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**PRIMARY CARE**

**INFECTION PREVENTION AND MANAGEMENT (IPM) GUIDANCE FOR MINOR SURGERY**

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| **Supported by:** | Somerset ICB |
| **Review Date:** | September 2026 |
| **To Be Reviewed By:** | Infection Prevention and Management Team |
| **Target Audience:** | Primary Care |

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With thanks to Hertfordshire and West Essex ICB’s.

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**PRIMARY CARE**

**INFECTION PREVENTION AND MANAGEMENT GUIDANCE FOR MINOR SURGERY**

This guidance should be used in conjunction with the GP Practices Minor Surgery Policy

**Introduction**

1. **Purpose**

The purpose of this guidance is to ensure that all GP Practices are consistently and safely following Infection Prevention and Management (IPM) [guidance](https://www.england.nhs.uk/national-infection-prevention-and-control-manual-nipcm-for-england/) in their approach to managing minor surgical procedures carried out in the practice.

Minor surgical procedures are deemed minimally invasive/superficial treatments performed under local anaesthetic. Minor surgical procedures can be an operation on the superficial structures of the body or a manipulative procedure that does not involve a serious risk to the patient such as excisions and incisions. These procedures are usually performed under local anaesthetic, in a sterile field where asepsis can be maintained.

The primary objective for minor surgical procedures is to protect patients from potential surgical site and other infections. Whilst some minor surgical procedures carry low risk of infection after the procedure, in some circumstances the consequences may be disproportionately serious; it is therefore essential that high standards of IPC are maintained and that high standards of environmental cleanliness can be achieved.

In order to provide a comprehensive, safe, quality service and minimise the risk of transmission of infections to both staff and patient’s; practices must ensure that:

* Ideally, a modern or newly refurbished space with designated facilities (i.e. a Minor Surgery Room) should be provided, which is clean, well-ventilated and heated, spacious, with adequate lighting; in line with current [guidance](https://www.his.org.uk/media/1634/guidelines_on_the_facilities_required_for_minor_surgical_procedures_and_minimal_access_interventions.pdf). In older premises where a designated Minor Surgery Room is not available, a designated treatment room should be used; as long as the following can be achieved:
  + A thorough clean of the treatment room is undertaken and all surfaces are decontaminated prior to the minor surgery list starting and between each patient;
  + All surfaces are decluttered and any extraneous items are removed;
  + There is all round access to the treatment couch;
  + That all the minor surgery procedures are performed in the treatment room after a thorough clean has been performed, ideally this is not immediately after dirty procedures such as leg ulcer dressings or podiatry nail filing;
  + Ideally, where possible the same standards for Minor Surgery Room Requirements (see Appendix 1) should be achieved.
* There are policies and procedures in place to manage single-use/sterile instruments/packs and decontamination processes for medical devices and clinical equipment.
* All staff have received infection prevention and control (IPC) training (including: surgical aseptic technique, surgical hand scrub and decontamination procedures for environment and equipment).
* High standards for IPC are maintained for all patients and procedures, to minimise the potential risk of surgical site infections and other infections.
* All minor surgery procedures are only undertaken by competent practitioners.

**INFECTION PREVENTION AND CONTROL**

GP Practices providing minor surgery clinics need to ensure that the minor surgical procedures are undertaken in a clean and safe environment that reduces the risk of patients getting a post-operative surgical site infection.

All staff undertaking minor surgical procedures will need to be trained and competent in principles of asepsis, including: aseptic technique; maintaining a sterile field; skin cleansing; management of sterile equipment, using safe surgical techniques; together with Standard Infection Control Precautions.

In addition to wearing PPE, and remaining bare below the elbow, all staff should practice high standards of infection prevention and control measures, including environmental cleaning and good hand hygiene techniques to reduce the risk of onward transmission of infections.

**2.0 Hand Hygiene**

Hand hygiene must be performed immediately before every episode of direct patient care, prior to surgical hand scrub and in accordance with local policy. Refer to Your [5 moments for hand hygiene](https://cdn.who.int/media/docs/default-source/integrated-health-services-(ihs)/infection-prevention-and-control/your-5-moments-for-hand-hygiene-poster.pdf?sfvrsn=83e2fb0e_21).

