**If so can the impact be avoided?**	No	
4b	**What alternative are there to achieving the policy/guidance without the impact?**	No	
4c	**Can we reduce the impact by taking different action?**	No	

For advice in respect of answering the above questions, and / or if you have identified a potential discriminatory impact of this procedural document, please contact the relevant person (see below), together with any suggestions as to the action required to avoid/reduce this impact.

For Service related procedural documents: Lynne Wyre, Deputy Chief Nurse & Lead for Service Inclusion and Diversity

For Workforce related procedural documents: Karmini McCann, Workforce Business Partner & Lead for Workforce Inclusion and Diversity.