

Title: **HAND HYGIENE STRATEGY AND POLICY**

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Classification: Policy

Directorate: Organisation Wide

Due for Review: 02/03/21

Responsible for review: Infection Prevention and Control Department

[Document Control](#)

Ratified by: Infection Prevention and Control Meeting

Applicability: All Staff

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1.0 Introduction

Hand Decontamination is the single most important means of preventing the spread of infection and responsibility for high standards of compliance with hand hygiene rests with each individual employee.

This policy applies to all Trust staff, including bank, agency and locum staff, wherever they are working. It includes visiting clinical staff and employees of other organisations working on Trust premises, volunteers, patients and visitors.

Staff non-compliance will result in disciplinary procedures appendix 2

Patients are put at potential risk of developing a healthcare -acquired infection when a healthcare practitioner caring for them has contaminated hands.

Hands must be decontaminated immediately before each and every episode of direct patient contact/care and after any activity or contact that potentially results in hands becoming contaminated, for example handling patient curtains or catheter bags. The World Health Organisation (WHO) and NHS Improvement has identified the 'Five Moments' for hand hygiene (see section 3.0 below).

2.0 Factors to Encourage Hand Hygiene Compliance

2.1 **The Environment (hand hygiene facilities)**

Compliance with hand hygiene is often poor and the absence of easy access to hand wash basins has been identified as one of the main reasons for non compliance

Provision of conveniently placed staff hand wash basins in addition to patient and visitor basins, should be available in clinical areas. Hand wash basins should be kept clean and free from limescale and be maintained in good working order.

Hand wash basins should not be used for other purposes e.g. cleaning equipment, emptying washbowls. Elbow/wrist operated or non touch mixer taps that are not aligned to run directly into the drain aperture should be used. Plugs and overflows should not be used as they can harbour bacteria and are difficult to clean). Every clinical area must provide appropriate hand washing facilities. Adequate numbers of sinks, stocked up with soap, paper towels and a pedal bin must be within easy reach of each bed and patient contact area

Access to these hand washing areas must be free from obstacles which may impede access by staff. Hand washing posters must be displayed demonstrating the correct hand washing techniques.

Alcohol gel should be available for use at the point of care to ensure that compliance is achieved where there is limited access to hand wash basins. Alcohol hand gel should not be placed over a wash basin due to risks of contamination. It is the responsibility of the manager of that area to ensure available at all times.

2.2 **Increasing Awareness for Hand Hygiene (Education & Role Modelling)**

Training (on Induction and annual updates), posters and positive role modelling are all important for increasing awareness for the importance of hand hygiene. Role modelling by senior staff members will encourage more junior staff to follow suit. Lapses in compliance with hand hygiene requirements are seen as a serious clinical issue.

2.3 Adherence to Uniform Policy

Nails must be kept short, clean and free from nail polish/false nails. Wristwatches, bracelets, and all rings (except a plain wedding/commitment band) must be removed at the beginning of each clinical shift before regular hand decontamination begins. *Compliance with the Trust 'Bare from the Elbow down' initiative is expected as well as compliance with the Trust Uniform Policy. Any variance should be discussed with the Infection Prevention and Control Support Department / Community Infection Control Team.* Cuts and abrasions must be covered with a waterproof occlusive dressing. The wearing of short-sleeved uniforms and other clothing worn for direct contact with patients or the clinical environment is important for ensuring healthcare workers are 'bare from the elbow down'.

2.4 Informing Patients and Visitors about the Importance of Hand Hygiene

Inviting patients to prompt staff to clean their hands if they think staff may have forgotten is encouraged. Hand hygiene for visitors is also strongly encouraged when they enter clinical environments. Signage must be available at all clinical area entrances to inform visitors where hand hygiene facilities are available.

2.5 Monitoring Compliance and Giving Feedback (Audit)

Compliance will be monitored by the Trust using an adapted version of the Lewisham Audit Tool/WHO hand hygiene audit tool. This will be done in all clinical areas on a monthly basis by the trained link nurse or the Infection Prevention and Control Team (IPCT). Feedback will be provided to non-compliant staff at the time of the audit by the auditor. Compliance figures will be emailed to the ADNs CD, consultant of area, matron, ward manager and patient safety lead. Hand hygiene compliance will be reported at the IPC&C and the Trust board.

2.6 Also see Appendix 2.

All staff entering clinical areas must comply with hand hygiene at all times. Any staff observed not performing hand hygiene appropriately will be advised of this and the incident documented by the Clinical Manager.

Any repeat of non-compliance will be reported to the Infection Prevention & Control Committee via the ADN Report. This relates to all staff from ward to board.