Please see UKHSA posters demonstrating recommended hand hygiene procedures for hand washing and alcohol hand rub.

**2.1 Surgical hand decontamination**

The aim of using a surgical hand scrub is to reduce resident micro-organisms (normal body skin flora) to a minimum and to inhibit their rapid re-growth.

Hand hygiene should be performed with soap and water prior to a surgical hand scrub.

Surgical hand scrub should be undertaken using a suitable antimicrobial antiseptic solution (which is: either an alcohol or aqueous based solution, is fast acting, has a broad spectrum of action and has a residual effect) or is an alcohol-based hand rub. Different products (such as: Hibiscrub (Chlorhexidine Gluconate 4%) and Betadine (Povidone-Iodine 7.5%)) have varying contact times and it is essential to ensure the manufacturer’s guidance is followed for each; but generally, hands and forearms should be washed for 3 - 5 minutes.

Surgical hand decontamination can be performed either with:

**2.2 Surgical hand scrub**

This procedure uses an antimicrobial antiseptic solution and water:

* Adjust the temperature and flow of water prior to procedure (i.e. warm enough and not too fast to cause splashing).
* Avoid touching taps and sink during procedure.
* Wet hands and arms up to the elbow.
* Apply appropriate amount of antimicrobial antiseptic solution (follow manufactures recommendations).
* Keep hands higher than the elbows.
* Allow water to drain away.
* Use the same method as for hand washing work from fingertips to elbow in one direction only. Include forearms to elbow using a corkscrew motion.
* Rinse hands and forearms, allowing water to flow from finger tips to elbows.
* Turn off taps using elbows.
* Towel dry hands and arms.
* When the hands and forearms are dry, sterile gloves and gowns can be donned.

Please see the [NIPCM Guidance](https://www.england.nhs.uk/wp-content/uploads/2022/09/nipcm-appendix-3-v2.5.pdf)

**2.3 Surgical Hand Rub**

This procedure uses an alcohol-based hand rub. The following procedure should be performed following hand washing with soap and water and the hands should be clean and dry:

* Apply three doses (approx. 5 ml) of alcohol-based hand rub from the dispenser to the palm of first hand.
* Dip fingertips of the opposite hand into the alcohol hand rub to decontaminate under the fingernails.
* Smear the alcohol hand rub using circular movement around the forearm to the elbow (from wrist to elbow in one direction only); ensuring all skin area is covered and the alcohol hand rub has fully evaporated (approx. 10-15 seconds).
* Repeat the above process for the opposite forearm.
* Using the elbow to operate the dispenser apply a further three doses (approx. 5 ml) of alcohol-based hand rub from the dispenser to the palm of first hand.
* Use the same method as for hand washing cover the whole surface of the hands to the wrists until the alcohol hand rub has fully evaporated.

Please see the [NIPCM Guidance](https://www.england.nhs.uk/wp-content/uploads/2022/09/national-infection-prevention-and-control-manual-appendix-4.pdf)

**3.0 Personal Protective Equipment (PPE)**

As a minimum staff should wear: a disposable apron, a fluid resistant surgical face mask, sterile gloves (and a full-face shield/visor if a risk of splashing of chemicals or body fluid is anticipated).

In accordance with the national guidance on personal protective equipment (PPE), the minor surgical procedures performed in GP Practices are not considered aerosol generating procedures (AGP) and therefore enhanced respiratory PPE is not required.

Personal Protective Equipment (PPE) is worn to protect both staff and patients during clinical activities and during direct care procedures (including minor surgical procedures), to reduce the risk of transmission of infections.

Clinical staff/healthcare workers must be trained to put on (don) and take off (doff) all PPE safely and avoid self-contamination. All PPE should be readily accessible and stored safely, in a clean dry area to prevent the risk of potential contamination from the environment and spillages, etc.

