



CARE, DECONTAMINATION AND MAINTENANCE OF ENDOSCOPES AND SIMILAR DEVICES POLICY

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'During the COVID19 crisis, please read the policies in conjunction with any updates provided by National Guidance, which we are actively seeking to incorporate into policies through the Clinical Ethics Advisory Group and where necessary other relevant Oversight Groups'

DOCUMENT HISTORY

(Procedural document version numbering convention will follow the following format. Whole numbers for approved versions, e.g. 1.0, 2.0, 3.0 etc. With decimals being used to represent the current working draft version, e.g. 1.1, 1.2, 1.3, 1.4 etc. For example, when writing a procedural document for the first time – the initial draft will be version 0.1)

Date of Issue	Version No.	Date Approved	Director Responsible for Change	Nature of Change	Ratification / Approval
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Jul 14	4.1		Executive Director of Nursing & Workforce	Minor Amendments	
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Jan 2019	5.1		Director of Nursing	Scheduled review of policy	
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23 Apr 19	6.0	23 Apr 19	Director of Nursing	Approved at	Policy Management Sub-Committee
29 Jan 21	6.0	23 Apr 19	Chief Nurse including Midwifery and Allied Health Professionals	12 month blanket policy extension due to covid 19 applied with author review date set 6 months prior to Valid to Date.	Quality & Performance Committee
13 May 21	6.0	23 Apr 19	Chief Nurse including Midwifery and Allied Health Professionals	Extended policy uploaded and linked back	Corporate Governance

NB This policy relates to the Isle of Wight NHS Trust hereafter referred to as the Trust

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1 Executive Summary

This policy provides a clear standard for the care, decontamination and maintenance of reusable, rigid and flexible endoscopes within the Trust. It has been developed to comply with national requirements relating to the care and maintenance of endoscopes.

The Health and Social Care Act 2008 Code of Practice on Infection Prevention and Control requires healthcare providers to ensure decontamination of reusable medical devices takes place in compliant facilities that are designed for the process of decontaminating medical devices through validated processing systems and controlled environmental conditions to ensure all potential environmental, cross-infection, handling and medical device usage risks are minimised. Appropriate policies are required to be in place and adhered to.

The policy provides detail on;

- Responsibilities of the endoscope user and managers of Endoscopy units
- Specific guidance for different endoscopes including rigid and flexible types.
- Requirements for training of staff in care and decontamination of endoscopes including competency assessment.

The main national guidance on which this policy is based is Health Technical Memorandum (HTM) 01-06): Management and decontamination of flexible endoscopes. 2016

2 Introduction

National recommendations exist for the management and decontamination of endoscopes. The highest standards of cleaning and decontamination must be achieved in order to prevent cross-infection. These national recommendations contain Essential Quality Requirements, which all organisations are expected to comply with, as well as Best Practice guidance, to which organisations are expected to work towards, encompassing non-mandatory policies and procedures that aim to further minimise risks to patients, deliver better patient outcomes and achieve cost efficiencies.

Specific national guidance on the use and decontamination of endoscopes on those identified at high risk of Creutzfeldt-Jakob Disease (CJD) or other transmissible spongiform encephalopathies is provided by the Department of Health (Minimise transmission risk of CJD and vCJD in healthcare settings), which is summarised in the Trust's Infection Prevention and Control policy: "Transmissible spongiform encephalopathies (TSEs) including Creutzfeldt-Jakob Disease (CJD)".

Standard infection control precautions also apply to use, care, decontamination and maintenance of endoscopes; these must be applied rigorously during all procedures involving potentially contaminated endoscopes.

Decontamination of endoscopes with the Trust will be undertaken in an approved central reprocessing unit, which is either HSDU (Hospital Sterilisation and Disinfection Unit), or Endoscopy Decontamination Room. Local processing is not recommended and should only be undertaken with the written approval of the Director of Infection Prevention and Control (DIPC) and agreement of the Trust

Board. Currently this only applies to non-lumened nasendoscopes, processed within the ENT department in accordance with the local SOP.

3 Definitions

Endoscope: An instrument for examining visually the interior of a bodily canal or a hollow organ such as the colon, bladder, or stomach.

Transophageal echocardiography (TOE) probes allows real time visualisation of the heart via the stomach and oesophagus

Transrectal ultrasound (TRUS) probes and **transvaginal ultrasound (TVUS)** probes are used to examine the prostate gland and female reproductive organs respectively.

