Standard Infection Prevention and Control Precautions Policy

This procedural document supersedes: PAT/IC 19 v.5 – Standard Infection Control Precautions Policy

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<table>
<thead>
<tr>
<th>Author/reviewer: (this version)</th>
<th>Beverley Bacon – Infection Prevention and Control Practitioner</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date revised:</td>
<td>January 2015</td>
</tr>
<tr>
<td>Approved by (Committee/Group):</td>
<td>Infection Prevention and Control Committee</td>
</tr>
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<td>26 February 2015</td>
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<td>12 March 2015</td>
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<tr>
<td>Target audience:</td>
<td>All staff, Trust-wide</td>
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## Amendment Form

<table>
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<th>Version</th>
<th>Date Issued</th>
<th>Brief Summary of Changes</th>
<th>Author</th>
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</table>
| Version 6 | 12 March 2015 | - Policy updated in line with new Trust format  
- Change of Policy title  
- Added 4.8 section on Last Offices  
- Added Appendix 1 Risk assessment guide for selection of PPE  
- Added Appendix 2 Safe order for “Donning” or “Doffing” of PPE  
- Added Appendix 3 Equality Impact Assessment  
- References updated                                                                 | B Bacon Infection Prevention & Control Practitioner |
| Version 5 | March 2012    | - Page 4 - Section added on “Equality Impact Assessment”  
- Paragraphs re-named and re-numbered in line with (CORP/COMM 1)                                                                 | B Bacon Lead Nurse IPC                       |
| Version 4 | March 2009    | - Title Change  
- Individual and Group Responsibilities  
- Safe Handling of Specimens in own section  
- Policy Monitoring and Audit                                                                 | Infection Prevention and Control Team        |
- Added a section on ‘policy monitoring and audit’ – page 8                                                                 | Infection Prevention and Control Team        |
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1. INTRODUCTION

Standard precautions are the practices that must be adopted by all healthcare workers (HCWs) when potentially coming into contact with any patient’s blood, tissue or body fluid. They are based on a set of principles designed to minimise exposure to and transmission of a wide variety of micro-organisms. Since every patient is a potential infection risk it is essential that standard precautions are used for all patients all of the time. It is not possible to know who is, and who is not, infected with a potentially transmissible disease or infection. Thus all body fluids should be regarded and dealt with, as if they were a potential source of infection.

There are a number of key elements to standard control precautions, all of which when appropriately implemented are designed to reduce the risk of transmission of micro-organisms.

The application of transmission based precautions when patients are managed with known infections will support the prevention of the spread of healthcare associated infections.

2. PURPOSE

To implement safe working practices within the healthcare setting to protect staff from the potential risks involved in handling blood, body fluids, the patient, materials or equipment contaminated with micro-organisms.

3. DUTIES AND RESPONSIBILITIES

This policy covers infection prevention and control management issues for Trust staff this includes:

- Employees
- Volunteers
- Agency/Locum/Bank Staff
- Contractors whilst working on the Trust premises

All staff working on Trust premises, outreach clinics and community settings, including Trust employed staff, contractors, agency and locum staff are responsible for adhering to this policy, and for reporting breaches of this policy to the person in charge and to their line manager.

Chief Executive: To ensure that infection control is a core part of clinical governance and patient safety programmes. Promote compliance with infection control policies and national standards in order to ensure low levels of health care associated infections.

Board of Directors: The Board of Directors and executives, through the Chief Executive, is ultimately responsible for ensuring that systems are in place that effectively manage the risks associated with Infection Control. Their role is to support the implementation of a Board to Ward culture to support a Zero Tolerance approach to Health Care Associated Infections.

The Director of Infection Prevention and Control will provide assurance to the board that effective systems are in place.
**Director of Infection Prevention and Control:** Is responsible for the development of infection prevention and control strategies throughout the Trust to ensure best practice.

**The Infection Prevention and Control Team:** is responsible for providing expert advice in accordance with this policy, for supporting staff in its implementation, and assisting with risk assessment where complex decisions are required.