3.0 The Five Moments of Hand Hygiene

The 'Five Moments of Hand Hygiene' assist in determining when to decontaminate the hands. Figure 1 represents the 'patient zone' or 'patient space', in which are to be found the patient's microbes (inside the dotted line). Contamination and cross-infection can occur when microbes are passed from one 'patient zone' into another 'patient zone'. The patient zone includes the patient and their immediate surroundings. The area outside the dotted line represents the 'healthcare environment'.

There are other occasions when you must wash your hands and these include:

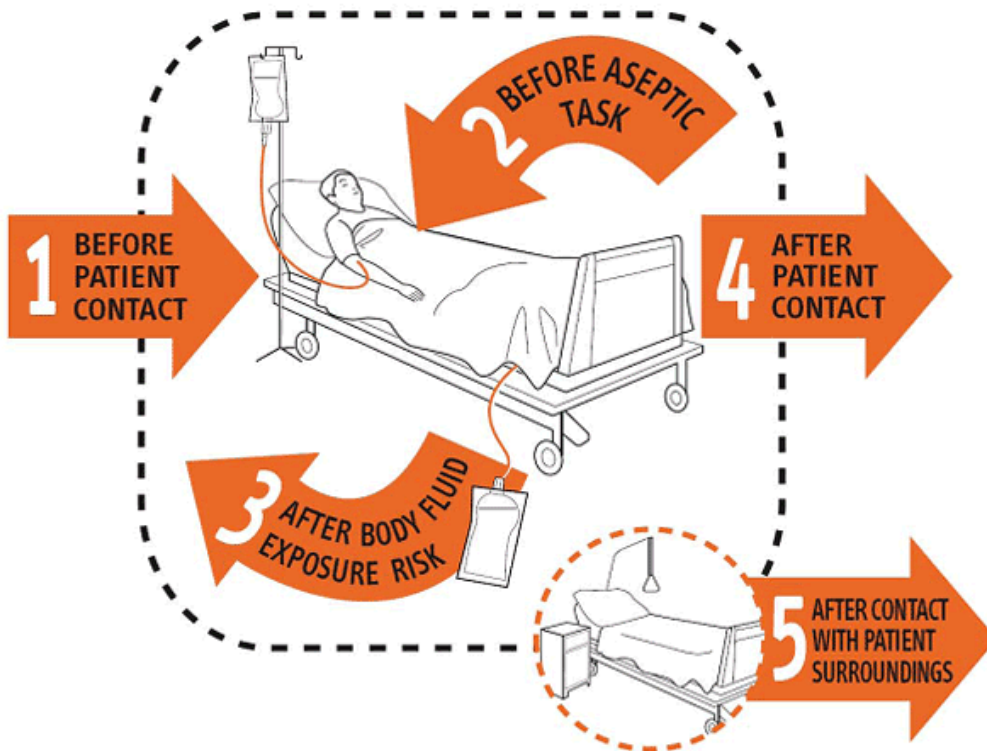
- Before handling or serving food
- After going to the toilet
- After handling specimens
- After handling waste, used laundry or contaminated equipment
- Patients with infectious diarrhoea i.e. *Clostridium difficile* /norovirus

Patients should be offered hand hygiene facilities and encouraged to wash their hands particularly after using toilet/commode/bedpan (**handwipes must be available at sluice entrances**) and prior to meals. Hand cleansing wipes must be offered to patients who are unable to access hand washing facilities.

Figure 1

The 5 Moments of Hand Hygiene

Your 5 moments for HAND HYGIENE



1 BEFORE PATIENT CONTACT	WHEN? Clean your hands before touching a patient when approaching him or her WHY? To protect the patient against harmful germs carried on your hands
2 BEFORE AN ASEPTIC TASK	WHEN? Clean your hands immediately before any aseptic task WHY? To protect the patient against harmful germs, including the patient's own germs, entering his or her body
3 AFTER BODY FLUID EXPOSURE RISK	WHEN? Clean your hands immediately after an exposure risk to body fluids (and after glove removal) WHY? To protect yourself and the health-care environment from harmful patient germs
4 AFTER PATIENT CONTACT	WHEN? Clean your hands after touching a patient and his or her immediate surroundings when leaving WHY? To protect yourself and the health-care environment from harmful patient germs
5 AFTER CONTACT WITH PATIENT SURROUNDINGS	WHEN? Clean your hands after touching any object or furniture in the patient's immediate surroundings, when leaving - even without touching the patient WHY? To protect yourself and the health-care environment from harmful patient germs



WHO acknowledges the Hôpitaux Universitaires de Genève (HUG), in particular the members of the Infection Control Programme, for their active participation in developing this material.



October 2006, version 1.