TSEs/CJD: Transmissible spongiform encephalopathies (TSEs), also known as prion diseases, are a group of rare, degenerative and fatal brain diseases, including Creutzfeldt-Jacob disease (CJD) The causative agents are different to bacteria and viruses and pose a particular challenge due to resistance to conventional chemical and physical decontamination methods.

vCJD: variant Creutzfeldt-Jakob Disease

IPCT: Infection Prevention and Control Team

HSDU: Hospital Sterilisation and Disinfection Unit

AER: Automated Endoscope Reprocessor, also known as Endoscope Washer Disinfector (EWD)

4 Scope

This policy sets out clear standards required for safe decontamination of endoscopes. It applies to all types of endoscope used throughout the Trust and to all staff involved in the use, care, decontamination and maintenance of endoscopes.

5 Purpose

To provide guidance on safe care, decontamination and maintenance of endoscopes in accordance with national standards.

6 Roles and Responsibilities

- 6.1 Director of Infection Prevention and Control** is the designated Board lead for infection prevention and control and has overall responsibility for the management and implementation of related policies.
- 6.2 Heads of Nursing and Quality and Clinical Leads** are accountable for the infection control practices and standards within their Care Group and should ensure that this policy is complied with in their area of responsibility.

- 6.3 The Decontamination Lead** is the designated Board Lead for decontamination and responsible for ensuring implementation of this policy
- 6.4 The Decontamination Implementation Group** is responsible for ongoing review and monitoring compliance with this policy and for providing assurance to the Decontamination Lead and Infection Prevention and Control Committee.
- 6.5 The HSDU Manager and HSDU Quality Manager are responsible for the decontamination of rigid and heat stable endoscopes:**
- Ensuring that decontamination processes are carried out in line with this policy and relevant national guidelines.
 - Ensuring that staff carrying out decontamination processes are trained and competent to do so.
 - Ensuring that monitoring, validation, testing and other quality control monitoring of systems for reprocessing endoscopes are carried out to agreed national standards
 - Ensuring that transportation containers/boxes are decontaminated after each use before returning to departments.
- 6.6 The Endoscopy manager and endoscopy staff are responsible for The management and decontamination of flexible and heat labile endoscopes:**
- Ensuring that decontamination processes are carried out in line with this policy and relevant national guidelines
 - Ensuring that staff carrying out decontamination processes are trained and competent to do so
 - Ensuring that monitoring, validation, testing and other quality control monitoring of systems for reprocessing endoscopes are carried out to agreed national standards and areas of concern reported appropriately.
 - Ensuring that transportation containers/boxes are decontaminated after each use before returning to departments.
- 6.7 The User is responsible for** ensuring the endoscope is decontaminated in line with this policy immediately after each use.
Ensuring that if used in departments without direct access to the decontamination unit, endoscopes are kept moist and are transported to the decontamination unit immediately after use in an appropriate container, in line with the guidance in this policy.
Ensuring that flexible, heat labile endoscopes are appropriately stored in a designated climate controlled drying cabinet or other approved storage area and are reprocessed before use in accordance with guidance in this policy
Ensuring that rigid and heat stable endoscopes are stored in clean, dry conditions when not in use.

7 Policy detail/Course of Action

7.1 ESSENTIAL QUALITY REQUIREMENTS

The following Essential Quality Requirements relating to endoscope decontamination must be met:

- Decontamination of reusable medical devices must take place in appropriate facilities designed to minimise the risks that are present
- Appropriate procedures must be followed for the acquisition, maintenance and

validation of decontamination equipment

- Staff must be trained in cleaning and decontamination processes and hold appropriate competences for their role;
- A record-keeping regime must be in place to ensure that decontamination processes are fit for purpose and use the required quality systems.
- Endoscopes should be decontaminated in accordance with manufacturers' recommendations.
- Water quality must be monitored and controlled in line with national guidance
- Lumened instruments should be reprocessed using a validated automated process following the manual cleaning stage.
- Policies and guidelines on the minimisation of recontamination or recolonisation should be in place.
- Following decontamination, a high standard of care is needed to ensure that neither recontamination nor recolonisation occur to an extent such that it compromises patient safety. Standard precautions including handwashing, gloving and the use of barrier precautions such as aprons (where appropriate) must be used and high standards of personal hygiene are required from staff.
- Up to date written procedures for each stage in the management, use and decontamination of endoscopes are required.
- Reprocessed instruments should be inspected to show that they clean and safe for reuse.
- An effective form of manual or computer-based instrument track and trace system should be in place.
- A procedure for the withdrawal of endoscopes from service should be in place including the management of prion-related incidents or other events that may render the endoscope unfit for purpose (such as damage or failing a leak test).