**Microbiologists:** As part of their role provide expert advice to CSM / senior staff out of hours. They will also be responsible in alerting the IPC team of any new alert organisms and difficulties in isolation out of hours.

**Senior Nurses:** are responsible for ensuring implementation within their area by undertaking regular audits in ward rounds activities. Any deficits identified will be addressed to comply with policy.

**Ward and Department Managers:** are responsible for ensuring implementation within their area, and for ensuring all staff who work within the area adhere to the principles at all times.

**Consultant Medical Staff:** are responsible for ensuring their junior staff read and understand this policy, and adhere to the principles contained in it at all times.

**Clinical Site Managers:** are responsible for ensuring patients are managed in accordance with this policy, and for escalating any situations where safe placement cannot be achieved.

**Chief operating officer / On-call Managers:** are responsible for providing senior and executive leadership to ensure implementation of this policy, and for ensuring infection risks are fully considered and documented when complex decisions need to be made regarding capacity and patient flow.

### 4. STANDARD PRECAUTIONS

#### 4.1 Hand Hygiene

Effective hand hygiene will reduce the risk of transmission of micro-organisms from or via the hands of staff. Hands must be decontaminated between caring for different patients or between different care activities for the same patient.

The most important times during care delivery and daily routines when this should occur are described in *Your 5 moments for Hand Hygiene*.

Five Moments uses the concept of the ‘patient zone’ which includes the patient and their immediate surroundings, and sets out when hand hygiene should occur.
Patient hand washing should not be forgotten. All patients should be reminded about good hand washing practices and help should be offered if their physical or mental condition makes it difficult for them to wash their hands. Non ambulant patients must be offered means of decontaminating their hands before eating and after using bedpans/commodes. Hand cleansing wipes are suitable for this purpose and should be stocked on all wards.

PLEASE NOTE
- The Infection Prevention and Control Team along with other colleagues will continue to observe and challenge staff if they do not conform with the WHO 5 moments for hand hygiene with a zero tolerance stance.
- Use safe working practices for ALL patients. Decontaminate hands before and after all procedures/contact with patients and after removing gloves.
- Cover ALL cuts and breaks to the skin. Skin conditions should be reported to the Occupational Health Department.

4.2 Use of Personal Protective Equipment (PPE)

Personal Protective Equipment is used for two reasons:

1. To protect staff from blood/body fluid contamination.
2. To reduce the risk of cross infection through the reduction in contamination and transferring of micro-organisms to other patients, staff, visitors and the environment.

The selection of protective equipment should be based on an assessment of the risk of contamination of the staff members clothing or skin by patient’s blood, body fluids, secretions and excretions and the risk of transmission of micro-organisms from the staff member to patients.

Protective clothing (e.g. plastic apron and disposable gloves) must be worn when there is a danger of exposure to blood, body fluids or cleaning chemicals. If there is a danger of aerosols to the face, (e.g. Respiratory Virus Infections), facial protection must be worn.

Visiting staff, for example Site Services, must be provided with appropriate protective clothing when visiting wards/departments.

See Appendix 1 Risk Assessment Guide for Selection of Personal Protective Equipment based on risk of Exposure to Blood or Body Fluids
See Appendix 2  Correct order for donning and doffing of Personal Protective Equipment.

4.2 a  Guidelines for the Correct Use of Gloves

The use of gloves can reduce the risk of acquiring infection through direct skin contact between HCW and patients (WHO, 2009). Gloves should not be worn unnecessarily or as a substitute for hand decontamination as prolonged and indiscriminate use may cause adverse reactions and skin sensitivity.