4.0 Hand Decontamination

4.1 Preparation

In the majority of clinical situations, soap and water or/and alcohol hand gel will be sufficient. There is a need for a surgical scrub in some situations

4.2 Routine Hand washing

- To remove most micro-organisms from the hands and render hands socially clean.
- Before contact with a susceptible site on a patient (e.g. wound, intravenous site).
- After any activity where hands may have become contaminated.

You must use soap and water for washing your hands in the following situations:

- when a patient has diarrhoea and /or vomiting
- when arriving on duty and before leaving the ward or department
- after using the toilet, or toileting others
- before and after aseptic procedures
- before handling food and drink
- when dealing with infected patients in side rooms and/or during bay/ward closure
- When hands are visibly dirty
- When wards are closed with outbreaks of diarrhoea and/or vomiting

4.3 Alcohol Gel

- To be used as an alternative method of hand decontamination when hands are not visibly soiled or dirty and rapid decontamination of hands is necessary.
- Alcohol hand gel has been introduced to all clinical areas for use between patient contacts and their environment e.g. Bed linen, curtains.
 - **Alcohol hand gel should only be used as an alternative method of hand decontamination when hands are not visibly dirty or soiled.**
 - When the alcohol hand gel has been used on six consecutive occasions, hands should then be washed in the usual manner.
- Alcohol hand gel is to be used when soap, water and towels are not available (e.g. in the community).

4.4 Surgical Hand washing

See operating theatres infection prevention and control policy ([CG1710](#))

- Essential before all surgical or invasive procedures.

5.0 Effective Hand Decontamination

5.1 Soap and water

If hands are decontaminated soon after acquiring potentially infective micro-organisms, most of these micro-organisms will be transient and easily removed.

Effective hand washing technique involves three stages: washing, rinsing, and drying (see [Appendix 1 please build link](#)).

Preparation requires wetting hands under tepid running water **before** applying liquid soap or antimicrobial preparation. The hand wash solution must come into contact with **all** surfaces of the hands. The hands must be **rubbed** together vigorously for a minimum of 10-15 seconds, paying particular attention to the tips of the fingers, the thumbs and the areas between the fingers. Hands should be rinsed thoroughly prior to drying with good quality paper towels. **Nail brushes must not be used in clinical areas.** Bar soap is not permitted for staff hand washing in healthcare premises. Waste bins must be foot-operated to prevent re-contamination of the hands after washing.

5.2 Community/social care Staff

If hand washing facilities are not available in the community when you are visiting patients/service users it is acceptable to use clinell handwipes or use alcohol hand gel toggles, until you can access a sink. Then you must decontaminate your hands with liquid soap and water as soon as you return to your base.

5.3 Alcohol Hand Gel

When decontaminating hands using **alcohol gel**, hands should be free from dirt and organic material. The hand rub solution must come into contact with all surfaces of the hands. The hands must be **rubbed** together vigorously, paying particular attention to the tips of the fingers, the thumbs and the areas between the fingers, and until the gel has evaporated and the hands are **dry (see diagram below)**.



Alcohol handrub hand hygiene technique – for visibly clean hands



1 Apply a small amount (about 3 ml) of the product in a cupped hand



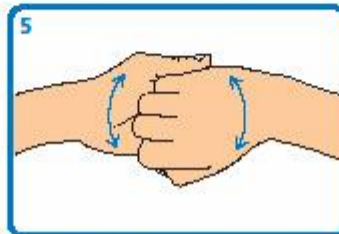
2 Rub hands together palm to palm, spreading the handrub over the hands



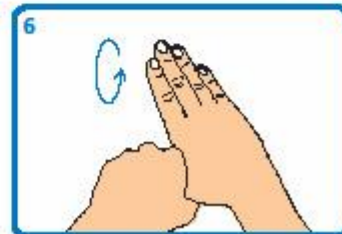
3 Rub back of each hand with palm of other hand with fingers interlaced



4 Rub palm to palm with fingers interlaced



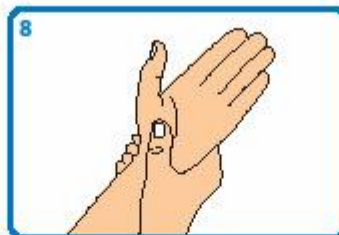
5 Rub back of fingers to opposing palms with fingers interlocked



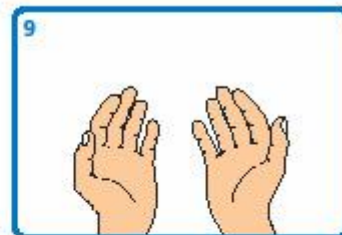
6 Rub each thumb clasped in opposite hand using a rotational movement



