

UNIVERSITY HOSPITAL OF NORTH DURHAM

OPERATIONAL PROCEDURE DOCUMENT

MAIN OPERATING THEATRES

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1. INTRODUCTION

The Operating Department consists of 10 operating theatres each with its own dedicated anaesthetic room, scrub room and preparation room. Other facilities such as dirty utilities, storage rooms and exit bays are shared one between two theatres.

The operating theatres will treat in-patients, day cases and outpatients for local and general anaesthetic procedures (both adults and paediatrics) across the following range of specialties

general, vascular & colorectal surgery
gynaecology
orthopaedics
oral surgery
plastic surgery
urology

Elective waiting list, urgent and emergency cases will be operated upon. When possible, urgent cases will be booked via the theatre computer system on to a daily trauma list with any potential or actual problems being referred to the Theatre Manager or deputy.

Each consultant or specialty will follow the operational procedure for the booking of cases via the sapphire theatre computer system.

Obstetrics

Obstetric cases, including both planned and emergency caesarean sections will be undertaken in the dedicated Obstetric Theatre adjacent to the delivery suite within the maternity theatre.

An emergency caesarean section will only be performed within the main theatre suite if the obstetric theatre on the Delivery Suite is in use and the mother and/or baby's condition is life threatening.

Adjacencies

The theatre complex is situated in close proximity to both the Surgical Day Unit and Intensive Therapy Unit.

The Surgical Day Unit which includes changing facilities for patients together with second stage recovery rooms and interview rooms for pre-assessment and admission of day cases has its own operational procedure document which relates to these activities.

2. ROLE OF THEATRE CO-ORDINATOR

The role of Theatre Co-coordinator will be carried out on a 3 monthly rotational basis by all G grades, Monday–Friday, 8am–5pm. The appropriate name will be displayed on the whiteboard at the reception area. The coordinator will carry the emergency bleep and list.

Purpose of the role

The main purpose of the role of Co-coordinator is to ensure maximum efficiency in terms of utilisation of theatre sessions and the deployment of staff.

Booking of emergency and trauma patients

All emergency and trauma or surgeon of week list patients must be booked with the Theatre Co-coordinator. The Theatre Co-coordinator will communicate with Consultant Surgeons and Anaesthetists to minimise delays and avoid problems. However there must be communication between the operating surgeon and the anaesthetist to communicate any patient problems.

Where difficulties remain, the Theatre Co-ordinator will liaise with the Clinical Director or Consultant Anaesthetist on duty/call and agree a decision which she/he will then communicate to those involved.

Booking of Equipment

All major pieces of theatre equipment required by Consultants, e.g. camera system or image intensifier must be booked with the Theatre Co-ordinator either in writing in the diary at reception or by telephone, giving as much notice as possible.

Session Utilisation

Anaesthetic Coordinator circulates available sessions to the Clinical Services Manager. (CSM)

When it has been established that the Clinical Services Manager will use the session, the Theatre Manager/Coordinator advises if theatre staff are available.

If theatre staff unavailable the following steps must be taken:

- Bank Staff
- Ask Day Surgery for staff
- Ask part-time staff to work extra
- Ask full-time staff for overtime
- Ask CSM for South Durham staff
- Agency

Co-ordination of theatre and anaesthetic non-medical staff

The Theatre Coordinator will prepare duty rosters for the deployment of staff in the normal way.

The Theatre Co-ordinator will be responsible for the deployment of staff on a daily basis.

(a) **Theatre Receptionist**

The main duties and responsibilities of the Theatre Receptionist are to:-

- act as a switchboard for the theatres
- answer bleeps deposited by medical staff
- relay messages as appropriate
- Enter patients details on to the sapphire system
- undertake duties as detailed in specific theatre receptionist job description.
- undertake secretarial duties for Theatre Manager
- undertake typing duties for Theatre Sisters
- Facilitate access for Planned Preventative Maintenance (PPM) in the absence of the Reception Auxillary Nurse
- Coordinate maintenance of the Image Intensifier
- Produce trauma/surgeon of the week lists
- It is the responsibility of the medical secretary to ensure the typed list is delivered to theatre by 4pm the day before. If any delay may occur the Theatre Receptionist must be advised.

(b) **Theatre Reception Nurse**

The main duties of the Theatre Reception Nurse are to:-

- send for patients from inpatient wards at the appropriate time to ensure there is no delay to theatre lists
- Check patients in to the operating department as per check list procedure protocol and to enter them on to the sapphire system
- Provide nursing care to patients waiting in the reception area when the ward nurse is unable to stay with the patient
- Inform the appropriate anaesthetic nurse when their patient is checked in and ready to enter the anaesthetic room
- To check with the theatre recovery sister to see if any patients can be returned to the same ward by the nurse escorting the patient to theatre reception
- To record base line observations
- To apply ECG electrodes

(c) **Theatre Reception Auxillary Nurse**

The main duties of the Reception Auxillary Nurse are to:-

- Greet visitors to the department, issue badges and maintain an up to date list of all visitors to the department.

- Relay messages as appropriate
- Enter patient details onto the Theatre System when required
- Act as switchboard for Theatre
- Provide assistance to the reception nurse, remain with patient as directed
- Coordinate small works requirements in the department
- Facilitate access for Planned Preventative Maintenance.

3. STAFF ROSTERING

(a) Staff Rostering Policy

The Theatre Coordinator will prepare nursing and non-medical staff rosters. Rosters will be planned one month in advance whenever possible following the guidelines specified in the Trust Rostering Policy.

Off duty requests

Special off duty requests must be made in writing in the off duty request book prior to the planning of the duty roster for the relevant week.

Booking holidays

Holidays will be booked in accordance with the Annual Leave Policy (Appendix 1)

(b) On-call guidelines

Working time limit

As an employer, the Trust is required to take all reasonable steps to ensure that its employees do not work more than an average of 48 hours per week over a reference period of 4 months (17 weeks).

On-call

On call is defined as being immediately available for work but not present on the work site. Staff who are required to be on call shall be regarded as working from the time that they are contacted to attend work until the time that they return home directly from work, or begin another activity at the end of the work related call.

Standby

Staff required to be at their place of work and sleeping in for a specified period shall be regarded as working for the purposes of the Trust's Local Agreement. However, working time does not equate to paid time under the terms of this agreement.

Rest periods

Daily rest: Each employee is entitled to a rest period of 11 consecutive hours between each working shift, although this does not apply on a change of shift pattern or a split shift system. However, arrangements must be made to allow for an equivalent period of compensatory rest (see below).

In order to follow the spirit of the agreement wherever possible an early start (ie 07.00) should not follow a late shift (ending at 21.00 or later).

Weekly rest: Each employee is entitled to an uninterrupted rest period of not less than 24 hours in each 7 day period, or 2 days rest over a fortnight.

Daily or weekly rest are separate entitlements which should be taken consecutively, ie entitlement to 35 hours consecutive rest each week (24 hours + 11 hours) or 70 hours per fortnight (24 + 24 +11 + 11).

Weekly rest is additional to any paid annual leave.

In work rest breaks

Where the working day is 6 hours or more employees are entitled to a break away from the 'work station' of at least 20 minutes at some point during the shift. This break must not be at the beginning or end of the shift or added to the daily rest period. The majority of staff have a lunch break which meets this entitlement.

Compensatory rest

Where there is a need for continuity of service, exceptional circumstances or emergency situations there will be occasions when rest periods cannot be given. In such circumstances there will be a right to an equivalent period of compensatory rest which equates to the rest hours lost.

Example

If a member of staff is delayed at work due to circumstances beyond their control, or on call, and at work until 23.00 hours the 11 hour rest period is calculated from the time they arrive home, eg 23.30 + 11 hours = 10.30 am the next day.

If the member of staff is required to come to work earlier than 10.30 because they have been rostered for an early shift and their failure to attend may result in patient cancellation the period between 08.00 and 10.30 equates to the lost rest period and is identified as compensatory rest.

Compensatory rest which is not taken in full at the relevant time can be paid as overtime or added to the employees flexitime, but should be clearly identified as such on the relevant actual duty roster. If staff wishes to take time back for hours worked i.e. take 11 hours compensatory rest and work a shorter shift that day, they can claim

enhanced hours worked during the night.

The following table illustrates the effect of the 11-hour rest period. For theatres and anaesthetic nursing and ODP staff.

| <u>End of work time</u> | <u>Return to duty time</u> |
|-------------------------|----------------------------|
| 22.00 | 09.00 |
| 23.00 | 10.00 |
| 24.00 | 11.00 |
| 01.00 | 12.00 |
| 02.00 | 13.00 |
| 03.00 | 14.00 etc. |

Conclusion

In order to maintain the health and safety of all theatre and anaesthetic personnel, comply with the legislation and to meet the spirit of the agreement, all staff should take an 11 hour rest period between spans of duty whenever possible. When this is not possible the member of staff is entitled to a period of compensatory rest equal to that which they were unable to take.

As a general principle any member of staff who is at work after 03.00 am and rostered for an early shift the following day should not be expected to attend work the next day.

