# Aseptic Non Touch Technique Policy

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<th>Author(s) &amp; Designation</th>
<th>Sofia Salim, Practice Educating Facilitator</th>
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<tr>
<td>Lead Clinician <em>if appropriate</em></td>
<td>Mary Lewis, Director of Nursing and Therapies</td>
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| In consultation with | Control of Infection Committee  
Clinical Cabinet  
Bladder and Bowel Service  
Tissue Viability Service  
Podiatry  
IV service |
| To be read in association with | Hand Hygiene Policy,  
Health and Safety, Incident Reporting Policy,  
Infection Control Policy,  
Latex Policy  
Waste Disposal Policy  
Standard Precaution for Infection Control  
Uniform Policy |
| Ratified by | Control of Infection Committee (COIC) now  
Infection Prevention Control Forum (IPCF) |
| Re-issue/Ratification date | November 2016 |
| Version | 9 |
| Review date | November 2018 |
| This policy supports compliance with the CQC 5 Domains: | Safe  
Caring  
Effective  
Responsive  
Well Led |
| NHSLA Risk Management Standard(s): | 5.7, 5.9 |

*If you require this document in a different format, please contact the Governance team on 01275 546831*
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1. Purpose

The purpose of this policy is to prevent Healthcare Associated Infections (HCAI's) within North Somerset Community Partnership (NSCP). This policy will provide staff with the guidance and knowledge required, to carry out clinical procedures safely and in a manner that promotes and standardises Aseptic Non Touch Technique (ANTT) across NSCP. This is in line with the Health and Social Care Act 2008 code of practice, on the prevention and control of infections and related guidance (Department of Health (DH) 2015).

2. Scope

This policy applies to all staff working within NSCP that carry out procedures requiring an Aseptic Non Touch Technique, within the community team, outpatient clinic and community hospital settings.

3. Background

The National Institute for Health and Clinical Excellence (NICE) (NICE 2012) has identified that “an estimated 300,000 patients each year acquire a healthcare associated infection (HCAI) as a result of care within the NHS”. In 2007, Methicillin Resistant Staphylococcus Aureas (MRSA) bloodstream infections and Clostridium difficile were identified as having contributed to being the main cause of death for approximately 9000 deaths in hospital and primary care in 2007. NICE (2012) detail the cost of HCAI's to the NHS being £1 billion per year, £56 million is estimated to be incurred post discharge from the acute setting.

The impact of acquiring a HCAI can be detrimental to the patient, ranging from physical, emotional and psychological aspects to possible death.

“Patients have a right to be protected from preventable infections and practitioners have a duty to safeguard the wellbeing of their patients” (King, 1998).

The Health and Social Care Act (2008) code of practice on the prevention and control of infections and related guidance (DH 2015) have identified that good infection prevention and control is essential to ensure that people who use health and social care services receive safe and effective care. The Health and Social Care Act 2008, states that the following should be adhered to:

- “Clinical procedures should be carried out in a manner that maintains and promotes the principles of asepsis.
- Education, training and assessments in aseptic technique should be provided to all persons undertaking such procedures.
- The technique should be standardised across the organisation
- An audit should be undertaken to monitor compliance with the technique”.

In order to prevent the introduction of the organisms into the body, it is important to strictly adhere to ANTT when accessing a susceptible site. This can include areas on
the body that are more vulnerable to infection for example; cannula insertion sites and where skin integrity is breached for example in the case of a wound.

Due to the conventional aseptic technique being un-standardised and undefined, Aseptic Non Touch Technique has now become internationally used as the standardised framework for asepsis, reducing practice variations and the potential risk of HCAIs.

Aseptic Non Touch Technique is divided into two different processes; Surgical Aseptic Non-Touch Technique and Standard Aseptic Non-Touch Technique (ANTT). Within NSCP a clean technique is also used. All 3 techniques have the same objective i.e. to prevent infection and hospital readmission to name a few, however the processes are independently specific and are dependent on environment and procedure.