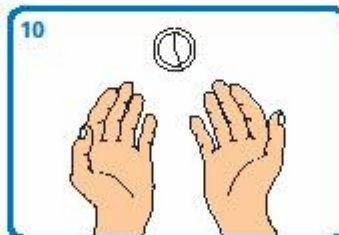
7 Rub tips of fingers in opposite palm in a circular motion



8 Rub each wrist with opposite hand



9 Wait until product has evaporated and hands are dry (do not use paper towels)



10 The process should take 15–30 seconds



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Adapted from World Health Organization *Guidelines on Hand Hygiene in Health Care*



5.4 Skin Care and Hand Cream

Bacterial counts increase when the skin is damaged therefore care must be taken to maintain skin integrity:

- Always wet hands thoroughly prior to applying liquid soap or antiseptic detergent
- Rinse hands thoroughly to remove soap or antiseptic detergent
- Dry hands carefully
- Always cleanse hands with soap and water or alcohol hand gel (ONLY if gloves not visibly contaminated AND IF NO diarrhoea) after removing gloves

Apply an emollient hand cream regularly to protect skin from the drying effects of regular hand decontamination. Do not use communal pots of hand cream. **If a particular soap, antimicrobial hand wash or alcohol product causes skin irritation, seek Occupational Health advice. Also consult Occupational Health should any staff develop eczema, dermatitis or other skin condition.**

6.0 Gloves

Gloves are in addition to, and not a substitute for, hand decontamination **and should be used in line with the 5 moments of hand hygiene.** The gloves must be CE marked and approved for the selected procedure i.e. when dealing with blood or bodily fluids are effective against blood borne viruses.

6.1 Glove Use in Clinical Practice

TABLE 1. GLOVE USE IN CLINICAL PRACTICE		
Gloves not indicated	Gloves indicated	
	Clean	Sterile
Taking patient observations	Touching/handling blood or body fluids (BBF)	Insertion of invasive devices (eg central venous catheters, urine catheters, endotracheal tubes, bronchoscope)
Subcutaneous/intramuscular injections ¹	Contact with mucous membranes	Surgical procedures
Administration/preparation of IV drugs ²	Insertion/removal of peripheral cannula	Preparation of total parenteral nutrition
Bathing/dressing patient (unless visible BBF)	Contact with non-intact skin	Dressing wounds
Handling used linen (unless soiled with BBF)	Removal of invasive devices (eg urine catheters, endotracheal tubes)	
Manipulation of vascular lines (using aseptic technique)	Taking a blood sample	
Physiotherapy (unless procedure involves direct exposure to BBF)	Vaginal/pelvic examination	
Giving oral medications	Oral/tracheal suctioning	
Feeding a patient	Handling hazardous chemicals, eg disinfectants, chemotherapy agents	
Transporting a patient	Handling instruments, equipment or items contaminated with BBF	
Writing on charts	Handling waste contaminated with BBF	
	Handling sharp instruments contaminated with BBF	
	Cleaning BBF spills	

Gloves are a simple barrier; they do not have any mystical powers of viral or bacterial killing.

Gloves must be worn as single use items. Put gloves on immediately before an episode of patient contact or treatment and remove them as soon as the activity is completed. Change gloves between caring for different patients or between different care/treatment activities for the same patient. Failure to do so will significantly increase the risk of transmission of infection.

Sterile gloves must be worn for all invasive procedures and contact with susceptible sites, i.e. non-intact skin and non-intact mucous membrane.

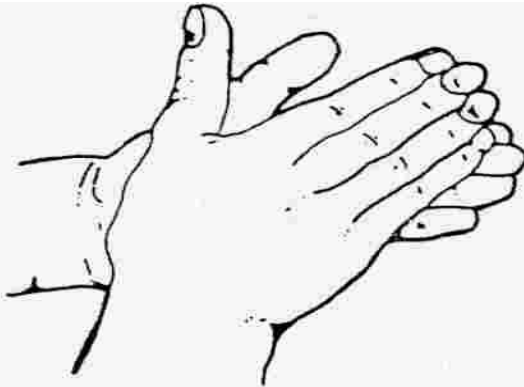
- Gloves must be disposed of as clinical waste and **hands must always be washed after the removal of gloves**
- Glove integrity can be damaged if in contact with substances such as isopropanol or ethanol, therefore alcohol hand rubs/gels should **not** be used to decontaminate gloves.
- Gloves should **not** be washed as liquids may penetrate through microscopic holes in the glove and compromise the barrier efficacy.
- Storage of gloves should follow manufacturer's recommendations.