Please see the [National Infection Prevention and Control Manual](https://www.england.nhs.uk/national-infection-prevention-and-control-manual-nipcm-for-england/chapter-1-standard-infection-control-precautions-sicps/#1-4) – NHS England

**3.1 Personnel Performing the Procedure**

The following PPE should be worn:

* Sterile surgical gloves
* Disposable plastic apron (fluid repellent gown should be worn if there is a potential risk of extensive splashing of blood/body fluids).
* Fluid repellent surgical masks (FRSM)
* Eye protection - goggles/visor/face shield (should be risk assessed and worn if there is a potential risk of splashing of blood/body fluids).

Disposable gloves and plastic aprons or fluid repellent gowns must be single-use i.e. should be removed after every patient and discarded.

**Disposable gloves must not be decontaminated with alcohol-based hand rub or soap between uses.**

**Double gloving is not required for minor surgical procedures.**

Some eye protection is licensed for re-use and must be thoroughly decontaminated after each use (using a combined detergent and disinfectant (1,000ppm av.cl. or EN Standard 14476 virucidal activity) solution/wipe), and then rinsed, and stored in a named zip-lock bag or lidded box. If single-use eye protection is used, this should be discarded immediately after use.

Headwear (i.e. theatre caps) are not routinely required for minor surgical procedures.

Foot/shoe coverings are not required or recommended for minor surgical procedures.

**3.2 Donning PPE**

Staff should ensure that the correct PPE is worn during the minor surgical procedure and should be donned in the following order:

* Wash hands
* Put on disposable apron/gown
* Put on fluid repellent surgical mask
* Put on face shield/visor/goggles
* Perform surgical hand scrub/rub
* Put on gloves

Please see the [NIPCM Guidance](https://www.nipcm.hps.scot.nhs.uk/appendices/appendix-6-putting-on-and-removing-ppe/)

Please see [WHO Guidance](https://apps.who.int/iris/bitstream/handle/10665/44102/9789241597906_eng.pdf?sequence=1)

**3.3 Doffing PPE**

Staff should doff (take off) PPE after the patient has left the room and the order for removal set out below always applies.

When doffing PPE; ensure each item of PPE is discarded immediately and safely into the clinical waste stream.

This should be doffed in the following order:

* Remove gloves
* Decontaminate hands (wash with soap and water or use alcohol hand rub/gel)
* Remove apron/gown
* Decontaminate hands (wash with soap and water or use alcohol hand rub/gel)
* Remove eye protection if worn
* Decontaminate hands (wash with soap and water or use alcohol hand rub/gel)
* If FRSM is being worn for sessional use; decontaminate hands and arms up to the elbows by washing with soap and water to the elbow
* Remove FRSM
* Decontaminate hands and arms up to the elbows by washing with soap and water.

Please see the [NIPCM Guidance](https://www.nipcm.hps.scot.nhs.uk/appendices/appendix-6-putting-on-and-removing-ppe/)

**4.0 Staff Uniforms**

Staff should adhere to local uniform policy including being bare below the elbow.

If uniforms/clothing become contaminated or soiled during the minor surgical procedure these should be changed immediately after the procedure is completed.

Uniforms and clothing should be laundered:

* Separately to other household laundry
* In a load not more than half of the washing machines capacity
* Washed at the maximum temperature the fabric can tolerate (ideally at 60oC).
* Where lower temperatures are used the uniform/clothing should either be ironed or tumbled-dried

**5.0 Decontamination of Clinical Equipment and Medical Devices**

After each procedure and between patients, all re-usable non-invasive clinical equipment (i.e. treatment couch, trollies, diathermy equipment (hyfrecators), procedure trays, overhead theatre/examination light, etc.) should be decontaminated with combined detergent and disinfectant (1,000ppm av.cl.) based solution or wipes. If a chlorine-based disinfectant is not available, the disinfectant should meet the EN Standard 14476 for virucidal activity.

Please see the [NIPCM Guidance](https://www.england.nhs.uk/wp-content/uploads/2022/09/national-infection-prevention-and-control-manual-appendix-7.pdf) for Routine Decontamination of Re-usable Non-Invasive Care Equipment.