Any member of staff who has been delayed at work or called in on call must not be pressurised or otherwise coerced into foregoing their 11 hour rest period, if on health or safety grounds they consider that they are too tired to attend work for their rostered shift time, (if this is inside the 11 hour rest period). Where this will effect the next days work load and potentially result in patient cancellations or the loss of an operating list the members of staff concerned must ensure that the senior nurse in charge of the theatre is made aware of the situation at the beginning of the affected shift.

It is the responsibility of the Theatre Coordinator on duty to inform the Theatre Manager, (or Directorate Manager) and to re-allocate staff to cover the list if at all possible.

(c) **Dedicated Emergency Theatre: Staffing Cover**

Introduction

The dedicated emergency theatre (Theatre 5) will be used Monday-Friday for emergency cases from the following specialties:

General, Vascular & Colorectal Surgery
Gynaecology & occasional Emergency Caesarian Sections
Plastic Surgery
Oral Surgery
Urology

When ever possible orthopaedic trauma and vascular emergency cases will be operated upon in a clean air theatre (theatres 7,8, & 10).

Staffing cover for the 24-hour period (from August 2001)

1. Monday – Friday 08.00 – 17.00 (excluding Public Holidays)
 - i. 08.00 – 13.30
Staff drawn from other lists will cover emergency cases. If there are insufficient staff available, a planned list may be delayed or cancelled to enable the emergency case to proceed.
 - ii. S.O.W. lists (Surgeon of Week) 13.30 – 17.00
These lists are planned to take place Monday – Friday 13.30 – 17.00
Staff will be rostered to cover the SOW list and will be identified on the duty roster.
Minimum requirements for staffing cover are as follows:
Anaesthetic nurse/ODP x1
Qualified Scrub nurse/ODP x 1
Qualified Circulating nurse/ODP x 1
Team assistant x 1
Recovery nurse/ODP x 1
 - iii. 17.00 – 21.00
One emergency team will be available to cover emergency cases from all specialties during this time. **A lead nurse will be identified on the duty roster as documented in Guidelines for the Management of Emergency Sessions, (Appendix 2)**

The team will consist of:

Anaesthetic nurse/ODP x 1

Recovery nurse/ODP x1

The number of staff available to scrub will depend upon the experience of the Scrub Nurse. The minimum total number of staff available for the emergency team between 5pm – 9pm will be 4.

Orthopaedic Scrub nurse/ODP x 1
General/Gynae scrub nurse/ODP x 1
Plastic surgery scrub nurse/ODP x 1
Team Assistant x 1

There is no dedicated out of hour's obstetric cover. Obstetric cover is provided by the availability of Anaes/Recovery staff on duty during this period.

- iv. 21.00 – 08.00 (night duty)
One team will be on duty in the department during this time. The team will consist of:
Anaesthetic nurse/ODP x 1
Recovery nurse/ODP x 1
1 scrub nurse
Team assistant x 1
There is no dedicated out of hour's obstetric cover. Obstetric cover is provided by the availability of the Anaes/Recovery staff on duty during this period

2. Weekend/Bank Holiday cover:

- i. 08.00 – 17.00
2 separate teams will be available during this time: one to cover general/vascular, gynaecology and urology emergency cases, and the second team will be to cover plastic and orthopaedic trauma.

Although separate orthopaedic/plastic and general surgery/gynae urology teams have been identified to enable orthopaedic and plastic trauma lists to proceed, the teams will need to work flexibly in order to maximise the number of procedures performed.

This process will be enhanced if a senior member of the nursing staff acts as co-coordinator. It will be the co-coordinator's responsibility to liaise with medical staff from the different specialties and co-ordinate the cases to be done, and the operating teams. The respective operating surgeons in discussion must prioritise these cases with the anaesthetist. **A lead nurse will be identified on the duty roster.**

Minimal cover per specialty team.

General/Vascular, Gynaecology, Urology Team:

Anaes nurse/ODP x 1
Recovery nurse/ODP x 1
Scrub nurse/ODP x 2

Team Assistant/Auxiliary x 1
Recovery nurse/ODP x 1

Orthopaedic, Plastic Team:

Anaes nurse/ODP x 1
Scrub nurse orthopaedic x 1
Scrub nurse plastics x 1
Team Assistant/Auxiliary x 1
Recovery nurse/ODP x 1

There is no dedicated out of hour's obstetric cover. Obstetric cover is provided by the availability of the Anaes/Recovery staff on duty.

- ii 17.00 – 21.00
One team on duty.

Anaesthetic nurse/ODP x 1

Recovery nurse/ODP x 1

The number of staff available to scrub will depend upon the experience of the scrub nurse. The minimum total number of staff available during this period will be 4.

There is no dedicated out of hour's obstetric cover. Obstetric cover is provided by the availability of the Anaes/Recovery staff on duty during this period.

- iii Night duty:
1 Scrub nurse/ODP
2 Anaes/Recovery nurses/ODP's
1 Circulating nurse

On call or standby cover:

All Specialties:

The current arrangements are for 1 Scrub Nurse/ODP, 2 Anaes/Recovery Nurses/ODP's, 1 circulating to be rostered for night duty. Currently any required back up is provided in an informal way on an ad hoc basis. This tends to result in those staff living nearest to the hospital frequently being the ones to be called back.

Conclusion

It is expected that if a list guillotine policy is introduced with an extended

emergency team on duty from 17.00 that most of the urgent cases pending can be operated upon between 17.00 and 21.00.

The time after 21.00 will be for emergency cases, which cannot safely be deferred until the following day.

It is hoped and expected that staff will not be called in unless the circumstances are exceptional.

4 DEFINITION OF OPERATING THEATRE SESSION TIMES

Start and finish times

All day lists: start 09.00 within these times all staff must be ensured
end 17.00 of at least one ½ hour meal break between
12.00 and 14.00

Morning list start 09.00
end 12.30

ERPC list: start 12.30 in Theatre 5 prior to commencement of
Surgeon of week list
end 13.30

Afternoon list: start 13.30
end 17.00

Evening: start 17.30
end 21.00

Out of hours: all other times – acute emergency patients only

Weekends and Bank Holidays

Emergency work undertaken at weekends or on Bank Holidays should be scheduled during day time list periods and cases booked with the Theatre Co-coordinator

(b) Definitions

Sapphire reporting will provide theatre session utilisation.

Definition of start of operating list

The operating list start time is to be calculated from the commencement of induction of anaesthesia for the first patient on the list.

Definition of early start of operating list

An early start is deemed to have occurred if induction of anaesthesia for the first patient on the list commences 10 minutes, or more, before the agreed start time for the specialty.

Definition of late starts of operating list

An operating list is deemed to have started late if induction of anaesthesia for the first patient on the list commences 10 minutes, or more, after the planned list start time for the specialty.

Definition of end of operating list

The operating list ends at the time the last patient on the list is transferred from the operating theatre to the recovery room.

Definition of early finish of operating list

An operating list is deemed to have finished early if the last patient on the list is transferred to the recovery room 10 minutes, or more, before the planned end time for the list.

Definition of late finishes of operating list

An operating list is deemed to have finished late if the last patient on the list is transferred to the recovery room 10 minutes, or more, after the planned end time for the list.

Reports will be produced on a monthly basis and will include:

- Utilisation by specialty and theatre
- Cancellations on the day of admission or day of surgery
- Cancelled sessions
- Re-allocated sessions
- Detailed ad-hoc reports can be requested via the Theatre Manager

5. PROTOCOL FOR CHANGE OF THEATRE SESSIONS

Introduction

Theatre sessions are often not used when Consultant Surgeons are on annual/study leave or are surgeon of the week.

All Consultants must notify annual or study leave via their Medical Secretary by completing a cancelled/change form.

The Clinical Services Manager and Clinical Director (CD) will circulate the form after authorisation to the following:

- Waiting List Department
- Theatre Manager
- Nurse Practitioner Unit
- Day Surgery Manager
- Anaesthetic Coordinator

The Anaesthetics Co-coordinator will circulate all CSM with the vacant theatre sessions. Potential sessions available will be notified as near to the beginning of each month as possible. Uptake of these sessions will be dependant upon the availability of theatre staff.

Purpose

To ensure full utilisation of theatre sessions during a consultant's absence, eg annual leave, study leave.

Procedural Guidelines and Rules of Play

1. Notification of a cancelled session should be made to the Anaesthetic Co-coordinator with six weeks notice via the appropriate form.
2. When junior staff are covering their consultants' planned leave, notification is still required.
3. Sickness and unavoidable short notice leave should be made known to the Anaesthetic Co-coordinator as soon as possible.
4. Once notification of a cancelled session has been sent to the Anaesthetic Co-coordinator, the specialty concerned can no longer assume it still has control of that session.
5. If a consultant wishes to reclaim a session this **must** be done via the Anaesthetic Co-coordinator. If the session has already been re-allocated, the re-allocation stands.

6. Where a session is re-allocated to another surgeon the full session should be utilised
7. Uptake of cancelled sessions will be dependant on the availability of theatre staff.