7. Education

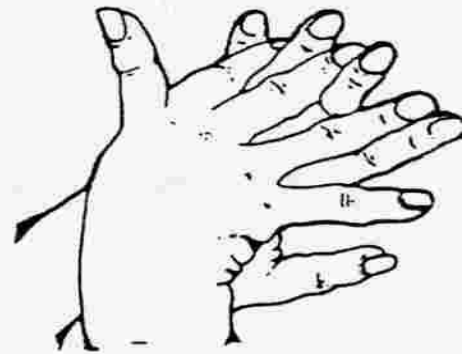
All staff will receive hand hygiene training at clinical induction and annually at mandatory training. The educational centre will collate compliance and this will be monitored through the IP&C committee

8. Equality and Diversity – This document complies with Torbay and South Devon NHS Foundation Trust equality and diversity statement.

Effective Handwashing Technique



1. Palm to palm



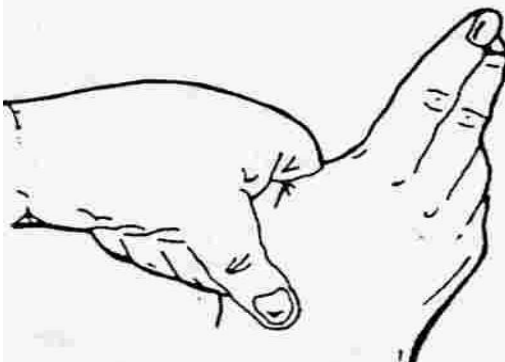
2. Right palm over left dorsum and left palm over right dorsum