Risk assessment of patient, environment and procedure should be carried out in order to distinguish the correct technique to be used. There may be a combination of techniques used in order to reduce the risk of a HCAI.

4. Key Responsibilities

Chief Executive

The Chief Executive has responsibility to ensure that infection prevention and control is a core part of clinical governance and patient safety programmes.

Promote compliance with infection prevention and control policies in order to reduce health care associated infections.

Awareness of legal responsibilities to identify, assess and control risk of infection.

Director of Infection Prevention and Control

The Director of Infection Prevention and Control is responsible for:

- Ensuring that NSCP are providing safe, quality care in line with evidence based practice.
- Oversee infection prevention and control policies and their implementation.
- Challenges inappropriate hygiene practice.
- Report directly to the Chief Executive and Executive Team.

Infection Prevention and Control Team (IPCT)

The Infection Prevention and Control Team are responsible for providing advice and support with regards to ANTT and the prevention of infection. The IPCT will also disseminate training and information on ANTT where appropriate.

Head of Learning and Development

The Head of Learning and Development is responsible for ensuring the workforce has the correct skills to practice safely within their role. The Head of Learning and
Development will ensure that the relevant training is monitored, accessible and available to the appropriate practitioners.

**Practice Education Facilitators (PEF’s)**

The PEF’s will provide training and education re: ANTT to ensure that best practice is standardized and embedded within NSCP. Competencies will be drawn up and the PEF’s will aid facilitation of competency completion.

**Managers**

Managers are responsible for ensuring employees undertaking clinical procedures that require ANTT are trained and competent in the procedures ensuring compliance with this policy and best practice guidance.

**Staff**

Staff undertaking procedures that require ANTT have a responsibility to ensure that they have received initial training, completed their competencies successfully and are compliant with this policy. They will also ensure that update training is attended and competencies reassessed when appropriate.

5. **Aseptic Non Touch Technique**

Within NSCP, all procedures, particularly those of an invasive nature must be undertaken using Aseptic Non Touch Technique. Rowley and Clare 2011 identify that the aim of ANTT is to prevent infection and enable asepsis, whilst carrying out invasive clinical procedures, be that of any complexity.

When carrying out ANTT procedures, practitioners are required to perform effective hand hygiene using the six step technique as outlined in the hand hygiene policy and wear appropriate protective clothing. Practitioners will need to identify key parts of equipment and the susceptible / key site of the patient, which if contaminated by pathogenic organisms, may increase the risk of infection. The ANTT guidelines (2013) p 14 state “a non-touch technique, the skill of being able to identify key-parts and not touch them directly or indirectly, is a vital safeguard of achieving asepsis” …and that “the safest way to protect a key-part is simply not to touch it”.

Within Asepsis there are two main techniques utilised: Surgical Aseptic Non Touch Technique and Standard Aseptic Non Touch Technique

**Surgical Aseptic Non Touch Technique**

This technique may be utilised when:

- The procedure is lengthy and / or
- There are numerous key parts / key sites and / or
- The procedure is significantly invasive and / or
- Technically complex to achieve asepsis (ANTT Clinical Practice Framework, 2013)
This technique can involve the use of sterile drapes, gloves and gowns i.e. full barrier personal protective equipment (PPE) and uses a main critical aseptic field to manage risk. Surgical ANTT is mainly used within theatres however there may be aspects that are utilized within many procedures carried out within NSCP. For example the use of a main critical aseptic field and the use of sterile gloves within wound care and urinary catheterisation. Although sterile gloves are worn the protection of key parts and key sites must be maintained using a non-touch technique.

Standard or a combination of both standard and surgical ANTT will be used for all invasive procedures or where the skin’s integrity is breached.

**Standard Aseptic Non Touch Technique**

- Standard ANTT is the method employed to help prevent contamination of key parts and susceptible sites by pathogenic organisms, by ensuring that only uncontaminated equipment and fluids come into contact with sterile / susceptible body sites during certain clinical procedures.