7.2 RIGID & HEAT STABLE ENDOSCOPES

Rigid and heat-stable endoscopes (e.g. hysteroscopes, laparoscopes), where used, must either be disposable single-use, or must be returned to the Hospital Sterilisation and Disinfection Unit (HSDU) after each use for cleaning and heat sterilisation.

Any detachable accessories which are not suitable for re-processing in HSDU should either be disposable or have an appropriate decontamination procedure in place (approved by the Infection Prevention and Control Team).

7.3 FLEXIBLE ENDOSCOPES

Many flexible endoscopes are heat labile and will not tolerate heat disinfection or sterilisation. Heat labile flexible endoscopes should not be returned to HSDU but after each use should be returned as soon as possible to the Endoscopy decontamination unit. Endoscopes should be transferred from the point of use to the decontamination area as soon as possible, following the procedures in 7.7.

All lumened flexible endoscopes must be decontaminated in an automated washer disinfector (AER) after prior cleaning.

Flexible nasendoscopes without lumens are currently used and cleaned in the ENT department in line with local standard operation procedure procedure (approved by the IPCT) held within the department. Future purchasing and service developments must recognise the recommendations for best practice for automated centralised decontamination of such devices.

7.4 PURCHASE AND ACCESSORIES

Purchasing must be in line with the Medical Devices Management Policy and operational procedures. Scopes must be able to tolerate approved decontamination methods and comply with this policy. HSDU and the endoscopy unit must be involved in purchasing decisions.

All accessories such as biopsy forceps must be single use, disposable items. The Department purchasing the accessory is responsible for carrying out risk assessment prior to purchase to ensure single use only.

7.5 TRACEABILITY

A system must be in place to enable rapid tracing of all patients who have undergone procedures using a particular flexible endoscope. This is in addition to the requirement to document the endoscope number in the patient's records. A traceability audit is completed once a month. Variances are monitored and managed appropriately.

PROCEDURES FOR CLEANING AND DECONTAMINATION WITH ENDOSCOPY DEPARTMENT (Read in conjunction with Endoscopy department protocol)

7.6 DECONTAMINATION AREA

Cleaning and decontamination of flexible endoscopes must only be performed in designated facilities. These must include:

- An environment that allows flows of work to pass from “dirty” to “clean” without crossover or potential for cross-contamination.
- A sink for decontamination, separate to the hand-washing sink. This must be deep enough to immerse the scope for cleaning, and must have a plug.
- An enzymatic detergent, cleaning cloths and appropriate disposable cleaning brushes.
- Adequate work surface space.
- Suitable AERs validated for decontamination purposes.
- Spillage kit and protective clothing for use in the event of emergency chemical spillage or leak.
- Adequate ventilation.
- Prominently displayed Health and Safety guidance and guidance for use of the area including use of the washer-disinfectors and any chemicals used.

7.7 CLEANING

Cleaning is ESSENTIAL prior to any disinfection process. Thorough cleaning of all lumens must be achieved prior to automatic processing with a chemical disinfectant / sterilant.

After use:

As soon as the endoscope is removed from the patient, the lumens should be flushed in accordance with the endoscope manufacturer's instructions.

Flexible endoscopes should be kept moist after use and before manual cleaning. If endoscopes are allowed to dry during this period, soil will be difficult to remove. Therefore endoscopes should be transferred from the point of use to the decontamination area as soon as possible and an appropriate dedicated container must be used.

Manual cleaning:

Follow local protocols which should be based on instructions provided by the endoscope manufacturer, as endoscopes vary in construction and therefore the method of cleaning required. Manual cleaning is essential to remove deposits down the lumen and around the controls of an endoscope. An EWD is not able to reproduce the brushing action of manual cleaning or brushing between the control wheels.

Before cleaning, all endoscopes should be tested to determine whether there is a fracture or leak. A leak test should be performed and shown to be satisfactory before cleaning is undertaken. The endoscope manufacturer's instructions should be followed for this task.

The endoscope and accessories should be soaked in the detergent solution recommended by the detergent manufacturer. Under detergent fluid, the instrument/biopsy lumens should be brushed through several times with a cleaning brush designed for the instrument in accordance with the endoscope manufacturer's instructions.

7.8 DISINFECTION (Automated Endoscope Reprocessor)

High-level disinfection of heat labile flexible endoscopes must be performed in an automated endoscope reprocessor (AER). Chemical disinfection performed manually using a tank is an inferior process and **must not** take place.