**COUNTY DURHAM AND DARLINGTON ACUTE HOSPITAL NHS TRUST
PLANNING AND PERFORMANCE DIRECTORATE**

CANCEL OR CHANGE OF SESSION FORM

To: Waiting List Department, Theatre Manager, Nurse Practitioner Unit, Day Surgery Manager & Anaesthetics Co-coordinator

Copy to:

Please tick column as appropriate

| CONSULTANT | THEATRE DATE | THEATRE DAY | CANCEL | REDUCE | REINSTATE | REASON |
|------------|--------------|-------------|--------|--------|-----------|--------|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

Special instructions:

Requested by:

Date:

Authorised by: (Directorate Manager)

Date:

Authorised by: (Clinical Director)

Date:

Version 2 – October 2003

A minimum notice period of six weeks is required for all amendments.

All staff are instructed not to process this request unless signed by the Directorate Manager and the Clinical Director

6. **THEATRE BOOKINGS**

(a) **Booking of patients for trauma and surgeon of week lists.** **Booking of emergency patients.**

Patients should be booked onto planned trauma / surgeon of week lists as early as possible on the day of surgery, or before if this can be anticipated.

Patients may be booked by the surgeon attending Theatre Reception in person or by telephoning ext. **2345 or 2362** with the following details:

1. Patient's name, unit number, date of birth (not age) and ward number.
2. Surgery to be performed.
3. Name of consultant and operating surgeon and bleep/contact number.
4. Time of proposed surgery, or order number on operating list.
5. Any other relevant medical information, eg patient allergies, disabilities.

The Theatre Receptionist will book the patient on to the appropriate theatre list; enter the patient as an emergency via the Sapphire System.

The Theatre Co-coordinator will inform the operating surgeon and/or anaesthetist of any problems or delays to the list.

If trauma or surgeon of week lists are over-booked the consultant will be notified and should advise as to which patients can be deferred until the following day or added to the out of hours emergency surgery list.

(b) **Evacuation of retained products of conception (ERPC) planned operating lists**

(1) **Introduction**

An ERPC operating list will be undertaken Monday to Friday between 12.30 and 13.30 in Theatre 5.

Within the time available it will be possible to treat a maximum of 2 patients and this will be entirely dependent upon good communication between all the members of staff involved.

NB. The ERPC list should not be allowed to start after 12.30 if this will delay the surgeon of the week emergency list commencing in Theatre 5 at 13.30.

(2) **Staffing for the ERPC list**

The following individuals will staff the ERPC list: -

- The Anaesthetist identified as 'on call' for obstetrics
- The Registrar for Obstetrics and Gynaecology 'on call' for the Labour Ward (Ward 8) – on a Thursday Consultant of week carried out protocol
- The Anaesthetic Nurse/ODP identified for Obstetrics
- The Registered Theatre Nurse/ODP undertaking the late shift (from Main Theatre)
- Team Assistant

It is absolutely essential that the ERPC list start promptly at 12.30 hours.

(3) **Procedure to be followed by Operating Department Staff involved with the ERPC list**

3.1 The role of the Obstetric Anaesthetic Nurse/ODP

The Ward Clerk on Ward 10 (gynaecology) will bleep the Theatre Receptionist as soon as possible and inform him/her of the number of patients (maximum 2) on the ERPC list.

1. The Theatre Receptionist will record all the patients' details on the ERPC list sheet (emergency sheet as per Surgeon of Week list).
2. The Receptionist will inform the identified registered theatre and anaesthetic nurse/ODP of the number of patients on the list.
3. The Anaesthetic Nurse/ODP will alert the Theatre Coordinator to any potential problems.

3.2 The role of the Registered Theatre Nurse/ODP

The Registered Theatre Nurse (late shift) will be informed by the Receptionist of the number of patients on the ERPC list. The Team Assistant will prepare theatre 5 for the ERPC list.

1. At 12.15 hrs the Registered Theatre Nurse/ODP will ask the holding bay nurse to send for the first patient on the ERPC list.
Both patients will be escorted to theatre by a nurse from Ward 10, if they are fit they will walk to theatre, if they are unfit they will come in a wheelchair or on a trolley.
2. The Registered Theatre Nurse/ODP will check that Theatre 5 and the anaesthetist are prepared for the commencement of the ERPC list.

3. The Registered Theatre Nurse/ODP will be responsible for the management of the list.
4. She/he will liaise with the Anaesthetic Nurse/ODP and request that the reception nurse sends for the 2nd patient (if any) at the appropriate time.
5. She/he will assist the Team Assistant to clear up and set Theatre 5 at the end of the list.

3.3 The role of the Reception Nurse

The Theatre Receptionist will deliver a typed copy of the ERPC list to the Holding Bay.

1. The Reception Nurse will contact the anaesthetist and then send for the first patient from the ERPC list at 12.15 hrs.
2. The Reception Nurse will check in the patients from the ERPC list as per theatre check list procedure
3. The Reception Nurse will inform the Anaesthetic Nurse that the patients have arrived and that the first patient is checked in and ready for theatre.

The first patient must be in the Anaesthetic Room by no later than 12.30 for the commencement of the list.

3.4 The role of the Theatre Receptionist

1. The Theatre Receptionist will type up the list and distribute one copy to each area as follows: -
 - a) Reception
 - b) Anaesthetic Room (Theatre 5)
 - c) Theatre 5

A spare copy should be available for the Anaesthetist on call for Obstetrics.

2. The Labour Ward Clerk will inform the surgeon.

3.5 The role of the Theatre Manager, or her deputy

The Theatre Manager/Theatre Coordinator or her deputy will only be involved with the ERPC list if there are potential or actual problems.

Potential problems

- Emergency LSCS a) actual b) pending
- Overrun of planned Obstetric list
- Insufficient staffing resources
- Life threatening emergency case (non-Obstetric) in Theatre 5
- Anaesthetist busy with emergency elsewhere, eg A&E
- More than 2 patients requiring ERPC

Emergency LSCS

- a) Actual an emergency LSCS will always take priority. If an emergency LSCS is taking place at 12.30 the ERPC list cannot take place.

The Theatre Manager or her deputy will discuss the possibility of the ERPC list following the emergency LSCS with the Anaesthetist for Obstetrics and the Obstetric Registrar.

The decision to proceed with the ERPC list will depend upon activity and staffing in the rest of the Department. The decision to proceed or not will rest with the Theatre Manager or her deputy.

- b) Pending if an emergency LSCS occurs while the ERPC list is underway, the ERPC list will be stopped and the emergency LSCS will be performed.

The decision to continue and complete the interrupted ERPC list will depend upon activity and staffing resources in the wider Department. The decision will rest with the Theatre Manager or her deputy.

Overrun of planned obstetric list

If the planned obstetric list overruns it is unlikely that the ERPC list will be able to proceed. The decision will rest with the Theatre Manager or her deputy.

Insufficient staffing resources

If there are insufficient staffing resources the Theatre Coordinator will inform the Anaesthetist and Obstetric Registrar before 12.30 hrs.

Life threatening emergency case (non-obstetric)

Life threatening emergency cases in any specialty always takes priority over planned lists. If such a situation arises, the ERPC list may be cancelled or stopped.

If the Reception Nurse informs the Theatre Coordinator that the Obstetric Anaesthetist is busy with an emergency elsewhere in the hospital, the ERPC list will be deferred or cancelled. The list will only proceed if there is sufficient staff to cover it at a later time.

More than 2 patients requiring ERPC

It will only be possible to treat a maximum of 2 patients for ERPC in the time available. If there are more patients requiring treatment, the Registrar for Obstetrics will prioritise which patients are treated on the planned list and which patients will be treated out of hours or deferred until the following day.

It must be explained to any patient who is to be treated out of hours that they cannot be given an exact time for their operation.

(c) **Emergency caesarean section performed in main operating suite**

Introduction

An emergency caesarian section will only be performed within the main theatre suite if the obstetric theatre on the Delivery Suite is in use and the mothers and/or baby's condition is life threatening.

In the above circumstances theatre 5 (dedicated emergency theatre) should be used whenever possible.

Procedure for Organising Emergency Caesarian Section in Main Theatre Suite:

1. Communications:
 - I. Monday – Friday 09.00 – 17.00
 - The midwifery sister co-coordinator will bleep (2084) the Anesthetic Nurse.
 - The Obstetrician in charge of the case will contact the Anaesthetic Co-coordinator and request a second Obstetric Anaesthetist.
 - ii. Out of hours (anytime other than Monday-Friday 09.00 – 17.00) including Public Holidays.
 - The midwifery sister co-coordinator will bleep (2084) the anaesthetic nurse and request a second anaesthetic nurse. She will also indicate

to the anaesthetic nurse whether or not scrub team support will be needed from main theatre staff. If support is needed the midwifery sister co-coordinator must state what support is required.

- Eg. Scrub nurse
Circulating nurse
Team assistant.
- The Obstetrician on call will bleep the 2nd Consultant anaesthetist on call and request anaesthetic support for the second emergency caesarian section.

2. Transporting the Patients:

The patient will enter the operating department from the main lifts via theatre Reception and be taken by the most direct route to theatre 5, (or any other theatre designated for the case). The service lift can be used in an emergency situation.