- Gloves are a single use item
- Gloves can reduce the likelihood of contact dermatitis in staff exposed to chemical agents
- Gloves must be worn when direct contact with contact with blood, body fluids, non-intact skin or mucus-membranes is anticipated
- Gloves must be changed between patients and different procedures on the same patient
- Gloves must not be worn when using computer keyboards, answering the phone, writing in patient’s care records or serving meals
- Gloves must be disposed of in an orange clinical waste bin
- Hands must be decontaminated with soap and water immediately on removal of gloves

Indications for wearing gloves:
- Venepuncture
- Wound inspection
- Cannula insertion
- Aseptic Non Touch Technique
- Emptying urinary catheter bags/stoma bags
- Cleaning soiled equipment
- Cleaning the clinical environment
- IV drug administration
- Invasive procedures
- Contact with body fluids
- Surgical procedures – use sterile gloves

This is not an exhaustive list.

Staff must ensure that the appropriate type of glove is selected for each particular procedure and purpose. (See Glove Use Policy CORP/HSFS 13).

Inappropriate use of gloves increases the wearer’s exposure to the chemicals and accelerants in the glove material, which can result in skin sensitisation.

Gloves should be discarded after a period of care or task. Also, gloves must not be washed between use as damage may go undetected.
4.2 b  Aprons/Gowns

Disposable plastic aprons should be worn when there is a risk that clothing may become exposed to blood, body fluids and excretions with the exception of sweat or when close contact may lead to contamination by microbes from the patient, materials or equipment. Plastic aprons should be worn as single use items for one procedure or episode of patient care and then disposed of in accordance with Trust waste policy. Full body fluid repellent gowns should be worn where there is a risk of EXTENSIVE splashing of blood, body fluids, secretions and excretions, onto the skin of health care practitioners. In accordance with the management of Scabies – Guidance on Management (PAT/IC 7) staff must also wear long sleeved gown when applying treatment to patients diagnosed with scabies. Also long sleeve gowns must be worn when giving care to patients’ suspected/confirmed of having Carbapenamase resistant enterobacteriaceae (CPE).

**Disposable coveralls**

Disposable coveralls may be used if there is a risk of contamination from chemicals or when providing care for a patient with possible/confirmed viral haemorrhagic fever. Careful attention must be paid when donning and doffing coveralls as there is a risk that the clothing beneath the suit may become contaminated. Staff must consult local procedural documents and have received local training on wearing the suits before using them.

4.2 c  Face Mask/Eye Protection

Face masks and eye protection or a full face visor should be worn where there is a risk of blood, body fluids, secretions and excretions splashing into face and eyes.

Respiratory protective equipment for example a face mask should be used when clinically indicated. For the care of patients with suspected or smear positive respiratory TB high efficiency filter masks should be worn during cough induction, bronchoscopy or prolonged contact (PAT/IC 23). When dealing with patients with suspected/confirmed influenza virus see (PAT/IC 10).

4.3  Safe Use and Disposal of Sharps

Great care must be taken when using needles (PAT/IC 8): An injection tray with an integral sharps box should be used when a healthcare worker has to walk some distance to the point of use. Always dispose of sharps immediately after use and at the point of use. Used sharps must never be carried around by hand or in receivers, trays or other receptacles other than sharps containers as outlined above.

1. Disposable non-sterile gloves must be worn when taking blood samples.
2. **DO NOT** re-sheath needles.
3. **DO NOT** disassemble needles from syringes or other devices wherever possible. If disassembly is required, the needle should be removed using an approved device NOT fingers. Wherever possible dispose of as a single unit.
4. Place used needles directly into sharps container for disposal.

5. Patients who self administer medication or undertake blood glucose recording example diabetic patients must be provided with an appropriate sharps containers.

6. **DO NOT** overfill disposable sharps container. Full containers should be sealed for incineration and labelled with ward or department of origin.

If **any** injury occurs:

1. **ENCOURAGE** bleeding
2. **WASH** the injured area
3. **COVER** affected area with a fully occlusive waterproof dressing
4. **REPORT** the incident and follow the procedure stated in policy PAT/IC 14 if a sharps injury occurs, ensuring an incident form is completed.
5. **CONTACT** the Occupational Health Department for advice or the A&E department if out-of-hours.