3. Palm to palm fingers interlaced



4. Backs of fingers to opposing palms with fingers interlocked

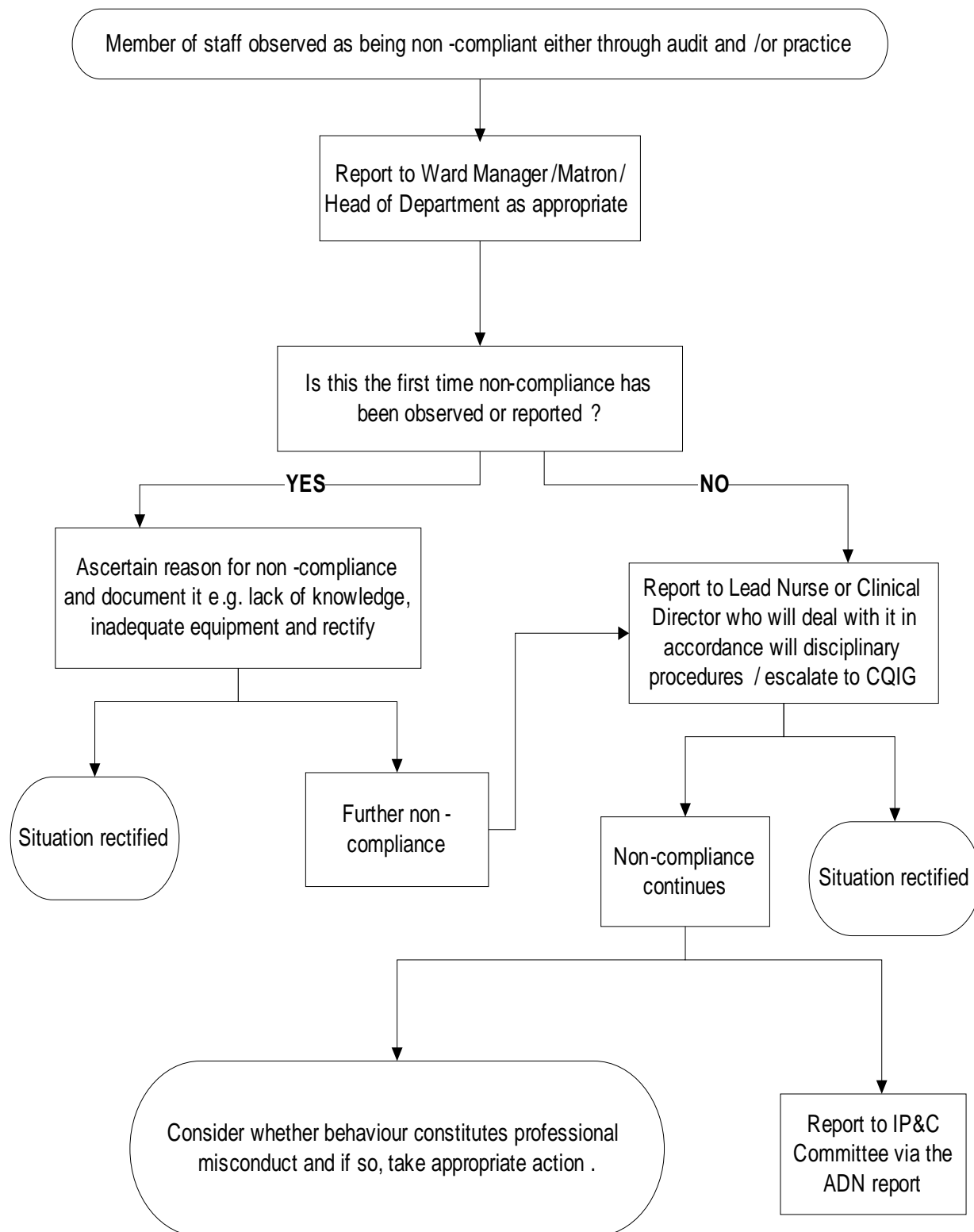


5. Rotational rubbing of right thumb clasped in left palm and vice versa



6. Rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa

**MANAGEMENT OF ALL STAFF WHO ARE NON COMPLIANT WITH
 INFECTION CONTROL PRECAUTIONS**



Hand Hygiene Auditing



Clean Hands Saves Lives



Revised Lewisham Observational Tool

Date:		Time:		Location:	
Observer:					
10 minute period	Nurses/Stn	Doctors	HCA's	Others – please describe e.g. Porters etc	
Please record who you have fed the results back to and sign					

Guidance on undertaking an observation

1. The staff member undertaking observation should undertake a number of practice observations to get familiar with the tool and to minimise the Hawthorne Effect. This also reduces staff on the wards' awareness of the presence of the observer.
2. Observations can take place by just one person or with a partner.
3. Identify an area within your ward/department where you can comfortably observe staff. Stay in this place for 10 minutes and observe your 'window' of activity. Do not move from this place during the 10 minutes. If staff walk away without you seeing whether they perform hand hygiene, do not follow them. Do not mark anything down unless you see it.
4. Position yourself so that you do not cause an obstruction but can still see what is happening. It may feel strange and you might think that you are too noticeable. This is normal and the best thing is to just carry on.
5. Observe for 10-minute periods.
6. Using the observation sheet mark a 'O' for a hand hygiene opportunity and a 'H' for an actual hand hygiene activity taking place. If hand hygiene does not take place leave it blank.
7. When you have completed 10 minutes' observation, give feedback to the staff. When you give verbal feedback try to stress positive findings first and if you give negative feedback give examples and suggestions for improvement.
8. Keep hold of the completed observations and hand to the Senior Nurse for your area.
9. While you are observing you may identify issues which are barriers to hand hygiene, e.g. no soap, obstructed sinks, no alcohol by the bed, alcohol not working, and alcohol empty – include this in your feedback.

Protocols & Guidelines – Document Control

This is a controlled document. It should not be altered in any way without the express permission of the author or their representative. On receipt of a new version, please destroy all previous versions.

Ref: 0239	Title: Hand Hygiene and Strategy Policy		
Date of Issue:	2 March 2018	Next Review Date:	2 March 2021
Version:	8		
Author:	Infection Control Department		
Index:	Infection Control		
Classification:	Policy		
Applicability:	All staff		
Equality Impact:	The guidance contained in this document is intended to be inclusive for all patients within the clinical group specified, regardless of age, disability, gender, gender identity, sexual orientation, race and ethnicity & religion or belief.		
Evidence based:	Yes		
References:	<ol style="list-style-type: none"> 1. Department of Health - The Health and Social Care Act (2008). Code of Practice for the Prevention and Control of Health Care Associated Infections. London: Crown Copyright. 2. Hand hygiene technical reference manual –WHO 2009 http://apps.who.int/iris/bitstream/10665/44196/1/9789241598606_eng.pdf 3. Pittet,D. Sax,H . Allegranzi, B. Uckay,I. Larson,E. Boyce, J. (2007). 'My five moments for hand hygiene': a user-centred design approach to understand, train, monitor and report hand hygiene'. Journal of Hospital Infection, 67, 9-21. 4. Pratt, R. 2014. EPIC3: National evidence-based guidelines for preventing healthcare associated infections in NHS hospitals in England. Journal of Hospital Infection, Vol 65; pp 1-64 5. National Institute of Health & Clinical Excellence 2012. NICE Healthcare-associated infections quality standard. NICE clinical guideline 139, guidance.nice.org.uk/cg139 6. National Institute of Health & Clinical Excellence 2016. NICE healthcare-associatedinfections QS113 https://www.nice.org.uk/guidance/qs113 <p>Infection control in the built environment (HBN 00-09)</p> <ol style="list-style-type: none"> 7. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/170705/HBN_00-09_infection_control.pdf 		
Produced following audit:	No		
Audited:	No		
Approval Route:	See ratification	Date Approved:	23 May 2016
Approved By:	Infection Prevention and Control Meeting		
Links or overlaps with other policies: 1710 - Operating Theatre infection prevention and control			
All TSDFT Trust strategies, policies and procedure documents.			