3. Theatre Equipment:

i. Resuscitaire

Main theatres will be supplied with a resuscitaire on permanent loan from the Obstetric Unit. This will be cleaned, fully stocked and maintained by midwifery staff.

The resuscitaire will be stationed in the exit bay outside theatre 2 in readiness to be used for an emergency caesarian section.

ii. Caesarian Section Sterile trays and sundries:

A trolley containing a sterile caesarian section set and other essential items will be kept in the Theatre 2 Preparation Room.

The responsibility for cleaning, maintaining and re stocking this trolley will rest with midwifery staff.

In the event of an emergency caesarian section coming to main theatre a team assistant support worker from main theatre will be instructed to take the trolley to theatre 5 or another designated theatre

4. Duties and Responsibilities of Anaesthetic Sister in charge:

i. Communication:

- The Anaesthetic nurse in charge will be bleeped (2084) by the midwifery sister co-coordinator who will request a second anaesthetic nurse +/- scrub team support. If scrub team support is needed this must be identified (see1 (ii) above).
- The Anaesthetic Sister will identify a second anaesthetic nurse.
- She will check on the availability of theatre 5 and liase with the Theatre Coordinator regarding scrub team support required.

- If theatre 5 is in use the Anaesthetic Sister will identify which theatre is to be used and relay this immediately to the Midwifery Sister Co-coordinator.
- The Anaesthetic Sister in charge will instruct a team assistant support worker to transfer the identified caesarian section trolley from the main/theatre sterile store to theatre 5 (or the identified theatre) and to move the resuscitaire from theatre 5's exit bay into the appropriate theatre.
- The Anaesthetic Sister in charge will notify theatre Reception of the imminent arrival of the emergency patient.
- Theatre reception will ensure that the patient has immediate access to the designated theatre.

(d) **Operational Policy for Elective Cardioversions**

Staff Involved

- Consultant Physician/Cardiologist
- Cardiac Liaison Nurse
- Anaesthetist
- Anaesthetic Recovery Nurse
- Anaesthetic Co-coordinator
- Medical Secretary

Introduction

A maximum of three cardioversions per week will be performed, dependent on the availability of an Anaesthetist.

The Anaesthetic Co-coordinator will liaise with relevant secretaries to confirm Anaesthetist availability for a Wednesday morning one month in advance.

The medical secretary will prepare the theatre list in liaison with the appropriate Consultant and forward a copy to: -

- The Anaesthetic Co-coordinator
- Theatre Recovery Sister
- Sister, OPD
- OPD Appointments
- Cardiac Liaison Nurse
- Medical Records
- Day Surgery Manager

The day prior to procedure, the patients will be pre-assessed in the outpatient department by the Cardiac Liaison Nurse.

Patients will be invited to attend the Day Surgery Suite at 8.30 a.m. on the

day of procedure. Patients arriving for cardioversion will be accommodated in the post-operative lounge of the day surgery suite. The Cardiac Liaison Nurse will be in attendance.

All cardioversions will be performed in the theatre recovery area commencing at 9 a.m. The Cardiac Liaison Nurse who will remain during the procedure will accompany the first patient. On completion of the procedure, the patient will be observed/nursed by the Recovery Nurse whilst the Cardiac Liaison Nurse escorts the next patient to the recovery area.

The above will be repeated until all three patients are in the recovery area and the cardioversions are complete.

When all patients are fully recovered, the Cardiac Liaison Nurse will accompany them back to the postoperative lounge of the Day Surgery Suite and provide the patients with breakfast.

The Cardiac Liaison Nurse will assess the patients for discharge, arrange transport and prepare discharge letters. If any patient requires admission, they will be referred to the Coronary Care Unit.

7. BOOKING OF THEATRE EQUIPMENT SUCH AS IMAGE

INTENSIFIER OR CAMERA EQUIPMENT

All bookings for theatre equipment will be co-coordinated by the Reception Nurse. When problems occur the Theatre Co-coordinator will inform the Consultant concerned and attempt to resolve the problem.

All bookings will be treated on a first come first served basis unless the circumstances are exceptional, eg emergency situation.

Booking procedure

All bookings must be entered in the diary held at Theatre Reception.

1. The following details must be recorded: -

- Consultant
- Date and time of planned procedure
- Procedure to be performed
- Time and date when booking made

2. Potential clashes within the booking system.

If the equipment is booked as above clashes of use should not occur.

If however problems do occur it is the responsibility of the Consultants to discuss prioritisation of the use of the I.I.

3. Orthopaedic Trauma Lists

Orthopaedic trauma lists will have one image intensifier allocated without the requirement of booking for each individual list. However, if trauma cases are being operated upon at other times, eg during vacant morning sessions, there will be a requirement to book the Image Intensifier as for other specialties.

4. Use of equipment without prior booking

Use of equipment without prior booking is to be discouraged. If the equipment is needed but has not been previously booked the Theatre Co-coordinator must be contacted to ensure that the equipment is free for use.

Surgeons or theatre staff must not hijack equipment without consultation with the Theatre Co-coordinator.

8. AREAS WITHIN THE OPERATING DEPARTMENT

The operating department will be divided into 2 main zones

- (1) Open access area
- (2) Restricted access area

(1) **Open Access Area**

This covers the geographical area from the main theatre reception and day surgery area through to the theatre access corridors in the east and west of the department.

The rooms in the open access area are as follows:

- Main Theatre reception
- Male and female changing area
- Staff rest room and beverage bay
- Recovery area
- Equipment maintenance room (Electronics)
- Sister's office
- Theatre manager's office

Changing into theatre clothing and footwear is not a requirement in these areas.

(2) **Restricted Access Area**

Any area beyond the orange door frames included.

All operating theatres and anaesthetic rooms, scrub rooms, preparation rooms, sluices, store cupboards etc.

Staff wearing theatre clothing should also only access the main sterile equipment cupboard and decontamination room.

Maintenance staff will be allowed into the decontamination room to service fixed equipment in their normal working overalls.

The restricted access area includes all corridor areas, which give direct access to the operating theatres and anaesthetic rooms.

Main Theatre Reception Area

A Theatre Receptionist and a member of the nursing staff will staff the main theatre reception area from Monday to Friday from 0900 until 1700.

9. POLICY FOR VISITORS TO THE DEPARTMENT

All visitors to the department

All visitors to the department must report to Reception and obtain a name badge from the Theatre Receptionist before entering the department.

The name and details of all visitors must be entered in the Theatre Visitor Log and the visitor signed out when leaving the department.

(1) Nurses from ward areas

Nurses from ward areas who are either escorting patients to reception or collecting patients from the recovery area do not need to change into theatre clothing or footwear.

(2) Nurses from ITU, A&E and Paediatrics

Nurses from these areas do not need to change into theatre clothing or footwear when either escorting patients to reception or collecting patients from the operating theatres. However, if entering the restricted access area, clean theatre gown and theatre footwear should be donned in Theatre Reception prior to entering the restricted access area.

(3) Professions allied to Medicine

Physiotherapists, Radiographers, Photographers, students etc. who are required to be present during operations **must** change into theatre clothing including theatre hat and footwear.

(4) Parents and Guardians

Parents accompanying children into the anaesthetic room do not need to change into theatre clothing but will be supplied with a theatre gown and theatre footwear. However, if the anaesthetic is to be given in the operating theatre and not in the anaesthetic room the parent accompanying the child **must** change into theatre wear, including hat and footwear.

Only one parent must accompany their child beyond the Theatre Reception area.

The parent must be accompanied at all times by the paediatric nurse.

Parents must never be left unattended in the operating department or the day surgery area both for their own safety and for security reasons.

(5) Company Representatives

Company representatives must follow the Trust policy and report to the Supplies Department.

Company representatives will only be seen in the operating department by prior appointment with the Theatre Manager, deputy or a theatre sister/charge nurse. Appointments can also be made with the Theatre Storekeeper.

Appointments can be arranged via the Supplies Department or through the Theatre Receptionist on extension 2362.

10. STAFF ENTERING AND LEAVING THE OPERATING DEPARTMENT

N.B. The use of mobile phones is prohibited in the theatre complex.

(1) **Entering the department**

Staff will enter the department via the main reception entrance.

Sign in at the reception desk.

Access to the changing rooms is from the main access corridor, which runs parallel to the recovery area.

Once changed into theatre clothing and footwear staff should exit the changing rooms via the ITU access corridor opposite to the staff rest rooms.

(2) **Leaving the department**

Staff leaving the theatres must access the changing rooms from the ITU access corridor.

Soiled theatre clothing must be left in the laundry skips provided.

Soiled theatre footwear must be placed in the boot washroom for cleaning.

Egress from the changing areas should be via the washing area exiting on to the main access corridor beside recovery and thence to the main theatre reception area.

Sign out at the reception desk.