### 4.4 Safe Handling of Specimens

Extreme care should be taken at all times with all specimens. For further information refer to policy PAT/IC 11.

### 4.5 Waste Disposal

All waste must be handled, segregated and disposed of in accordance with the ‘Waste Disposal Policy’ (CORP/HSFS 17).

### 4.6 Disinfection of Equipment

Any equipment used by patients should be cleaned and decontaminated between each use and when soiled, using an appropriate cleaning agent.

In the event of spillage of blood and/or body fluids, decontaminate in accordance with Spillages of Blood and Other Body Fluids - PAT/IC 18.

Reusable equipment can be a potential source of infection if not appropriately decontaminated after each use.

Cleaning is an essential stage in the decontamination process and must always precede disinfection and/or sterilization. Selection of the appropriate decontamination method will ensure that the equipment is clean and fit for purpose. Check manufacturer’s instructions for use of suitable cleaning agents.

The user of the device is responsible for ensuring that it is visibly clean and free from contamination with blood/body fluids following each procedure and prior to re-use or prior to sending for repair (internally/externally).

The user must sign and date the appropriate labels to confirm that cleaning has taken place. During decontamination, the user must check clinical equipment for signs of damage and send for repair or disposal if appropriate.
A completed label must accompany each piece of equipment sent for repair. Suitable personal protective equipment must be worn during decontamination procedures to protect the healthcare worker from exposure to microorganisms or infectious agents, where the risk of splash is anticipated.

Refer to Cleaning and Disinfection of Ward Based Equipment - PAT/IC 24 for detailed guidance of suitable methods of decontamination.

4.7 Linen

Linen must be handled correctly to reduce the risk of cross-infection to healthcare staff. Used linen may be contaminated with potential pathogens therefore should be removed from the bed with care and placed immediately into the appropriate bag at the bedside and not on the floor or carried through the ward/department. Although linen may be contaminated with body fluids, which may carry disease, there is little risk if the correct bagging procedure is followed. See Laundry Policy- Bagging Procedure for Linen and in particular Appendix A which details the way in which used linen should be sorted and categorised. The procedure design is such as to reasonably ensure that laundry staff do not manually open bags containing infectious linen and are protected from infectious agents.

4.8 Last Offices

When carrying out the last offices the following should be implemented.

- Wear PPE; gloves and apron
- Remove all drains, catheters and intravenous lines except where a post mortem is required
- Contain leakage from wounds and line sited by ensuring they are covered with a waterproof dressing

After carrying out last offices a body bag must be used in the following circumstances:

When a body is leaking body fluids or there is gross external contamination with blood. Staff must ensure that mortuary staff are aware of the reason for using a body bag. When a patient has or is strongly suspected of having one of the following biohazard conditions:

- Anthrax
- Classic or variant Creutzfeldt-Jakob disease (CJD)
- Diphtheria
- Hepatitis B, C
- HIV
- Meningococcal septicaemia / meningitis if death occurs before 48 hours of appropriate antibiotic therapy being completed
- Rabies virus
- Invasive β-haemolytic Streptococcus Group A disease if death occurs before 48 hours of appropriate antibiotic therapy being completed
- Tuberculosis
- Typhoid/ Paratyphoid
- Viral Haemorrhagic fever

When relatives are collected patients property, any soiled patient’s clothing must be placed in a water-soluble clothing bag which must be secured and placed inside a property bag. An itemised list of contents must be attached.

5. TRAINING AND SUPPORT

All staff should understand how organisms spread in order to apply isolation procedures. Each staff member is accountable for his or her practice and should always act in such a way as to promote and safeguard the well being and interest of patients. Staff will receive instructions and direction regarding infection prevention and control practice and information from a number of sources:-

- Trust Induction
- Trust Policies and Procedures available on the intranet
- Ward/departmental/line managers
- As part of the mandatory infection control education update sessions which can be delivered by a number of formats e.g. face to face and e-learning
- Infection Prevention and Control Educational displays/ posters
- Trust Infection Prevention and Control Team
- Infection Prevention and Control Link Practitioners will be provided with education sessions about the policy at their meetings which will facilitate local training and supervision to take place.
- Advice is also available from the Doncaster & Bassetlaw Hospitals internet sites.