- These procedures will not be lengthy and will be simple to carry out. There will be few key sites and these can be managed using critical micro aseptic fields such as caps / bungs for covering an IV flush.

- Sterile gloves may not always be worn and the aseptic field is more of a general one i.e. a decontaminated plastic tray used to prepare IV medications.

- Non touch technique of key parts and key sites is paramount to reduce the risk of HCAI transmission.

Please see appendix 2 for an example of wound care using ANTT

Standard Aseptic Non Touch Technique can be applied when carrying out procedures such as intravenous therapy, venepuncture and cannulation. Risk assessment should take place prior to carrying out the procedure in order to identify the correct technique to be used.

Indications for the use of Aseptic Non Touch Technique (surgical or standard ANTT) include;

- Wound care
- Suturing of wounds
- Nail surgery
- Intramuscular injections
- Intravenous therapy
- Insertion of urinary catheters
- Vaginal examination using instruments (e.g. taking a smear, high vaginal swabbing or colposcopy)
- Biopsies
- Removal of sutures or drains
- Venepuncture
- Insertion, re-siting, access, maintaining or dressing intravenous cannulae
- Insertion, re-siting, access, maintaining or dressing of subcutaneous cannulae
- Access, care and maintenance of central lines e.g. Peripherally Inserted Central Catheters (PICC's). This includes dressing changes and therapy
- Insertion of gastrostomy and jejunostomy tubes
- Assisted delivery (e.g. forceps and ventouse)

This list is not exhaustive. It is intended to act as a guide to the types of procedure that will require ANTT. Aseptic Non Touch Technique should be seen as a single procedure. For example, it is not best practice to carry out several dressing changes on different sites using the same sterile pack and equipment.

As set out in the ANTT clinical practice framework 2013, the type of aseptic field that is used must be fit for purpose. The use of cardboard trays is not permitted for any procedure. Plastic trays which can be decontaminated must be used for procedures such as: venepuncture, IV therapy and administration and intramuscular injections. These trays must be decontaminated with detergent wipes prior to and post procedure as per ANTT guidelines 2013 (ANTT Clinical Practice Framework, 2013).

**Key principles and safeguards of Aseptic Non Touch Technique**

Taken from the Association for Safe Aseptic Practice (ASAP), 2015 via http://antt.org/ANTT_Site/theory.html

The following key principles and safeguards are applicable to any invasive procedure that requires an ANTT. To ensure a high standard of safe, quality care, staff must ensure that these key principles and safeguards are adhered to at all times throughout the procedure:

**Principle 1**

Asepsis is the aim for all invasive clinical procedures, including the maintenance and use of invasive clinical devices
Principle 2
Asepsis is achieved by protecting key parts and key sites from microorganisms that may be transferred from the healthcare worker and the immediate environment.

Principle 3
ANTT needs to be efficient as well as safe and depending on procedure; standard or a combination of both standard and surgical ANTT will be practiced within NSCP.

Principle 4
The need for surgical ANTT, standard ANTT or a combination of both techniques will be determined on risk assessment of procedure and technical difficulty of achieving asepsis.

Organisationally:
Principle 5
Aseptic technique should be standardised.

Principle 6
Safe aseptic technique is reliant upon effective education / training and environments with equipment that is fit for purpose.

Safeguard 1: Basic Infective precautions
Environmental controls, effective hand hygiene, personal protective equipment and disinfecting medical devices significantly reduce the risk of contaminating key parts and key sites.

Safeguard 2: Identification of key parts and key sites
Key parts are the critical parts of the procedure equipment that if contaminated are most likely to cause infection. Key sites are open wounds and medical device access sites.