All re-usable non-invasive clinical equipment not used during the minor surgical procedure should be decontaminated at the end of the procedure and at regular intervals as part of routine equipment cleaning/decontamination.

If electrical equipment or medical device cannot withstand decontamination with combined detergent and disinfectant then the manufacturer’s instructions must be followed, or if not available, then a 70% isopropyl alcohol wipe can be used.

All invasive medical devices (scalpels, forceps, scissors, etc.) used during minor surgical procedures should be single-use and discarded immediately after the procedure is completed.

Equipment decontamination schedules should be available and a regular decontamination audit process in place.

**6.0 Decontamination of the Environment**

All surfaces should be free from clutter and all non-essential equipment should be removed from the minor surgery room.

Decontamination of the minor surgery room should always start from the higher-level surfaces (e.g. operating light), moving towards the lower level surfaces and from the cleanest areas to the dirtier areas.

Decontamination of the environment should be undertaken using a combined detergent and disinfectant (1,000ppm av.cl.) based solution or wipes. If a chlorine-based disinfectant is not used the disinfectant should meet the EN Standard 14476 for virucidal activity. It is essential that the manufacturer’s recommendations for use for decontamination products are followed and that recommended product contact times are adhered to.

Damp dust removal is important to prevent the accumulation of micro-organisms. All horizontal environmental surfaces in the minor surgery room should be decontaminated prior to the start of the minor surgery list and at the end of each session. After the patient has left the minor surgery room, all the environmental surfaces touched by the patient should be thoroughly decontaminated.

The floor in the minor surgery room should be cleaned at the end of each session and immediately if blood or body fluid spillages occur. A blood/body fluid spillage kit should be readily accessible and be in date, staff should be familiar with the use of the spill kit.

Please see the [NIPCM Guidance for Best Practice: Management of Blood and Body Fluid Spillages.](https://www.england.nhs.uk/wp-content/uploads/2022/09/nipc-manual-appendix-9-blood-body-spills.pdf)

Where privacy curtains are in use, these should be replaced on a 6 monthly basis and immediately if soiled.

After the patient has left, the room should be ventilated (i.e. windows should be opened to promote flow of air through the room) to reduce the number of airborne contaminants) and the doors kept shut during decontamination.

All staff undertaking cleaning tasks should wear appropriate PPE (including: gloves, apron and mask; eye protection should be worn if splashing of chemicals or blood/body fluid is anticipated).

Once the minor surgery room has been thoroughly decontaminated it can be put back into use immediately.

Disposable cleaning equipment should be used for cleaning the environment, such as disposable cloths, mop heads, etc. These should be discarded in the clinical waste stream after use.

If re-usable microfibre cloths or mop heads are used, processes must be in place to ensure these are thoroughly laundered at high temperatures after each minor surgery clinic. Discoloured, heavily soiled, damaged cloths and mop heads should be discarded and replaced.

Re-usable mop handles and buckets should be decontaminated after use and stored clean and dry.

Environmental cleaning schedules should be available and checklists completed to evidence that decontamination of the minor surgery room environment has been undertaken.

At the end of each minor surgery clinic a thorough clean of the minor surgery room should be undertaken, including floors and frequently touched surfaces.

**7.0 Waste and Sharps Management**

Sharps handling must be assessed, kept to a minimum and eliminated if possible with the use of approved safety devices.

At the end of the minor surgical procedure, disposal of all sharps (i.e. needles and blades) is the responsibility of the clinician undertaking the procedure.

There is a potential risk of transmission of a Blood Borne Virus (BBV) from a needle stick/sharps injury and staff must understand the actions they should take following an exposure incident. There is a legal requirement to report all sharps injuries and near misses to line managers/employers. (Please see the [NIPCM Guidance](https://www.england.nhs.uk/wp-content/uploads/2022/09/national-infection-prevention-and-control-manual-appendix-10.pdf)).

All PPE should be discarded in the clinical waste stream.

Please see the [HTM 07-01 Safe Management of Healthcare Waste](https://www.england.nhs.uk/estates/health-technical-memoranda/).