6. MONITORING COMPLIANCE WITH THE PROCEDURAL DOCUMENT

<table>
<thead>
<tr>
<th>Monitoring</th>
<th>Who</th>
<th>Frequency</th>
<th>How Reviewed</th>
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<tr>
<td>The policy will be reviewed in the following circumstances:-</td>
<td>APD Process Group</td>
<td>Every three years routinely, unless:</td>
<td>Approved Procedural Document (APD) database</td>
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<td></td>
<td>IPCT</td>
<td>- When new national or international guidance are received.</td>
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<td>- When newly published evidence demonstrates need for change to current practice.</td>
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<td>- Action required from Root Cause Analysis Serious Incident Investigation Report</td>
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<td>Policy will be approved and ratified by the Infection Prevention and Control Committee</td>
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</table>
Compliance with policy to negate cross-infection

The Infection Prevention and Control Practitioners
Weekly
“Alert organism review” to monitor adherence with the policy.

Audits in ward rounds activities
Matron
Weekly
Incidents where non-compliance with this policy is noted and are considered an actual or potential risk should be documented on an Adverse Incident and near miss report form.

Training needs for infection prevention and control
Ward and Department Managers
Training and Education Department
Annually
Stiffs Professional Development Appraisal
Attendance will be captured by the via OLM system

7. DEFINITIONS

**Standard Precautions** underpin all infection prevention and control practice. The precautions must be used for all patients whether they are known to have an infection or not. Universal/standard precautions are a collection of essential practices that when used together will reduce the risk of patients, visitors and staff from developing transmissible infections.

**Personal protective equipment (PPE)** is the equipment that must be worn by HCWs to protect patients and staff against the risk of infection.

“**Donning**” Putting on

“**Doffing**” Removal of.

8. EQUALITY IMPACT ASSESSMENT

As part of its development, this policy and its impact on equality, an Equality Impact Assessment (EIA) has been conducted in line with the principles of the Equality Impact Assessment Policy CORP/EMP 27.

The Purpose of EIA is to minimise and if possible remove and disproportionate impact on employees and or patients on the grounds of race, sex, disability, age, sexual orientation or religious belief. No detriment was identified. (See appendix 3)
9. ASSOCIATED TRUST PROCEDURAL DOCUMENTS

This policy should be read in conjunction with other Trust Policies and protocols for the prevention and control of HCAI in line with the Health and Social Care Action 2008. In particularly:

- Cleaning and Disinfection of Ward Based Equipment (previously called Decontamination Policy – PAT/IC 24
- Death of a Patient (now incorporates Last Offices Policy) - PAT/T 60
- Glove Use Policy – CORP/HSFS 13
- Hand Hygiene – PAT/IC 5
- Hazard Group 4 Viral Haemorrhagic Fevers - PAT/IC 32
- Laundry Policy – PAT/IC 21
- Management of Respiratory Influenza Type Viruses - PAT/IC 10
- Mental Capacity Act 2005 - PAT/PA 19
- Pathology Specimens - Collection and Handling of Pathology Specimens – PAT/IC 11
- Privacy and Dignity Policy – PAT/PA 28
- Scabies – Guidance on Management – PAT/IC 7
- Sharps Policy - Safe Use and Disposal – PAT/IC 8
- Sharps Injuries Management and Other Blood or Body Fluid Exposure Incidents – PAT/IC 14
- Spillages of Blood and Other Body Fluids – PAT/IC 18
- Tuberculosis – Care of the Patient with Open Tuberculosis in Hospital – PAT/IC 23
- Waste Disposal Policy and Manual - CORP/HSFS 17