PUBLICATION HISTORY:

Issue	Date	Status	Authorised
1	11 October 1999	New	Director of Nursing and Quality, Medical Director
2	30 January 2002	Revised	Medical Director
2	15 July 2004	Date Change	Director of Nursing and Quality, Medical Director
3	1 May 2008	Revised	Director of Infection Prevention and Control
4	5 August 2010	Revised	Director of Nursing and Governance, Director of Infection Prevention and Control
5	28 June 2012	Revised	Director of Nursing & Governance Director of Infection Prevention and Control
6	6 September 2012	Point 6 Review and Point 7 Equality and Diversity added	Specialist Nurse Practitioner, Infection Control
7	24 January 2014	Revised	Director of Nursing, Professional Practice and Patient Experience Director of Infection Prevention & Control Director of Nursing and Professional Practice in the Community
7	27 November 2015	Date change	Director of Nursing, Professional Practice and Patient Experience Director of Infection Prevention & Control Director of Nursing and Professional Practice in the Community
8	10 June 2016	Revised	Infection Prevention and Control Meeting
8	2 March 2018	Date change	Consultant Microbiologist

The Mental Capacity Act 2005

The Mental Capacity Act provides a statutory framework for people who lack capacity to make decisions for themselves, or who have capacity and want to make preparations for a time when they lack capacity in the future. It sets out who can take decisions, in which situations, and how they should go about this. It covers a wide range of decision making from health and welfare decisions to finance and property decisions

Enshrined in the Mental Capacity Act is the principle that people must be assumed to have capacity unless it is established that they do not. This is an important aspect of law that all health and social care practitioners must implement when proposing to undertake any act in connection with care and treatment that requires consent. In circumstances where there is an element of doubt about a person's ability to make a decision due to 'an impairment of or disturbance in the functioning of the mind or brain' the practitioner must implement the Mental Capacity Act.

The legal framework provided by the Mental Capacity Act 2005 is supported by a Code of Practice, which provides guidance and information about how the Act works in practice. The Code of Practice has statutory force which means that health and social care practitioners have a legal duty to have regard to it when working with or caring for adults who may lack capacity to make decisions for themselves.

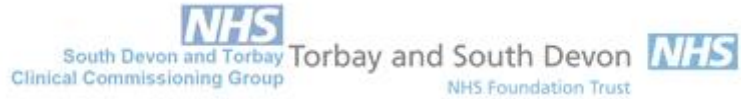
“The Act is intended to assist and support people who may lack capacity and to discourage anyone who is involved in caring for someone who lacks capacity from being overly restrictive or controlling. It aims to balance an individual's right to make decisions for themselves with their right to be protected from harm if they lack the capacity to make decisions to protect themselves”. (3)

All Trust workers can access the Code of Practice, Mental Capacity Act 2005 Policy, Mental Capacity Act 2005 Practice Guidance, information booklets and all assessment, checklists and Independent Mental Capacity Advocate referral forms on iCare

http://icare/Operations/mental_capacity_act/Pages/default.aspx

Infection Control

All staff will have access to Infection Control Policies and comply with the standards within them in the work place. All staff will attend Infection Control Training annually as part of their mandatory training programme.