**APPENDIX 1**

**MINOR SURGERY ROOM REQUIREMENTS**

All minor surgical procedures should be performed in designated facilities (i.e. a Minor Surgery Room/designated Treatment Room) which is free from clutter, carpets and extraneous items (which can build-up dirt and debris).

Current [guidance](https://www.england.nhs.uk/estates/health-building-notes/) indicates that as a minimum the minor surgery room should be at least 16m2 or large enough to facilitate [all round access to the treatment couch](https://www.england.nhs.uk/estates/health-building-notes/), and accommodate required furniture such as: operators stool, procedure trolley, equipment and storage of sterile supplies/packs.

All surfaces should facilitate easy decontamination and should be able to with stand regular cleaning with a detergent/disinfectant (which either meets - 1,000ppm available chlorine or the required EN standard 14476 for virucidal activity) solution/wipe. The minor surgery room must be thoroughly cleaned at the start and end of each session as well as touched surfaces between patients.

The minor surgery room should be well ventilated (ideally through mechanical extract ventilation of >10 air changes per hour). If a centralised ventilation system is used that recirculates air then [HSE guidance](https://www.hse.gov.uk/ventilation/how-to-improve-ventilation.htm) recommends that there should also be a fresh air supply from alternative methods (i.e. open window).

Where mechanical extract ventilation is in place [windows should ideally not be opened](https://www.england.nhs.uk/estates/health-building-notes/) during the procedure. Where natural ventilation is used (i.e. through open windows) a fly screen should ideally be in place to prevent ingress of dust, debris and insects, etc.

Electrical fans must not be used in minor surgery rooms.

Ideally, windows should be opened between patients and during cleaning procedures.

**APPENDIX 2**

**PRINCIPLES OF ASEPTIC TECHNIQUE**

Minor surgical procedures involve procedures which breach the patient’s natural body defences, i.e. via the skin or mucous membranes; or when handling sterile clinical equipment/medical devices which will enter a normally sterile area of the body, i.e. below the dermal layer or via a sterile orifice. During these procedures the wound or susceptible site may be contaminated with potentially pathogenic micro-organisms which may lead to an infection.

The fundamental and basic principles of aseptic technique is to prevent the contamination of the open wound, isolate the surgical site from the surrounding non-sterile physical environment and create, maintain and promote a sterile field so that minor surgical procedures can be performed safely. It is essential that all clinical practices and procedures that have an impact on the prevention and control of the development of post-operative wound infection (i.e. surgical site infection) are implemented.

* **Asepsis** - means the absence of potentially pathogenic micro-organisms (i.e. bacteria, viruses, fungi).
* **Aseptic Technique** - means using strict practices and procedures to prevent contamination from pathogens.
* **Sterile Field** - is an area kept free of micro-organisms.

Aseptic technique is a standardised technique to prevent pathogenic micro-organisms from being introduced to susceptible sites by contaminated hands, surfaces or equipment. The framework can be divided into:

* **Standard aseptic technique** – which should be used when the procedure is technically simple and of short duration (<20 minutes) i.e. simple wound dressing.
* **Surgical aseptic technique** – which should be used when the procedure is technically complex and of longer duration (>20 minutes), i.e. incision to skin, suturing.

To minimise the risk of contaminating the open wound (key-site) or sterile invasive medical device (key-part), staff need to ensure that asepsis is maintained throughout the minor surgical procedures. Key parts must only have contact with other key parts or key sites during an aseptic technique procedure. Where it will be necessary to touch the key parts, staff undertaking the minor surgical procedure should use a surgical aseptic technique and wear sterile gloves.

The prime principle of surgical aseptic technique is that the practitioner cannot introduce infection to the patient if a key-part or key-site is not contaminated, i.e. the correct use of surgical aseptic technique will prevent:

* Microbial contamination of wounds and other susceptible sites;
* Exogenous (external introduction of) infection;
* Transfer of micro-organisms between staff and patient and vice versa.