Safeguard 3: Non Touch Technique
Non touch technique is a critical skill that protects the key parts and key sites from the possibility of contamination via the healthcare worker or the environment.
Safeguard 4: Aseptic field management

Aseptic fields protect the key parts and key sites from the immediate procedural environment

6. **Clean Technique**

Clean technique adopts the same objective as ANTT i.e. to reduce the risk of introducing and transferring pathogenic organisms to patients and staff. ASAP, 2015 states that clean technique is “the action and process of rendering an object or person free from visible marks and stains”.

Clean technique is predominately used in non-invasive procedures i.e. vital signs monitoring and stoma care etc.

Within NSCP a clean technique may be used when washing the leg prior to the redressing of the leg ulcer. Tap water may be used to wash the leg; however the ulcer must then be cleansed and redressed using sterile saline and an ANTT. Within NSCP tap water must only be used to wash the leg prior to the cleansing and redressing of the leg ulcer. This is the only circumstance where the use of tap water with regards to wounds is permissible.

7. **Training Requirements**

All staff must receive infection prevention and control training as part of their induction and statutory mandatory training as per the NSCP training matrix. The Infection Control mandatory update is available for all staff.

All staff carrying out Aseptic Non Touch Technique (ANTT) must be trained and competent in the procedure that they are going to undertake.

ANTT is incorporated into the basic wound care study day and all other appropriate clinical skills training, i.e. venepuncture and catheterisation.

All relevant clinical skills will have ANTT competencies incorporated within individual skills competencies. There are also separate ANTT competencies that must be completed initially. All new and existing staff must complete the relevant competencies.

8. **Monitoring of Compliance with the Policy including frequency**

ANTT audits will be carried out annually at a minimum as part of the standard infection control audit. The results will be fed back to the Infection and Prevention and Control Forum alongside the Governance and Quality Committee. Gaps in training and competencies will be highlighted and managed via 1:1’s.
9. References

Association for Safe aseptic Practice (ASAP) (2015) Aseptic Non Touch Technique (ANTT) Practice principles and safeguards. ASAP [online]
Aseptic Non Touch Technique: The ANTT Clinical Practice Framework . . . For Surgery to Community Care. V4.1 201.
Available on request from ANTT.org.[Accessed 8th February 2016]

Further Reading

ASAP (2013) Aseptic Non Touch Technique (ANTT). ASAP [online]
Available from: http://antt.org/ANTT_Site/home.html:[Accessed on 20th January 2016]


10. Appendices
# Appendix 1 Checklist for the Review and Approval of Procedural Documents

To be completed and attached to any document which guides practice when submitted to the appropriate committee for consideration and approval.

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**Individual Approval**

If you are happy to approve this document, please sign and date it and forward to the chair of the committee/group where it will receive final approval.

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<th>Name</th>
<th>Sofia Salim</th>
<th>Date</th>
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<td>Signature</td>
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**Committee Approval**
If the committee is happy to approve this document, please sign and date it and forward copies to the person with responsibility for disseminating and implementing the document and the person who is responsible for maintaining the organisation's database of approved documents.

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Appendix 2 Procedure Guidelines

Example – Dressing change within the patients’ home

This procedure applies to all wound management except leg ulcer management across North Somerset Community Partnership.

Risk assessment of the procedure to be undertaken is necessary in order to determine what technique is to be applied in conjunction with what equipment is needed. In this instance it will be a combination of surgical and standard ANTT, i.e. the use of sterile gloves and a critically managed field but without the use of drapes and full barrier PPE etc.

Equipment required:
• Sterile dressing pack containing sterile gloves, apron and waste bag
• Clean non sterile gloves
• Appropriate dressings
• Normal saline – cleansing fluid
• Hand hygiene preparation
• Any additional sterile equipment i.e. scissors, forceps
• Tracing or camera equipment if required
• Care plan and documentation

Prior to entering the patients home ensure that all equipment is intact and in date.

Note on entering the patients home hand hygiene must take place in accordance with NSCP policies i.e. hand washing. If this is not appropriate, use alcohol gel.

The procedure must be explained to the patient, and informed consent gained for assessment and treatment.

Ensure privacy and dignity is maintained (close curtains / doors etc. – if appropriate).