11. **TRANSPORT POLICY**

(1) **Basic Principles**

- All patients will travel to the operating department by the shortest route
- Wherever possible patients being escorted into the operating suite will not see patients traveling to the recovery area following surgery and should follow a separate route
- All traffic will keep to the left hand side of theatre suite corridors

(2) **Priorities**

- Urgent or life threatening emergency cases will have priority over all other categories of patient
- Patients being transferred to recovery following surgery will have priority over patients being escorted to anaesthetic rooms prior to surgery
- Corridors must not be obstructed by theatre equipment which must be parked in the exit bay areas outside each twin theatre
- Day case patients and inpatients will have separate routes into theatre whenever possible

(3) **Care of the patient during transfer to theatre (Clinical Policy)**

Introduction

There are many ways of transferring patients to theatre, consideration must be given to the patient's wishes and what is practically possible.

Patient's anxiety levels will be at a peak and it is the nurse's role to minimize any discomfort and distress to the patient at this time.

It is therefore important that the Reception Nurse rings the ward to find out how the patient wishes to come to theatre and to ascertain from the ward staff whether it is feasible taking into account the patient's condition.

Aims

- To provide optimum care and safety during the transfer of the patient to Theatre.
- To ensure minimum disruption to the throughput of cases and maximise use of theatre resources.
- To maintain the patient's privacy and dignity.

Procedure

The holding area nurse, or the anaesthetic nurse for the theatre, (if no holding area nurse) will be responsible for arranging transport for the patient at the appropriate time with the theatre teams' agreement.

The patient will be sent for by the standard written or verbal request, which should contain:

Name
Patients Unit Number
Date of Birth
Ward
Theatre Number/Name
Date

The patient will arrive in theatre with completed checklist and correct documentation.

The receiving theatre personnel must check the accuracy of the documentation as per checklist procedure.

The transfer of patients will vary according to the type of operation and the patient's condition. Consideration will be given to the patient's choice where possible. The methods of transport available are:

1. Trolley 2. Bed 3. Wheelchair or 4. Walking

3.1 Trolley:

The team assistant support will select the appropriate trolley. They must have the correct request slip.

The team assistant support will arrive on the ward with patient request slip. Which he will show to a qualified nurse who will in turn arrange the transfer of the correct patient from bed to theatre trolley, ensuring the patients safety and modesty at all times.

Once on the trolley the sides must be raised and the patient covered and made comfortable. All IV lines, catheters and drains must be secure.

The accompanying nurse will position themselves at the head of the patient and remain with them until the theatre check in procedure has been completed.

3.2 Bed

The holding area nurse will verify with the appropriate ward staff that the patient will be sent on their bed.

The patient will be checked at Theatre Reception as above. As per checklist procedure.

The patient will be transferred to the anaesthetic area on their bed where the Anaesthetist will assess whether the patient will be anaesthetised on either: their bed or the theatre table.

3.3 Wheelchair

The team assistant support will transport the patient to main theatre reception in the wheelchair accompanied by a nurse.

All patients will wear a theatre gown, dressing gown and slippers.

The patient will either walk to the anaesthetic room or operating room accompanied by the nurse or is transported in the wheelchair.

The patient will be assisted onto the theatre table or trolley after removing slippers and dressing gown.

The patient's dressing gown and slippers will be placed in a property bag and labeled.

If the patient is to have a general or spinal anaesthetic then they will be returned to ward on a trolley or bed.

3.4 Walking

The patient will walk to theatre reception accompanied by a nurse from the ward.

All patients to wear a theatre gown, dressing gown and slippers.

The patient will be provided with a seat in the holding area or at theatre reception.

Day Surgery and Plastic Locals patients will walk to the anaesthetic/operating room accompanied by the anaesthetic or theatre nurse.

All other patients will be assisted onto the trolley.

4. Care of the patient during transfer from recovery to the ward (Clinical Policy)

- The patient condition must satisfy the discharge criteria as per the theatre nursing record.
- At least two people must transfer the patient back to the ward, one of which must be a qualified nurse.
- The patient must be transferred on a trolley or bed equipped with oxygen, suction apparatus, airway and an ambubag.

5. **Day Case Patient Movements**

Day case patients will be admitted to the Surgical Day Unit and will have their surgery in the dedicated day case theatres.

Theatres 1, and 3 have been identified for day case operations.

A day surgery nurse will escort patients from the Day Surgery Unit to the appropriate anaesthetic room.

Transport route for day surgery patients

Day case patients will leave the Day Surgery Unit and enter the main operating department reception area.

They will be escorted past the entrance to the recovery area and turn right into the restricted access zone of the main theatres via the west corridor. They will then be escorted into the appropriate anaesthetic room.

6. **In patient movement within the Department**

Inpatients will be operated upon in all theatres 2 –10 (excluding Theatre 1 and 3). They will travel from the theatre reception area and turn left to access theatres via the corridor in the east of the department.

Inpatients leaving theatre for recovery post operatively

Inpatients travelling from the operating theatres to the recovery area will travel by the shortest and most direct route.

Patients travelling from theatre to the recovery area will have priority over patients being escorted to anaesthetic rooms prior to their surgery.

Patient movements must be managed so that patients entering anaesthetic rooms do not see unconscious patients traveling to recovery.

12. **ORDERING AND DELIVERY OF STERILE SUPPLIES FROM THE CENTRAL STERILE SUPPLIES DEPARTMENT**

(1) **Ordering for routine planned operating lists**

Sets of sterile instruments, drapes and gown packs will be stored in the main theatre sterile store and individual theatre prep rooms.

On receiving the operating list the theatre sister/deputy will check the availability of

the required numbers of instrument sets, drapes and gowns plus any special requirements.

Requests to CSSD for extra equipment will be made directly to the Department, giving as much notice as possible.

(2) **Special orders, eg Orthopaedic revision joint surgery**

Orders for the sterilisation of trays and instruments on loan or hired to support specialist surgery will be notified to CSSD giving as much notice as possible prior to the date of the planned surgery.

(3) **Orders for sterile equipment for emergency surgery**

Orders for sterile equipment for emergency surgery will be placed as in 1 and 2 above. In addition to the above, trolleys containing sterile equipment for each speciality and/or surgeon will be kept in the theatre department.

Theatre staff will be responsible for restocking and replacing equipment used from specialist trolleys, which will need to be checked on a daily basis.

Specialty trolleys will be based in the theatre prep rooms appropriate to the particular speciality but will follow the surgeon if he or she operates in a different area, eg emergency theatre, or day surgery theatre.

(4) **Delivery of sterile supplies from CSSD**

There will be 4 large caddies used by CSSD for supplying sterile theatre trays to the operating department. It is anticipated that these will be in constant use with 2 in the CSSD being replenished and 2 delivering sterile supplies to the theatres.

Deliveries of sterile instrument trays will be made to the theatre department by CSSD staff, and will be returned to the CSSD by a Team Assistant Support Worker from the theatre department who is undertaking 'clean stores' duties.

13. **RETURN OF CONTAMINATED INSTRUMENT TRAYS AND EQUIPMENT TO CSSD**

4 large caddies will be provided from CSSD for the return of all contaminated instrument trays.

(1) Major cases

At the end of a major case all instrument trays and specials should be loaded on to a trolley and taken immediately to one of the dirty CSSD caddies. Contaminated equipment must not be parked in theatre exit bays or left in dirty utility rooms.

It will be the responsibility of a Team Assistant Support Worker from theatre to collect up the contaminated trays etc. and load the dirty caddy that must then be dispatched directly to CSSD via the identified soiled cart lift. Access to this lift is via the Lobby opposite the equipment service and main orthopaedic storerooms in the east of the department.

(2) Minor cases and rapid through put lists

Contaminated equipment from minor cases or rapid through put lists should be contained until sufficient has been collected to make a return journey to CSSD with a full caddy where possible. However, contaminated equipment from the morning list must be returned to CSSD before the afternoon list commences, even if the trolley is not full to capacity. The return of contaminated equipment to CSSD will be the responsibility of the Team Assistant Support workers from the theatre department identified for disposal duties.

14. DISPOSAL OF CLINICAL WASTE

The removal of clinical waste from the Operating Department will be the responsibility of Haden Building Management.

(1) Collection of clinical waste within the Operating and Recovery Area

Clinical waste will be bagged according to Hospital Policy and transported to dirty utility rooms in each appropriate area. The Team Assistant Support worker identified for disposal duties will ensure that these areas are kept clean and tidy. When there is no TAS on duty it is the responsibility of the Team Assistant.

Clinical waste from the recovery area will be held in the dirty utility beside the Day Surgery Unit (10.08), which will be included in the clinical waste collection from the Day Surgery area.

(2) **Removal of clinical waste from Theatre and Anaesthetic areas**

The Team Assistant Support identified for disposal duties will ensure that clinical waste is taken via the CSSD lift to the collection area on the A&E corridor and is safely secured within the clinical waste disposal bin for collection by Haden Building Management.

15. PLANNED PREVENTATIVE MAINTENANCE (PPM)

Annual PPM is carried out:

- Saturday, Sunday and Monday for clean air theatres 7, 8 and 10.
- Saturday and Sunday for theatres 2, 4, 5, 6 and 9.

This work is undertaken with close liaison between theatres and the Estates Department.