A plumbed-in automated endoscope reprocessor (AER) must be used for disinfection of endoscopes after they have been cleaned.

The endoscope must be connected to the machine using the correct connectors. On no account should pieces of oxygen tubing or other devices not specified by the manufacturer be used to adapt a connector.

The endoscope must be compatible with the machine, and the chemical disinfectant being used. The correct chemical contact time for the scope must be set on the machine and the scope must not be removed until the cycle is complete.

7.9 DRYING

Immediately after disinfection, flexible endoscopes must be placed in a drying cabinet. If there are no drying cabinet facilities available, immediately after disinfection endoscopes should be placed appropriate storage cabinet.

7.10 STORAGE

After reprocessing and drying, flexible endoscopes must be placed in a cabinet designed for that purpose.

The cabinet must allow the air to circulate freely.

Endoscopes must not be in contact with each other. They should not be stored in the case provided by the manufacturer or in other inappropriate units. The time an endoscope is placed in a drying cabinet must be recorded to ensure the device does not exceed the storage time.

Requirement for reprocessing after storage

If not in a specific drying cabinet as below, stored endoscopes must be reprocessed before their next use if the time elapsed since the previous disinfection procedure exceeds 3 hours.

Where a climate controlled drying cabinet specifically designed for endoscope storage is used, the endoscope may be used without reprocessing providing use occurs within 7 days of the last disinfection process.

All such cabinets should fully comply with BS EN 16442 and undergo testing in line with HTM 01-06. They must not be used to store endoscopes for longer than the time validated by the manufacturer without reprocessing.

The departmental Work Instructions for drying cabinet operation must be followed.

7.11 PROCESS QUALITY MONITORING IN ENDOSCOPY including maintenance and testing

All flexible endoscopes must be adequately serviced and maintained via a service and maintenance contract with a reputable contractor. This must include all items used in conjunction with the endoscopes, i.e.: light source, automated endoscope reprocessors (AERs), etc.

AERs must be subject to a documented scheme of validation that should include checks and tests in line with guidance contained in HTM 01-06 before being put into service.

AERs and other equipment and services associated with decontamination processes must be subject to documented periodic testing and preventative maintenance to comply with standards laid out in HTM 01-06.

The disinfection process in AERs must have regular quality checks to an agreed schedule and in line with recommendations in HTM 01-06, including weekly tests for total viable count of the final rinse water.

In the event of a quality monitoring test failing to meet the standards required, a member of the Infection Prevention & Control Team should be informed without delay and the relevant manager(s) must be informed. In the event that water quality test results indicate more than 9cfu/100ml, immediate action must be taken in line with local protocols (See appendix A).

ACTION IF DECONTAMINATION FAILURE OCCURS (Endoscopy unit)

Inability to reprocess appropriately may occur unexpectedly for a variety of reasons, for example;

Breakdown of AERs

AER fails to complete cycle

AER does not validate cycle

Lack of staff trained in decontamination techniques

Lack of capacity for decontaminating numbers of scopes presented
Unavailability of “on-call” staff to undertake decontamination
Scope not suitable to undergo the process
AER’s fail the weekly, quarterly or yearly tests as per HTM 01-06

These examples do not form an exhaustive list.

Any failure to decontaminate a scope must be considered an adverse untoward incident and the appropriate documentation should be completed and manager(s) and the Infection Control Doctor (ICD) must be informed (or Infection Prevention & Control Nurse if ICD unavailable).

Endoscopes that cannot be decontaminated through a designated AER or through HSDU should be immediately removed from service and quarantined until decontamination can take place.

Under no circumstances should a scope that has not undergone a high-level disinfection or sterilisation process be re-used for patient procedures.

CHEMICAL DISINFECTANTS & C.O.S.H.H. (CONTROL OF SUBSTANCES HAZARD TO HEALTH)

Only Trust-approved chemical disinfectants must be used for high-level disinfection of flexible endoscopes. Advice should be sought from Infection Control if any change of chemical is contemplated; any change in chemical agent used must be discussed with the Infection Prevention & Control Team, C.O.S.H.H Officer, Health and Safety Officer and the Endoscopy Unit Manager.

7.12 TRANSOESOPHAGEAL ECHOCARDIOGRAPHY (TOE), TRANSVAGINAL (TVUS) AND TRANSRECTAL (TRUS) PROBES.

TOE, TVUS and TRUS probes that do not have internal lumens are manually decontaminated after use in line with local standard operation procedure procedure (approved by the IPCT) held within the relevant departments.