Identify a clean surface on which to lay out dressing pack. A tray maybe used which should be decontaminated using detergent wipes or detergent and water.

Gather required equipment. Ensure that all equipment is intact and in date.

Decontaminate hands with alcohol hand rub / gel.

Remove dressing pack from packaging on to appropriate surface

Prior to opening up the sterile pack, decontaminate hands with alcohol gel / hand rub.

Carefully open the sterile pack suitable for the type of procedure to be carried out, taking care to touch only the corners or edges.

Put on apron

Place hand inside disposable bag carefully – take care not to touch the outer part and arrange contents of sterile field for easy accessibility.
Open the other sterile items (e.g. dressings) and drop onto the sterile field, taking care not to contaminate the sterile field. Place all packaging in rubbish bag.

Decontaminate hands with alcohol rub, as hands may have become contaminated from handling the outer packaging of items.

Put on non-sterile gloves and remove used dressing. Discard used gloves and dressing in rubbish bag.

Decontaminate hands with alcohol gel / hand rub.

Apply sterile gloves, touching only the inside wrist end to avoid contamination.

Carry out procedure, taking care to not touch key parts or any non-sterile items.

Note: for specific procedures please refer to specific policies and guidelines.

Remove gloves and apron.

Dispose of the waste in the appropriate waste streams.

Decontaminate hands thoroughly with soap and water and dry hands on clean towel. A supply of paper towels should be carried for use where there are no suitable hand washing/drying facilities.

Document procedure in the patient’s medical records

Carry out appropriate hand hygiene prior to leaving patients house.

**Hospital / clinic setting**

Risk assessment of the procedure to be undertaken is necessary in order to determine what technique is to be applied in conjunction with what equipment is needed. In this instance it will be a combination of surgical and standard ANTT, i.e. the use of sterile gloves and a critically managed field but without the use of drapes and full barrier PPE etc.

**Equipment required:**

- Decontaminated dressing trolley
- Sterile dressing pack containing sterile gloves, apron and waste bag
- Clean non sterile gloves
- Appropriate dressings
- Normal saline – cleansing fluid
- Hand hygiene preparation
- Any additional sterile equipment i.e. scissors, forceps
- Tracing or camera equipment if required
- Care plan and documentation

Ensure that all equipment is intact and in date.

Hand hygiene must take place in accordance with NSCP policies i.e. hand washing. If this is not appropriate use alcohol gels.
The procedure must be explained to the patient, and informed consent gained for assessment and treatment.

Ensure privacy and dignity is maintained (close curtains / doors if appropriate).

Although there may be some differences re: preparation within this setting, the main process remains the same.

The shelves and sides of the trolley must be cleaned. Suitable agents for cleaning the trolley are detergent wipes, or warm water and detergent. Allow to dry.

Decontaminate hands with soap and water.

Gather required equipment and place on the bottom of the clean dressing trolley. If a different dressing pack is used where there is no apron within pack, use a disposable apron available within the area. Decontaminate hands with soap and water, or alcohol hand gel if hands are physically clean. Ensure that hands are dried thoroughly.

Screen the patients bed/trolley area, using curtains or a mobile screen. When moving the trolley to patient area ensures that curtains/screens are disturbed as little as possible to help reduce the risk of airborne contamination.

Decontaminate hands with alcohol hand rub / gel.

Remove dressing pack from packaging on to the top surface.

Prior to opening the sterile pack, decontaminate hands with alcohol gel / hand rub.

Carefully open the sterile pack suitable for the type of procedure to be carried out, taking care to touch only the corners or edges.

Place hand inside disposable bag supplied within the sterile pack, taking care not to touch the outer part and arrange contents on sterile field for easy accessibility.

Open the other sterile items (e.g. dressings) and drop onto the sterile field, taking care not to contaminate the sterile field. Place all packaging in rubbish bag.

Decontaminate hands with alcohol rub, as hands may have become contaminated from handling the outer packaging of items.