16. DELIVERIES AND COLLECTION OF THEATRE CLOTHING AND OTHER LAUNDRY

(1) **Delivery**

Theatre scrub suits and other laundry items will be delivered to the Trust by Healthtex and transported to the Operating Department by Haden's Portering Service on a daily basis Monday – Friday.

The Theatre Team Assistant Support workers identified for 'clean duties' will distribute theatre scrub suits to male and female changing rooms.

Other laundry, eg patient sheets and blankets will be distributed to identified linen storage areas and mobile holders within the department by the Team Assistant Support identified for 'clean' duties.

(2) **Collection**

Haden Building Management Portering Services will undertake the collection of dirty laundry from the Operating Department.

Dirty scrub suits will be bagged in clear polythene bags and retained within the male and female change to await collection. Team Assistant Support workers remove bags for collection at lift area.

Patient sheets or blankets will be bagged in clear polythene sacks and retained within the dirty utility 10.08 at the theatre recovery exit beside Day Surgery until collection by Haden's Portering Service.

17. ORDERING AND DELIVERY OF MEDICAL AND SURGICAL SUPPLIES

(1) **Stock items**

The ordering and topping up of stock items will be the responsibility of members of the Trust's Supplies staff.

Checking of top up items will take place on Tuesday for delivery on Friday of the same week.

The appropriate storekeeper will put away stock and non-stock medical and surgical supplies delivered to the department.

(2) **Non-Stock items**

Ordering of non-stock items will be via the Electronic Requisitioning and Ordering System (EROS). Items will be ordered, authorised and received by appropriate storekeeper or deputy and will be put away by the appropriate storekeeper or deputy.

Sisters/Charge Nurse and Storekeepers only can authorise supplies on EROS.

18. **ORDERING, SUPPLY, STORAGE, PREPARATION AND ADMINISTRATION OF DRUGS, IV AND IRRIGATION FLUIDS IN THE OPERATING DEPARTMENT**

(1) **Ordering and Supply**

Anaesthetic and theatre department drugs, IV and irrigation fluids will be ordered through the Pharmacy Department. A pharmacy Assistant Technical Officer (ATO) will visit the Department twice weekly (Tuesday and Friday mornings) to check the pre-agreed stock levels and order accordingly. Any pharmacy item required between visits will be ordered on a pharmacy requisition, signed by a registered nurse.

(i) **Drugs**

The drugs required will be delivered to the department the same afternoon. These will be checked against the order and locked away in the main drugs cupboard by a Registered Nurse.

(ii) IV and irrigation fluids

Bulk IV and irrigation fluids will be delivered direct to theatres from the manufacturer. The storekeeper or deputy will check these fluids off against the order, checking batch numbers and expiry dates, and decant into IV and fluid warming cabinets within the department. Any discrepancies in the order must be reported to the Anaesthetic/Recovery Sister, or her deputy.

Reserve supplies of IV and irrigation fluids are held within the IV cupboard.

(iii) Ordering and Delivery of Controlled Drugs (CD)

The ordering and delivery of CD's will be in accordance with Trusts Policy. The responsibility for the ordering, possession, safe custody and supply of controlled drugs in hospital wards and departments rests with the Sister in Charge. A registered nurse may carry out the ordering of controlled drugs although the Senior Sister in Charge/Departmental Nurse Manager carries ultimate responsibility.

Controlled drugs will be ordered in the appropriate CD order book and the order books taken to Pharmacy by a Team Assistant Support Worker.

The ordered controlled drugs will be delivered to the operating department together with the returned CD order books which are signed by a registered nurse to indicate receipt of the drugs.

Two qualified practitioners, one of who must be a registered nurse, and entered in the appropriate Controlled Drugs Record Book, will check the controlled drugs against the order book.

The controlled drugs will be locked away in the appropriate controlled drugs cupboard. The CD record and order book will also be kept securely in a locked cupboard.

(2) **Procedure for checking controlled drug stocks in the Operating Department**

Stocks of controlled drugs are to be checked twice in every 24 hours by two qualified practitioners one of whom must be a registered nurse. Usually these checks will occur before the commencement and at the end of a full days operating session.

(i) Prior to the commencement of an operating session the total number of

controlled drugs in stock must be checked against the Controlled Drugs Record Book by the anaesthetic nurse/ODP and another qualified practitioner. One of the two checkers must be a registered nurse.

- (ii) In order to ensure that no boxes of CDs are overlooked one practitioner should read the drug name and page details from the index to the CD record book and the other practitioner identifies the appropriate box. Both members of staff check the numbers of ampoules remaining in boxes, which are in use. Sealed and unopened boxes are assumed to be full.

All boxes should be removed from the cupboard prior to the check and replaced back on the shelf, as they are checked and correct.

- (iii) The two members of staff completing the check will sign in the back of the CD record book with date and time to confirm that the stock is correct.

Any discrepancy in the CD stock check must be reported immediately to the Anaesthetic Sister on duty or her deputy who will investigate the discrepancy.

If the discrepancy cannot be satisfactorily resolved the Theatre Manager or Senior Nurse must report it to the Director of Nursing or Directorate Manager on duty.

(3) Custody and safe keeping of keys

The keys for all departmental medicines, CD cupboards and drug refrigerators must be stored in a locked key cupboard. The key cupboard key must remain at all times with the Anaesthetic Sister on duty or the senior nurse in charge of the department who is acting as her deputy for a span of duty.

To ensure that medicines and controlled drugs are readily available when needed, the Anaesthetic Sister or her deputy will delegate the appropriate keys and control of access to the anaesthetic room drugs and CD cupboard to another registered nurse, qualified medical practitioner or a qualified Operating Department Practitioner. A registered nurse or qualified ODP may only remove controlled drugs from a controlled drugs cupboard or return them to the CD cupboard on the specific authority of either the Anaesthetic sister or her deputy or a qualified medical practitioner.

(4) Qualified Operating Department Practitioners and the handling of controlled drugs

The Misuse of Drugs Regulations 1985 authorised doctors, pharmacists and certain other (statutorily regulated) health professionals to order, supply, possess, prescribe or administer controlled drugs in the practice of their professions. They do not authorise ODPs to order, supply or possess controlled drugs. However, the 1985

Regulations also authorise any person who is engaged in conveying a controlled drug to have that drug in his possession, provided that the person to whom he is conveying and supplying it may lawfully have that drug in his possession. A qualified ODP is therefore authorised to convey a controlled drug to a doctor, a registered nurse, or a patient for whom the drug has been prescribed.

(5) **The Qualified Operating Department Practitioner and the administration of medicines, including controlled drugs**

The NVQ Level 3 ODP course covers the handling and administration of medicines via the oral, rectal, subcutaneous and intramuscular routes.

Newly qualified operating department practitioners working in theatre and anaesthetic areas must undergo a period of practice supervised by a registered nurse during their preceptorship period to demonstrate their competence in administering medicines via the above routes.

Qualified ODPs must not administer medicines or controlled drugs via the intravenous route (through an established cannula or line) until they are assessed as fully competent to administer drugs via all other routes and have attended the intravenous drugs study day. A period of supervised practice will also be required during which the ODP will be assessed for competence in the administration of IV drugs following attendance at the study day.

Qualified ODPs should only administer medicines in the presence of a registered nurse or medical practitioner.

(6) **Preparation of drugs by Operating Department Practitioners**

ODPs may only draw up drugs on the direct instruction verbal/written and in the presence of the anaesthetist or surgeon.

The anaesthetist must check the prepared drugs. Any uncertainties must be clarified with the anaesthetist or prescribing doctor. All syringes must be correctly labelled but not pre-labelled in advance of being drawn up.

(i) **Drugs requiring dilution**

The dilution of agents must be made in the presence of, and checked by a registered nurse or qualified medical practitioner. The bottles/syringes must be labeled detailing the name of the drug and diluents strength, the date and the signatures of the practitioners concerned.

(ii) **Preparation of infusions requiring addition of drugs by ODPs**

The addition of drugs to an infusion must be made in the presence of a registered nurse or qualified medical practitioner. The bottles/bags must be labelled, dated and detail the name of the drug and diluents strength and be signed by the two persons concerned.

All staff administering medicines to patients must follow the procedure for the administration of medicines as defined in the Trust Policy for the Prescription, Supply, Storage and Administration of Medicines.

Until such time as Operating Department Practitioners have a statutory regulatory body all medicines prescribed to be administered to patients must be checked by the prescribing doctor or a registered nurse prior to being administered to the patient by the qualified Operating Department Practitioner.

Qualified ODPs should only administer medicines in the presence of a registered nurse or medical practitioner.

19. COLLECTION OF SPECIMENS

Microbiological and small pathological specimens can be sent, together with the appropriate documentation, direct to the laboratory via the pneumatic tube system.

NB Blood samples for blood gas analysis must not be sent via the pneumatic tube system. Urgent samples should be telephoned through to the laboratory and then taken straight to the laboratory by the Team Assistant Support (Theatres) during normal working hours and by a porter from Haden Management out of hours.

Medium and large non-urgent specimens will be collected by the identified Team Assistant Support and transported to the laboratory twice daily at 10.00 and 15.00 Monday to Friday.

Each specimen will be labeled (as per clinical policy “The Care of Specimens”) and will have the appropriate documentation.