8 Consultation

The Policy was revised in consultation with the Endoscopy manager and the HSDU quality manager, before being circulated to the Decontamination Implementation Group (DIG) and Infection Prevention and Control Committee in March 2019 following which no further amendments were received.

9 Training

Most endoscopes have narrow lumens and channels capable of harbouring organic matter and microorganisms. If not thoroughly cleaned they cannot be adequately decontaminated. Cleaning and disinfection of these instruments must therefore only be performed by staff trained to an agreed standard, using appropriate equipment and facilities.

This Endoscope Policy has the following mandatory training requirements

It is a requirement that staff are trained in decontamination processes and can demonstrate that they hold appropriate competencies for their role. Every member of staff involved in any

stage of decontamination of endoscopes must be fully trained appropriately for their role; training should include identification of all channels for every type of endoscope used.

Each member of staff working in HDSU or the Endoscopy Unit decontamination room will complete a competency assessment regarding decontamination practice, manual cleaning of endoscopes and operation of the endoscope automated reprocessors (Endoscopy) or washer-disinfectors (HDSU) including any test procedures for endoscopes or machinery.

Records of training and competency will be kept by the Department Manager and will be updated annually.

10 Monitoring Compliance and Effectiveness

Exception reports on compliance with this policy, including testing of AER's and other associated services/equipment, should be monitored via the Decontamination Implementation Group (DIG) which should report any concerns to the Infection Prevention and Control Committee.

11 Links to other Organisational Documents

- Infection Prevention and Control: (CJD Policy) Transmission Spongiform Encephalopathies (TSEs) including Creutzfeldt – Jakob disease.
- Infection Prevention and Control: Clean patient environment policy.
- Medical Devices Management policy and associated procedures
- Infection Prevention and Control: Hand Hygiene Policy
- Medical Devices single use protocol
- Water systems policy
- Waste management policy

12 References

1. Medical Device Directive 93/42 EEC as amended by 2007/43/EC
2. MHRA Single use Medical Devices implications and consequences of re-use
3. The Medical Device Regulations <https://www.gov.uk/guidance/medical-devices-eu-regulations-for-mdr-and-ivdr>
4. [Dept. of Health. Decontamination of flexible endoscopes HTM \(Health Technical Memorandum\) 01-06. 2016. Accessed February 2019](#)
5. Health & Safety at Work Act (1974)
6. Control of Substances Hazardous to Health Regulations (2002) <http://www.hse.gov.uk/coshh/basics.htm>
7. [Department of Health. The Health and Social Care Act 2008. Code of practice for health and adult social care on the prevention and control of infections and related guidance. 2015](#)

8. [Dept of Health. Minimise transmission risk of CJD and vCJD in healthcare settings. Prevention of CJD and vCJD by the Advisory Committee on Dangerous Pathogens' Transmissible Spongiform Encephalopathy \(ACDP TSE\) subgroup. 2017](#)
9. BS EN 16442:2015. Controlled environment storage cabinet for processed thermolabile endoscopes.

13 Appendices

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Endoscopy Rinse Water Failure Test Procedure

The table below describes the actions required in response to final rinse water bacterial count results as per HTM 01-06.

Results	Actions
<1 cfu / 100ml	Satisfactory. No action required
1-9 cfu / 100ml achieved on a regular basis	Acceptable – indicates that bacterial numbers are under a reasonable level of control.
10 – 100 cfu / 100ml	Risk assessment required to investigate potential problems and super-chlorinate or repeat EWD self disinfect
>100 cfu / 100ml	Risk assessment required to consider taking EWD out of service until water quality improved

Microbiological results from weekly test should be plotted on a graph to give a trend. This will allow 'normal' and 'unusual' results to be distinguished for a particular situation. Investigation of unusual or unsatisfactory results can then be undertaken if results demand (for example, if routine results are below 10cfu/100ml occasionally some of the results may be above 10cfu/100ml).

If a bacterial count above 10cfu/100ml is obtained from test water, identification of the species is advised. If a significant proportion of the microbes appear the same species from their colonial morphology, carry out an oxidase test to presumptively identify pseudomonas spp. If the test is positive, further investigations are required to determine whether Pseudomonas aeruginosa is present.

If only one bath has raised counts, arrange for re- testing and do not use to process the endoscopes until acceptable results received. If multiple baths affected and/or where capacity issues if affected baths out of use, discuss with Infection Control Doctor (or Infection Control Nurse if ICD not available) for risk assessment.