A surgical aseptic technique encompasses practices performed immediately before and during the minor surgical procedure. These include:

* Hand hygiene
* Surgical scrub
* Using sterile surgical drapes
* Personal Protective Equipment (PPE), including: face shields/visors, fluid repellent surgical face masks; aprons and sterile gloves
* Patient surgical skin preparation
* Maintaining a sterile field
* Using safe operative techniques
* Maintaining a safe environment in the operating room

Further guidance can be sourced from the [ANTT Website](https://www.antt.org/)

**Sterile Field**

A sterile field is an area kept free of micro-organisms to protect the health and safety of a patient during a minimally invasive minor surgical procedure.

This environment is aseptic; all items in the sterile field are sterilized and should not contain micro-organisms.

Sterile fields should be prepared as close as possible to the time of use. To reduce the risk of airborne cross infection, talking, movement, opening and closing doors, exposure of wounds, disturbance of clothing or drapes and the number of staff in the minor surgery area should be kept to a minimum. Special consideration must be taken to maintain the integrity of the sterile field at all times.

**Disposable Sterile Surgical Drapes**

For any minor surgical procedure requiring ‘knife to skin’ a disposable sterile surgical drape should be used to [create a barrier and isolate](https://www.onetogether.org.uk/downloads/OneTogether%20Maintaining%20Asepsis%20QIR_2019.pdf) the surgical site from unsterile surroundings.

Disposable sterile surgical drapes are used to cover areas around the surgical site, and used correctly, establish a sterile field. These are available in standard sizes for general use and also pre-cut for specific operations. Some surgical drapes are available with a variety of features such as fluid control, adhesive areas to help attach to the skin and are resistant to tearing/strike-through.

All sterile surgical drapes should be fire resistant to prevent ignition from equipment used during surgery such as diathermy.

Sterile surgical drapes used during minor surgical procedures must conform to the [EN Standard 13795-1:2019](https://www.rsb.gov.rw/fileadmin/user_upload/files/pdf/new_stds/Covid-19_stds/EVS_EN_13795_1_2019_en.pdf).

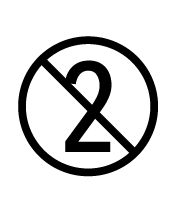
**APPENDIX 3**

**EQUIPMENT**

**Sterile Medical Devices/Instruments**

All sterile medical devices/instruments used for minor surgical procedures should be [single-use](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/956268/Single_use_medical_devices.pdf) and discarded at the end of the procedure. Please refer to [MHRA Guidance on single-use](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/743384/Single_use_medical_devices_leaflet_250918.pdf).

Symbol for single-use:



Any opened but un-used single-use sterile medical devices/instruments should be discarded at the end of the procedure.

All pre-sterilised packs/instruments must be checked prior to use for evidence of sterilisation, damage, integrity of packaging and expiry date. Please refer to [MHRA Guidance on Packaging and Symbols.](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/773058/Symbols_used_on_medical_devices.pdf)

Any packs/instruments found to be in an unsatisfactory condition must be discarded.

**Procedure Trolley**

All procedure trolleys should be stable; robust enough for the intended job; in good condition (free from surface abrasions) and in sound working order.

Preparation of procedure trolleys in advance, with surface items covered by a sterile sheet is not recommended.

The procedure trolley must be decontaminated prior to/after use, using a combined detergent and disinfectant solution/wipe.

Further guidance is available from the Medical Devices Directive [93/42/EEC](https://www.legislation.gov.uk/eudr/1993/42/2020-12-31) for specific requirements.

**APPENDIX 4**

**SKIN PREPARATION**

**Skin Disinfection**

[Skin disinfection](https://www.onetogether.org.uk/downloads/Surgical%20Skin%20Preparation%20Quality%20Improvement%20Guide_AW.pdf) is the process by which skin is cleansed to reduce the number of transient and resident skin flora before surgical incision. Most surgical site infections are associated with the patient’s own skin flora and thus skin should be disinfected prior to any minor surgical procedures being performed.