10. REFERENCES


### APPENDIX 1 – RISK ASSESSMENT GUIDE FOR SELECTION OF PPE BASED ON THE RISK OF EXPOSURE OF BLOOD OR BLOODY FLUID

Assess actual and potential of blood or body fluid exposure in task in being undertaken

- **No blood or body fluid contact**
  1. Gloves not required
  2. Aprons if clothing may be exposed i.e. moving patient or bed making.
  3. Eye protection and mask not required.
  4. Wash hand before and after contact.
  5. Dispose of disposable apron in appropriate waste category

- **Potential exposure to blood or body fluid. High risk of splash**
  1. Wear gloves.
  2. Wear apron
  3. Wear mask / eye protection
  4. Dispose of gloves/apron/mask/eye protection in appropriate waste category
  5. Wash hand before and after contact and on removal of gloves

- **Potential exposure to blood or body fluid. Low risk of splash patient confirmed as infectious e.g. Chicken pox, MRSA,**
  1. Wear gloves.
  2. Wear apron
  3. Wear mask if appropriate
  4. Wear eye protection if appropriate.
  5. Dispose of gloves/apron/mask/eye protection in appropriate waste category.
  6. Wash hand before and after contact and on removal of gloves.
APPENDIX 2 – SAFE ORDER OF “DONNING” OR “DOFFING” PERSONAL PROTECTIVE EQUIPMENT

PLEASE REMEMBER!
Before putting on PPE the Health Care Worker should:
- be wearing appropriate uniform and footwear as per uniform policy.
- perform hand hygiene
- ensure that any cuts or abrasions are covered with a waterproof dressing

Please Remember!
PPE should be safely removed, disposed of into designated waste receptacle and hand hygiene performed before leaving the patients room/ or undertaking the next task
### APPENDIX 3 - EQUALITY IMPACT ASSESSMENT PART 1 INITIAL SCREENING

<table>
<thead>
<tr>
<th>Policy</th>
<th>CSU/Executive Directorate and Department</th>
<th>Assessor (s)</th>
<th>New or Existing Service or Policy?</th>
<th>Date of Assessment</th>
</tr>
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</table>

1. **Who is responsible for this policy?** Infection Prevention and Control Team

2. **Describe the purpose of the policy?** To implement safe working practices within the healthcare setting.

3. **Are there any associated objectives?** To protect staff from the potential risks involved in handling blood, body fluids, the patient, materials or equipment contaminated with micro-organisms.

4. **What factors contribute or detract from achieving intended outcomes?** Adequate resources e.g. Gloves/Aprons. Staff will receive instructions and direction regarding infection prevention and control practice

5. **Does the policy have an impact in terms of age, race, disability, gender, gender reassignment, sexual orientation, marriage/civil partnership, maternity/pregnancy and religion/belief?** No

6. **Is there any scope for new measures which would promote equality?** N/A

7. **Are any of the following groups adversely affected by the policy?**

<table>
<thead>
<tr>
<th>Protected Characteristics</th>
<th>Affected?</th>
<th>Impact</th>
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<tbody>
<tr>
<td>a. Age</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>b. Disability</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>c. Gender</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>d. Gender Reassignment</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>f. Marriage/Civil Partnership</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>g. Maternity/Pregnancy</td>
<td>No</td>
<td></td>
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<tr>
<td>h. Race</td>
<td>No</td>
<td></td>
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<tr>
<td>i. Religion/Belief</td>
<td>No</td>
<td></td>
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<tr>
<td>j. Sexual Orientation</td>
<td>No</td>
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8. **Provide the Equality Rating of the service/ function/policy /project / strategy**

<table>
<thead>
<tr>
<th>Outcome 1</th>
<th>Outcome 2</th>
<th>Outcome 3</th>
<th>Outcome 4</th>
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</table>

9. **Date for next review** February 2018

**Checked by:** Maurice Madeo Deputy DIPC  **Date:** 26th February 2015.