The Team Assistant Support must check the entry of each specimen with the documentation in the appropriate theatre specimen book and ensure that the Laboratory Technician countersigns this as correct, before returning the book to Theatre.

20. FIRE AND EVACUATION POLICY

Main Operating Theatre

Introduction

This document must be read in conjunction with the Trust's Fire Procedure Document to which it is a subsidiary, and should be used as a reference by the Senior Person in Charge of the Department at the time.

The fire alarm system in the new hospital is an 'Intelligent Analogue Addressable Fire Alarm System'. This means that all Fire Break Glass Points, Smoke/Heat Detectors and automatic fire detectors have an exact address (room location). In the event of a fire the Fire Alarm System will pinpoint the exact location automatically.

All members of staff and all visitors must sign in and out of the Theatre Department.

(a) Raising the alarm

- 1) Break the glass of the nearest manual call point. These are located at short intervals (usually beside entrance/exit doors) throughout the department.

Breaking the glass of the manual call point will result in a continuous sound in the affected zone and an intermittent sound in all other zones throughout the hospital.

Should the alarm fail to sound when a manual call point is operated . . .

- 2) The alarm must be raised by shouting, "FIRE" and informing switchboard by dialing 666, stating location of the fire and as much other relevant information as possible.

- 3) If the fire has been extinguished before the alarm is raised, switchboard must still be informed by dialing 666 so that the Fire Brigade may attend to ensure that the fire is extinguished and that no further danger remains.

(b) **Action by the Senior Person in Charge/Theatre Manager or Deputy on hearing the Fire Alarm**

- 1) Continuous sound

Visible fire or smoke.

Can fire be safely extinguished? If not, plan to evacuate the immediate area.

- 2) Planned evacuation

The operating department is divided into 3 main fire compartments and sub-compartments.

The main zones are delineated by fire doors, which have reinforced glass with red piping bordering the window frames within the door.

Main fire compartments -

1. Recovery area
2. Theatre Reception area
3. Main theatre complex

These compartments will contain/resist fire for ONE HOUR.

Internal doors within these main compartments divide the area into sub-compartments and will contain the fire for HALF AN HOUR if kept shut.

KEEP ALL DEPARTMENTAL DOORS CLOSED AT ALL TIMES.

Planned evacuation is progressive and horizontal, i.e. by moving away from the affected area through fire resisting doors to an adjoining area on the same floor level and awaiting the assistance of the Fire Brigade.

When a progressive horizontal evacuation is necessary, where possible check all rooms to ensure no persons remain. Close all doors; isolate medical gases in the affected zone following a brief discussion with Clinical Director/Consultant Anaesthetist if theatre zone and anaesthetised patients are

involved.

3) Continuous alarm sounding but no visible signs of fire

In this situation, arrange a careful check of the zone include

- a) all break glass points and check for cracked glass
- b) automatic detectors – an activated detector will be illuminated

Report to the Nominated Officer (Fire) or to the Officer in Charge of the Fire Brigade.

4) Intermittent Fire Alarm Sounding

This indicates that the incident is not in the immediate fire zone.

At least one person from the Department must be released to attend the incident and should be dispatched to the fire alarm indicator panel, which is positioned on LEVEL 1 Hospital Street adjacent to staircase D.

08.00 – 21.00 Wait at panel for further instructions.

21.00 – 08.00 all responding staff to go directly to the incident to assist as required.

5) Fire Extinguishers

The department has a supply of water and carbon dioxide fire extinguishers. All extinguishers are RED in colour, so check labeling prior to use.

Dry Riser – The dry riser is located beside the Emergency Staircase at the west end of the Main Theatre corridor and is for Fire Brigade use only.

6) Fire Escapes

Escape routes are via the main staircases (staircase D) beside the entrance to the main department and also via Emergency Staircases at either end of the main theatre corridor.

Conclusion

The above policy is a brief outline of guidance for the Senior Person in Charge of the Department at the time of an incident and must be read in conjunction with the Trust's Fire Procedure Document.

21

. **MAJOR INCIDENT POLICY**

**OPERATING DEPARTMENT
UNIVERSITY HOSPITAL OF NORTH DURHAM**

INTRODUCTION

This policy is to be used within the Operating Department in University Hospital of North Durham in the event of a

Major Incident Standby

Major Incident Declared – University Hospital of North Durham Supporting

Major Incident Declared – University Hospital of North Durham Receiving

It must be used in conjunction with the University Hospital of North Durham's Major Incident Plan (September 1999) which is kept with all other hospital policy files in the Theatre Manager's/Sister's office.

The departmental policy is for the guidance of all theatre and anaesthetic staff but is intended mainly as a tool for the Senior Nurse on duty when a major incident is declared.

ACTIVATION OF MAJOR INCIDENT PLAN

Durham Ambulance Service will alert the hospital telephonist about a major incident via a designated major incident line.

The call will state, either: -

- a) Major Incident - Standby
- b) Major Incident - Declared – University Hospital of North Durham Supporting (When University Hospital of North Durham is the supporting hospital an anaesthetic nurse may be required to be part of the Mobile Medical Team).
- or c) Major Incident - Declared – University Hospital of North Durham Receiving

When on Standby, the information to the hospital switchboard will be updated every 15 minutes as to the state of the standby.

The initial preparations within the Department will be exactly the same regardless of which state of emergency is declared.

This policy is to be followed by the Senior Nurse on duty and all staff under her/his control.

The Senior Nurse for the Department is the Theatre Manager or his/her designated deputy.

Either the Director of Nursing or the Site Co-coordinator will notify the Theatre Department of the major incident alert.

For the purpose of this departmental policy, “IN HOURS” relates to Monday – Friday 9.00 a.m. – 5.00 p.m. (except Public Holidays). “OUT OF HOURS” relates to all other times.

On receipt of the STANDBY alert call, the Senior Nurse must: -

IN HOURS

1. Inform the nurse in charge in each individual theatre and anaesthetic/recovery area of the state of the alert (STANDBY)
2. Inform Theatre Team Assistant Supports
3. Inform midwives Ext 2908
4. Inform DSU ext 2265 or contact Lesley Smith via switchboard out of hours.
1 DSU theatre may need to become 2nd Obstetric Theatre
5. Do not send for any further patients
6. Prepare to empty recovery areas and Theatre Reception.
7. Contact Senior Nurse in ITU (ext 2019 or bleep 2114) regarding the potential need for extra ITU facilities in the recovery area.
8. Inform C.S.S.D. Clinical Nurse Manager or Deputy.

OUT OF HOURS

1. As IN HOURS
2. Notify Theatre Manager by telephone (or his/her designated deputy) giving as much information as is known.
3. Theatre Manager will implement departmental cascade.
4. Inform Clinical Nurse Managers or Deputy.
5. Inform Clinical Nurse Manager Deputy.
8. Inform C.S.S.D. Manager

On confirmation of Major Incident DECLARED

As 1, 2, 3, 4, 5, 6 and 7 above.

How the departmental cascade works: -

- | | | |
|-----|---|---|
| 8. | Inform all theatres of Major Incident DECLARED. Ensure all theatres know that all procedures <u>must</u> be completed as soon as is safely possible. | Theatre Manager/Deputy will ring Jean Wilkinson Mandy Patterson Peter Houghton Lynda Wales Ruth Taylor |
| 9. | Return all patients from Theatre Reception to wards with a brief explanation as to the reason. | Each of the sisters will ring in their team of staff. |
| 10. | Empty the recovery area of patients as quickly as is safely possible. | |
| 11. | The Senior Nurse <u>MUST</u> remain 'free'. She or he must not become directly involved in any area but be available to pass on information and co-ordinate all nursing staff. | |
| 12. | The Senior Nurse must gain as much information as possible relating to the nature of the incident, the number and types of casualties. | |
| 13. | Theatres 5, 6 and 9 to be set for laparotomy type procedures. | |
| | Theatre 10 should be set for a general surgical emergency occurring at the same time as the major incident (but not related to it), e.g. ruptured aneurysm | |
| | Theatre 7 and 8 for orthopaedics / multiple trauma. Must include laparotomy and vascular trays. | |
| | We aim to be able to staff 3 to 4 theatres over a 24-hour period with staff working shifts of 8 hours. | |
| | There may be a need to expand to 5 or 6 theatres if there are high numbers of casualties. However, it will be difficult to provide this level of cover over the 24-hour period. | |
| 14. | Senior Nurse to contact Day Surgery Unit (ext 2265, bleep 2006 or contact Lesley Clark, out of hours, via Switchboard). | |

Information to support the departmental Major Incident Policy

Information for staff

Theatre / Anaesthetics / Recovery Teams

You have been allocated to a particular team that will either be on duty or acting as a reserve
 – Out of Hours PLEASE DO NOT REPORT FOR DUTY UNTIL YOU ARE CONTACTED.

If your name does not appear as part of a Team or Reserve Team you will be part of a reserve list and may be asked to join an appropriate team if someone from that team is off sick or on holiday. If you are required on duty you will be contacted.