Rapid (E)quality Impact Assessment (EqIA) *(for use when writing policies)*

Policy Title (and number)		Version and Date	
Policy Author			
An (e)quality impact assessment is a process designed to ensure that policies do not discriminate or disadvantage people whilst advancing equality. Consider the nature and extent of the impact, not the number of people affected.			
Who may be affected by this document?			
Patients/ Service Users	<input type="checkbox"/>	Staff	<input type="checkbox"/>
Other, please state...		<input type="checkbox"/>	
Could the policy treat people from protected groups less favorably than the general population?			
<i>PLEASE NOTE: Any 'Yes' answers may trigger a full EIA and must be referred to the equality leads below</i>			
Age	Yes <input type="checkbox"/> No <input type="checkbox"/>	Gender Reassignment	Yes <input type="checkbox"/> No <input type="checkbox"/>
Race	Yes <input type="checkbox"/> No <input type="checkbox"/>	Disability	Yes <input type="checkbox"/> No <input type="checkbox"/>
Gender	Yes <input type="checkbox"/> No <input type="checkbox"/>	Pregnancy/Maternity	Yes <input type="checkbox"/> No <input type="checkbox"/>
Sexual Orientation		Yes <input type="checkbox"/> No <input type="checkbox"/>	
Religion/Belief (non)		Yes <input type="checkbox"/> No <input type="checkbox"/>	
Marriage/ Civil Partnership		Yes <input type="checkbox"/> No <input type="checkbox"/>	
Is it likely that the policy could affect particular 'Inclusion Health' groups less favourably than the general population? (substance misuse; teenage mums; carers ¹ ; travellers ² ; homeless ³ ; convictions; social isolation ⁴ ; refugees)			Yes <input type="checkbox"/> No <input type="checkbox"/>
Please provide details for each protected group where you have indicated 'Yes'.			
VISION AND VALUES: Policies must aim to remove unintentional barriers and promote inclusion			
Is inclusive language ⁵ used throughout?			Yes <input type="checkbox"/> No <input type="checkbox"/> NA <input type="checkbox"/>
Are the services outlined in the policy fully accessible ⁶ ?			Yes <input type="checkbox"/> No <input type="checkbox"/> NA <input type="checkbox"/>
Does the policy encourage individualised and person-centred care?			Yes <input type="checkbox"/> No <input type="checkbox"/> NA <input type="checkbox"/>
Could there be an adverse impact on an individual's independence or autonomy ⁷ ?			Yes <input type="checkbox"/> No <input type="checkbox"/> NA <input type="checkbox"/>
EXTERNAL FACTORS			
Is the policy a result of national legislation which cannot be modified in any way?			Yes <input type="checkbox"/> No <input type="checkbox"/>
What is the reason for writing this policy? (Is it a result in a change of legislation/ national research?)			
Who was consulted when drafting this policy?			
Patients/ Service Users	<input type="checkbox"/>	Trade Unions	<input type="checkbox"/>
Protected Groups (including Trust Equality Groups)		<input type="checkbox"/>	
Staff	<input type="checkbox"/>	General Public	<input type="checkbox"/>
Other, please state...		<input type="checkbox"/>	
What were the recommendations/suggestions?			
Does this document require a service redesign or substantial amendments to an existing process? <i>PLEASE NOTE: 'Yes' may trigger a full EIA, please refer to the equality leads below</i>			Yes <input type="checkbox"/> No <input type="checkbox"/>
ACTION PLAN: Please list all actions identified to address any impacts			
Action	Person responsible	Completion date	
AUTHORISATION:			
By signing below, I confirm that the named person responsible above is aware of the actions assigned to them			
Name of person completing the form		Signature	
Validated by (line manager)		Signature	

Please contact the Equalities team for guidance:

For South Devon & Torbay CCG, please call 01803 652476 or email marisa.cockfield@nhs.net

For Torbay and South Devon NHS Trusts, please call 01803 656676 or email pfd.sdht@nhs.net

This form should be published with the policy and a signed copy sent to your relevant organisation.

- ¹ Consider any additional needs of carers/ parents/ advocates etc, in addition to the service user
- ² Travelers may not be registered with a GP - consider how they may access/ be aware of services available to them
- ³ Consider any provisions for those with no fixed abode, particularly relating to impact on discharge
- ⁴ Consider how someone will be aware of (or access) a service if socially or geographically isolated
- ⁵ Language must be relevant and appropriate, for example referring to partners, not husbands or wives
- ⁶ Consider both physical access to services and how information/ communication is available in an accessible format
- ⁷ Example: a telephone-based service may discriminate against people who are d/Deaf. Whilst someone may be able to act on their behalf, this does not promote independence or autonomy

Clinical and Non-Clinical Policies – New Data Protection Regulation (NDPR)

Torbay and South Devon NHS Foundation Trust (TSDFT) has a commitment to ensure that all policies and procedures developed act in accordance with all relevant data protection regulations and guidance. This policy has been designed with the EU New Data Protection Regulation (NDPR) in mind and therefore provides the reader with assurance of effective information governance practice.

NDPR intends to strengthen and unify data protection for all persons; consequently, the rights of individuals have changed. It is assured that these rights have been considered throughout the development of this policy.

Furthermore, NDPR requires that the Trust is open and transparent with its personal identifiable processing activities and this has a considerable effect on the way TSDFT holds, uses, and shares personal identifiable data. The most effective way of being open is through data mapping. Data mapping for NDPR was initially undertaken in November 2017 and must be completed on a triannual (every 3 years) basis to maintain compliance. This policy supports the data mapping requirement of the NDPR.

For more information:

- Contact the Data Access and Disclosure Office on dataprotection.tsdf@nhs.net,
- See TSDFT's [Data Protection & Access Policy](#),
- Visit our [GDPR](#) page on ICON.