Dirt, skin secretions such as sweat and sebum, together with superficial microorganisms can be removed by cleaning skin with soap and water. However, microorganisms that live in the folds of the skin, sebaceous glands and hair follicles are not removed this way. Therefore, to achieve skin disinfection an antiseptic solution needs to be applied which rapidly kills or removes skin microorganisms from the skin at the surgical site.

There are two main antiseptics agents used for skin disinfection;

* Chlorhexidine gluconate (CHG)
* Iodophors (Povidone Iodine; PI)

These are available in both aqueous and alcohol-based forms. Alcohol solutions are deemed to be more efficient than aqueous solutions; but decisions about which preparation should be used, should be influenced by the surgical site, condition of skin and patient allergies; please see table below on possible options:

|  |  |
| --- | --- |
| **WHEN** | **CHOICE OF ANTISEPTIC SKIN PREPARATION** |
| First choice or the surgical site is next to a mucous membrane | Alcohol-based solution of chlorhexidine:   * 0.5% chlorhexidine in 70% alcohol solution, i.e:   + Hydrex   + SoluPrep * 2.0% chlorhexidine in 70% alcohol solution, i.e   + ChloraPrep |
| If surgical site is next to a mucous membrane | Aqueous solution of chlorhexidine:   * 4.0% aqueous chlorhexidine, i.e:   + Hydrex surgical scrub |
| If chlorhexidine is contraindicated | Alcohol-based solution of povidone-iodine:   * 10% povidone-iodine |
| If both an alcohol-based solution and chlorhexidine are unsuitable. | Aqueous solution of povidone-iodine:   * 10% iodine antiseptic solution, i.e:   + Videne |

Please see Appendix 5 for [One Together](https://www.onetogether.org.uk/downloads/OneTogether%20Skin%20Prep%20Poster_2019.pdf) UK Surgical Skin Preparation: Decision Guide.

When using an alcohol-based solution it is essential that after application the product completely evaporates and the skin is thoroughly dry (avoid pooling) and before applying electrocautery (diathermy) or laser treatment. Please note: spontaneous combustion can occur when flammable solutions are exposed to an ignition source when oxygen is present.

**APPENDIX 4**

**SKIN PREPARATION**

Skin preparation of the surgical site should occur as close to the time of surgery as possible and immediately prior to draping.

Ideally single-use skin preparation applicators should be used and discarded immediately after use. If an applicator is not used, then skin preparations should be provided in single-use sachets. Any unused solution should be discarded at the end of the procedure.

Although not the preferred option, multi-dose skin preparation bottles/containers of skin preparation can be used. These should be handled using an aseptic technique to minimise the risk of contamination to the remaining solution, i.e:

* Not touching the inside of the cap or neck of the bottle/container
* Label with date of opening
* Use within a defined period as recommended by the manufacturers