Teams On Duty: Duty Period

We will try to organise duty spans of approximately eight hours across the major accident period wherever possible.

When your duty span is over please leave the department and go home to rest, as we may need you back on duty again after 8 hours.

The reserve team will report on duty to relieve you.

We will probably need to work around the clock until all the emergency cases from the major incident have been operated upon.

We may need to convert part of the Recovery Area into a supporting ITU for ventilated patients.

Anaesthetic / Recovery Teams

Each Anaesthetic / Recovery Team includes 6 staff. It is expected that 2 staff will support each anaesthetist in each theatre initially.

The remaining staff will prepare Recovery, including extra ITU facilities if required (prepare the 2 High Dependency Bays initially). One nurse will need to be identified for emergency caesarean section cover and another for other life threatening general surgical emergencies (separate from the major incident victims).

Senior Nurse on duty at time Major Incident Declared

Must act as co-coordinator for the whole unit at all times, and must not become clinically involved.

Must obtain as much information relating to the incident as possible.

E.g. Geographical location of accident / incident.

Approximate number of vehicles involved / shooting incident / bridge collapse etc.

Approximate number and type of casualties.

Adults and / or children.

Best route in to hospital for staff to avoid traffic build up.

Ensure staff signs on (and off) duty on major incident sheet (Appendix 3).

Allocate staff to theatre teams (if possible as per Appendix 2) including Anaesthetics / Recovery as they report on duty.

Ensure that all patient details are accurately recorded on the Major Incident Patient Detail Sheet (Appendix 4) and entered on the computer

Ensure that Theatre Team Assistant Supports are called in sufficient numbers to support the flow of patients and the extra requirements for blood and other pathology/ laboratory requests.

Theatre and Anaesthetic Sisters

Will be in charge of their own individual areas and team of staff. All requests for extra support must be directed through the Senior Nurse who needs to have a clear picture of the department's activities and responsibilities at all times.

Staff must be made aware of the need for extra discipline and must not act on their own initiative without reference to their sister in charge.

Staff are advised to go off duty to rest when relieved, as they may be needed for a further duty period after 8 hours.

Post incident

Counseling facilities will be available for staff with group debriefing between 48 and 72 hours post incident. (Refer to page 21 counseling and debriefing in Hospital Major Incident Plan).

APPENDICES

Appendices 1, 1a, 1b, 2, 3 and 4 are not included in the Operational Policy/Procedure Document. Please refer to full policy filed within the Major Incident Policy kept in Theatre Manager's office.

OPERATING THEATRES

ANNUAL LEAVE POLICY

Holidays to be taken during the next financial year can be booked after 1st September.

Staff should initially book two summer weeks (April-September inclusive) and two winter weeks (October-March inclusive).

A **maximum** of one week plus Xmas and New Year lieu days should be reserved to be taken between January – March and must be booked before the end of January.

Completion of the holiday request form is mandatory **before** taking the holiday.

All holidays to be initially discussed with the Theatre Sister and documented with the Theatre Co-ordinator.

No holidays can be taken forward unless they comply with the Trust Annual Leave Policy.

Peak Period Requests:

In order to ensure as many staff as possible have the opportunity to request annual leave during the following peak holiday periods the following guidelines apply.

Easter Fortnight-one week only

Summer period- (July-September inclusive) 2 weeks only

Christmas/New Year fortnight-one week only

Requests for more than two weeks holiday at one time must be individually discussed with the Theatre Sister and the Theatre Co-ordinator.

The following guidelines denote how many staff of any grade will be allowed holiday at any one time.

ANAESTHETICS/RECOVERY

The number of Anaesthetic/Recovery staff on holiday during any one week must not exceed five (5) qualified staff.

No more than one Team Assistant Support from each area to be on holiday during any one week.

SCRUB

The number of scrub staff on holiday during any one week must not exceed seven (7).

The Theatre Co-ordinator must take skill mix into consideration when co-coordinating Annual Leave requests.

No more than one Team Assistant Support from each area to be on holiday during any one week.

April 2003
Reviewed Jan 2004
Carol Stoves

University Hospital of North Durham

Operating Theatres

Guidelines for the management of emergency sessions.

Introduction

Effective organisation is essential to the standard of care delivered and the efficient running of the out of hour's emergency session.

It is essential that clear lines of responsibility and communication be recognised by all members of the multi disciplinary team in order to assist decision-making.

To facilitate this process the following guidelines have been developed.

- The nurse in charge of the emergency session will be documented on the offduty/rota.
- The name of the nurse in charge will be documented on the emergency list, am and pm.
- The nurse in charge will carry the co-coordinators bleep (number 4100).
- Staff on a late shift (1700-2100hrs) will whenever possible take their tea break between 16.30 – 1700 hrs.
- Staff who wishes to use the restaurant will be allowed changing time only in addition to their half hour break.
- Staff must not wait so that tea breaks can be taken together but must relieve each other when necessary to enable the continuation of cases.
- Qualified staff working until 5.30 should be freed whenever possible to assist recovery.
- T.A. staff on duty until 5.30 will be responsible for cleaning theatre including the anaesthetic machine.

Two members of staff should be present when there is a patient in the recovery room who does not fulfill the criteria for discharge (Royal College of Anaesthetists). Therefore during the period 1700 – 1900 hrs the Team Assistants from the Pre-operative Reception Area will be based in the recovery room. After this time, to ensure continuation of the cases, the second anaesthetic nurse or an available member of the scrub team will support the recovery nurse until the patient fulfils the criteria for discharge. This should not interrupt the continuation of cases.

Night duty staff should continue with the current system of ensuring the patient in recovery is stable before commencing anaesthesia for the following patient. The next patient should be waiting in the anaesthetic room for an immediate start as soon as the patient in recovery is ready for discharge.

All delays in sending for emergency patients must be documented. A diary will be provided. It is the

responsibility of the nurse in charge to inform all surgeons and anaesthetists of any delay.

Issued: November 2002
Revised: January 2004
Carol Stoves

Appendix 3

**COUNTY DURHAM AND DARLINGTON ACUTE HOSPITALS NHS
TRUST**

UNIVERSITY HOSPITAL OF NORTH DURHAM

OPERATING DEPARTMENT

PROTOCOL FOR THE SENDING OF PATIENTS DURING ELECTIVE LISTS.

INTRODUCTION

In order to establish any delays/bottlenecks, which affect theatre utilisation, process mapping of the patients journey through theatre has been undertaken.

One area, which has been identified, as a result is the length of time that patients and ward staff are delayed in reception due to patients being sent for too early.

AIM

To assist the smooth running of theatre lists and effective utilisation of resources.

Prevent unnecessary delays and potential cancellations.

To improve quality of patient care.

PROCEDURE

The Senior Nurse within the theatre team (Sister/ Charge Nurse/Staff nurse) has the responsibility to ensure the effective utilisation of the theatre and its resources, to prevent any unnecessary delays.

On commencement of the list the Senior Nurse will liaise with the anaesthetic nurse to ensure the patient is in the anaesthetic room approximately ten minutes prior to the start of the list, unless a time has been prearranged.

To ensure the continuity of the list the senior nurse will assess the type of procedure and approximate finish time when arranging for the next patient to be sent for. In most cases this will be during wound closure.

An issue that may be considered is where the patient is being transferred. On some occasions patients come from medical wards and ITU and extra time should be given in anticipation of patients transfer time and immediate preparation.

Under no circumstances must other members of the multidisciplinary team send for patients without liaising with the Senior Nurse.

The Unit Coordinator will assess unit workload and liaise with Senior Nurse and Surgeon to decide which procedures may be undertaken from 16.30 onwards.

This will prevent any emergency surgery commencing on time and ensure NCEPOD recommendations are adhered to.

ORIGIN MANDY PATTERSON
THEATRE SISTER
MAY 2003

REVIEW MAY 2004

NORTH DURHAM HEALTH CARE NHS TRUST

UNIVERSITY HOSPITAL

OPERATING DEPARTMENT

Role and Responsibilities of the Theatre Coordinator:

The main purpose of the role of the Theatre Coordinator is to ensure maximum efficiency in terms of utilisation of theatre sessions and the deployment of staff.

During the three-month period of acting as Theatre Coordinator the Sister/Charge Nurse will:

- Compile the department off duty and rota ensuring adherence to the relevant off duty policy.
- Comply with off duty request when possible.
- Liaise with staff regarding any problems and deficiencies in the service and take prompt remedial action. E.g. booking of agency nurses, overtime, on call etc.
- Work with the Sisters/Charge Nurse to ensure the organisation of nursing services within the department in such a way as to provide continuity of care to patients.
- Lead on the development and implementation of a programme of rotation for staff ensuring equity for all.
- Plan, manage and coordinate annual and study leave in accordance with the Annual Leave Policy.
- Facilitate implementation of action plans developed to ensure necessary improvements are implemented.
- All emergency, trauma & surgeon of the week list patients must be booked with the Theatre Coordinator.
- Coordinate staffing for additional theatre capacity as required.
- Liaise with the Anaesthetic Coordinator and the Directorate Managers regarding additional capacity.

Original: Dec 2001
Revised: Sept 2003 Carol Stoves