Put on non-sterile gloves.

Remove used dressing with non-sterile gloves – take care to protect key site.

Discard used gloves and dressing in rubbish bag.

Decontaminate hands with alcohol gel / hand rub.

Apply sterile gloves, touching only the inside wrist end to avoid contamination.

Carry out procedure, taking care to not touch key parts, key sites or any non-sterile items.

Note: for specific procedures please refer to specific policies and guidelines.

Post procedure remove gloves and apron and dispose in waste bag – Dispose of in the appropriate waste streams.
Decontaminate hands and take trolley and its contents outside procedure area and clean as above.

Decontaminate hands thoroughly with soap and water.

Document procedure in the patient’s medical records

Carry out appropriate hand hygiene.
## Appendix 3 Equality Impact Assessment

### Equality Impact Assessment

#### Section 1: Initial Assessment

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<th>Policy Author</th>
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<td>Sofia Salim</td>
<td>November 2016</td>
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<th>Title of Policy</th>
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<td>Aseptic Non Touch Technique Policy</td>
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1. **Briefly describe the aims, objectives and purpose of the Policy / Guidance Document:**

To reduce the prevalence of Health Care Acquired Infections by providing staff with the knowledge of the most up to date evidence based practice re: Aseptic Non Touch Technique

2. **Who is intended to benefit from the proposed process and in what way?**

Patients will receive safe quality care  
Reduced workload for NSCP staff  
Organisational reduction in cost

3. **Who are the main stakeholders in relation to this Policy/Guidance?**

NSCP, Patients and staff

4. **Are there concerns that the Policy/Guidance does, or could have, a differential impact due to any of the equality areas?**

(Y/N – delete as appropriate)

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<thead>
<tr>
<th>Equality Area</th>
<th>Y/N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>N</td>
</tr>
<tr>
<td>Disability</td>
<td>N</td>
</tr>
<tr>
<td>Gender reassignment</td>
<td>N</td>
</tr>
<tr>
<td>Marriage and Civil Partnership</td>
<td>N</td>
</tr>
<tr>
<td>Pregnancy and Maternity</td>
<td>N</td>
</tr>
<tr>
<td>Race</td>
<td>N</td>
</tr>
<tr>
<td>Religion or Belief</td>
<td>N</td>
</tr>
<tr>
<td>Sex</td>
<td>N</td>
</tr>
<tr>
<td>--------------</td>
<td>---</td>
</tr>
</tbody>
</table>

5. What existing evidence (either presumed or otherwise) do you have for this?

Adhering to this policy is not determined by any of the above nor will it impact on any of the above.

6. Based on the answers given in questions 4 & 5 is there potential for an adverse impact in this policy/guidance?

No

7. Can this adverse impact be justified?

N/A

If you have not identified adverse impact or you can justify the adverse impact, finish here.

If you have identified adverse impact that cannot be justified, please continue to Section 2

**Section 2: Full Impact Assessment**

8. What experts/relevant groups have you approached to explore their views on the issues? Please list the relevant group/experts, how they were consulted and when.

<table>
<thead>
<tr>
<th>Relevant groups/experts</th>
<th>How were the views of these groups obtained?</th>
<th>Date contacted</th>
</tr>
</thead>
</table>

9. Please explain in detail the views of these groups/experts on the issues involved:

10. Taking into account the views of the groups/experts and the available evidence, what are the risks associated with the policy, weighed against
If you have found that the risks outweigh the benefits you need to review the policy further and put together an implementation plan which clearly sets out any actions you have identified as a result of undertaking the EIA. These may include actions that need to be carried out before the EIA can be completed or longer-term actions that will be carried out as part of the policy or development.

<table>
<thead>
<tr>
<th>Risks</th>
<th>Benefits</th>
</tr>
</thead>
</table>

11. Monitoring arrangements and scheduled date to review the policy and Equality Impact Assessment:

| Review Date | November 2018 |