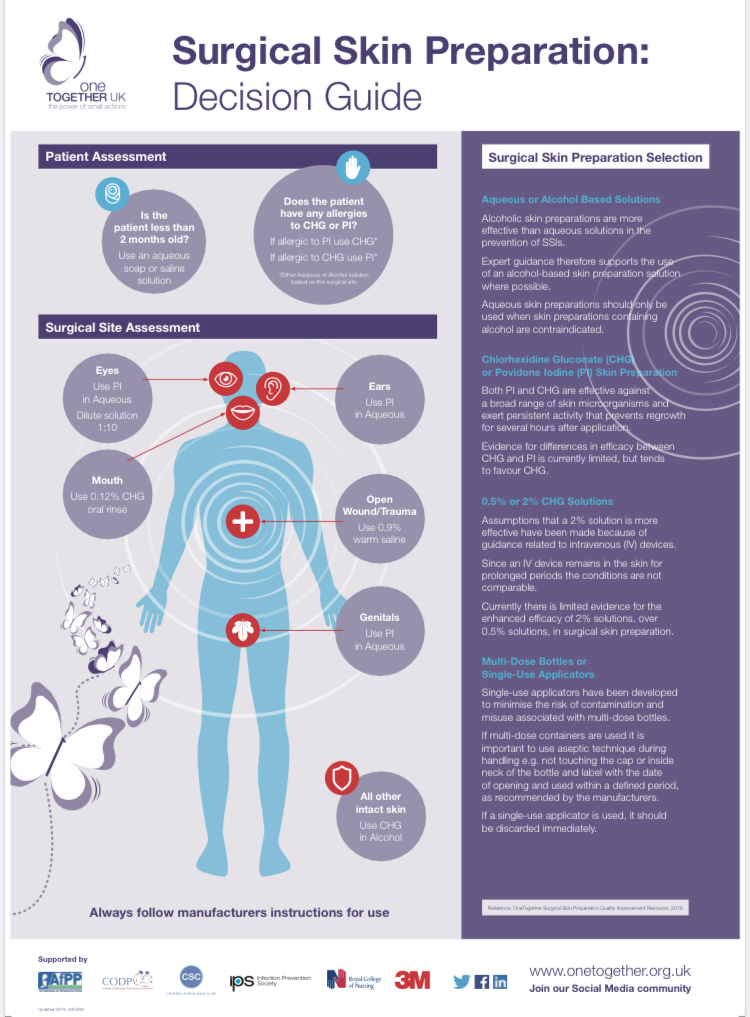
**Shaving**

Shaving is no longer recommended because it causes small nicks and breaks in the skin; hair around the site may be clipped short if it will interfere with the minor surgical procedure (i.e. hair from a head wound) or contaminate the wound site. Patients consent must be sought before clipping hair.

Clipping should be undertaken using electrical/battery powered clippers. The head of the clippers should be suitable for being disinfected or ideally should be single-use.

**APPENDIX 5**

**ONE TOGETHER UK SURGICAL SKIN PREPARATION: DECISION GUIDE**



**APPENDIX 6**

**WOUND MANAGEMENT**

**Dressing the Wound**

If required, appropriate sterile dressings should be applied to the minor surgical wound site, which comply with the local wound formulary.

Dressing should be chosen to facilitate and promote the wound healing process.

Dressings may be cut to size using single-use sterile scissors. Single-use sterile scissors must be discarded in the sharps bin after use.

Any primary dressings left over must not be re-used.

Rolls of surgical tape must be stored in their boxes and returned after use.

**APPENDIX 7**

**WORLD HEALTH ORGANISATION (WHO) SURGICAL SAFETY CHECKLIST**

**Background**

The Safer Surgery Saves Lives initiative was launched by the World Health Organisation (WHO) in 2008 to reduce the number of surgical errors and enhance patient safety during the perioperative phase of their care. The launch saw the introduction of a surgical safety checklist. The Five Steps to Safer Surgery was introduced in 2010. It is a process for improving the way theatre teams communicate with each other. It consists of 5 steps:

1. Briefing
2. Sign in
3. Time out
4. Sign out
5. Debriefing

The WHO surgical safety checklist forms steps 2, 3 and 4 of the five steps.

**Assessment**

The WHO surgical safety checklist is a core set of safety checks, identified for improving performance at safety critical time points within the patient’s perioperative journey. The 3 steps in the checklist are not intended as a tick-box exercise but as a tool to initiate effective communication between the clinical team.

The WHO checklist should be carried out for all patients including those having procedures under local anaesthetic or sedation.

The Briefing and Debriefing should be carried out for all minor surgery lists and should include all members of the minor surgery team.

**Objectives**

* To ensure a safe operating environment for patients and staff
* To reduce the number of serious incidents and never events
* To complete WHO checklist for all patients
* To improve efficiency and safety through effective briefing

Use of the checklist helps in systematically integrating safety measures, thereby reducing the likelihood of errors and enhancing patient outcomes.

Please see [NHS England guidance on surgical/anaesthetic/maternity safety](https://www.england.nhs.uk/patient-safety/patient-safety-alerts/enduring-standards/standards-that-remain-valid/surgical-anaesthetic)

Please see [WHO Surgical Safety Checklist](https://apps.who.int/iris/bitstream/handle/10665/44186/9789241598590_eng_Checklist.pdf;jsessionid=5D6A3C141F385E02549EFCD3641AA256?sequence=2)