Financial and Resourcing Impact Assessment on Policy Implementation

NB this form must be completed where the introduction of this policy will have either a positive or negative impact on resources. Therefore this form should not be completed where the resources are already deployed and the introduction of this policy will have no further resourcing impact.

Document title	CARE, DECONTAMINATION AND MAINTENANCE OF ENDOSCOPES AND SIMILAR DEVICES POLICY
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Totals	WTE	Recurring £	Non Recurring £
Manpower Costs			
Training Staff			
Equipment & Provision of resources			

Summary of Impact: Nil new

Risk Management Issues: Minimise risk of infection from endoscope use

Benefits / Savings to the organisation: Comply with national guidance to avoid endoscope related infections, required for service accreditation

Equality Impact Assessment

- | | |
|--|-----|
| ▪ Has this been appropriately carried out? | YES |
| ▪ Are there any reported equality issues? | NO |

If "YES" please specify:

Use additional sheets if necessary.

Please include all associated costs where an impact on implementing this policy has been considered. A checklist is included for guidance but is not comprehensive so please ensure you have thought through the impact on staffing, training and equipment carefully and that ALL aspects are covered.

Manpower	WTE	Recurring £	Non-Recurring £
Operational running costs			
Totals:			

Staff Training Impact	Recurring £	Non-Recurring £

Totals:		
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Equipment and Provision of Resources	Recurring £ *	Non-Recurring £ *
Accommodation / facilities needed		
Building alterations (extensions/new)		
IT Hardware / software / licences		
Medical equipment		
Stationery / publicity		
Travel costs		
Utilities e.g. telephones		
Process change		
Rolling replacement of equipment		
Equipment maintenance		
Marketing – booklets/posters/handouts, etc		
Totals:		

- Capital implications £5,000 with life expectancy of more than one year.

Funding /costs checked & agreed by finance:	
Signature & date of financial accountant:	
Funding / costs have been agreed and are in place:	
Signature of appropriate Executive or Associate Director:	



Equality Impact Assessment (EIA) Screening Tool

Document Title:	CARE, DECONTAMINATION AND MAINTENANCE OF ENDOSCOPES AND SIMILAR DEVICES POLICY
Purpose of document	Minimise risk of infection from endoscopy
Target Audience	<i>Health Care Workers involved in endoscope use and decontamination</i>
Person or Committee undertaken the Equality Impact Assessment	<i>E Macnaughton</i>

1. To be completed and attached to all procedural/policy documents created within individual services.
2. Does the document have, or have the potential to deliver differential outcomes or affect in an adverse way any of the groups listed below? No

If no confirm underneath in relevant section the data and/or research which provides evidence e.g. JSNA, Workforce Profile, Quality Improvement Framework, Commissioning Intentions, etc.

If yes please detail underneath in relevant section and provide priority rating and determine if full EIA is required.

		Positive Impact	Negative Impact	Reasons
Gender	Men	<i>no</i>	<i>no</i>	
	Women	<i>no</i>	<i>no</i>	
Race	Asian or Asian British People	<i>no</i>	<i>no</i>	
	Black or Black British People	<i>no</i>	<i>no</i>	
	Chinese people	<i>no</i>	<i>no</i>	
	People of Mixed Race	<i>no</i>	<i>no</i>	
	White people (including Irish people)	<i>no</i>	<i>no</i>	

	People with Physical Disabilities, Learning Disabilities or Mental Health Issues	<i>no</i>	<i>no</i>	
Sexual Orientation	Transgender	<i>no</i>	<i>no</i>	
	Lesbian, Gay men and bisexual	<i>no</i>	<i>no</i>	
Age	Children	<i>no</i>	<i>no</i>	
	Older People (60+)	<i>no</i>	<i>no</i>	
	Younger People (17 to 25 yrs)	<i>no</i>	<i>no</i>	
Faith Group		<i>no</i>	<i>no</i>	
Pregnancy & Maternity		<i>no</i>	<i>no</i>	
Equal Opportunities and/or improved relations		<i>no</i>	<i>no</i>	

Notes:

Faith groups cover a wide range of groupings, the most common of which are Buddhist, Christian, Hindus, Jews, Muslims and Sikhs. Consider faith categories individually and collectively when considering positive and negative impacts.

The categories used in the race section refer to those used in the 2001 Census. Consideration should be given to the specific communities within the broad categories such as Bangladeshi people and the needs of other communities that do not appear as separate categories in the Census, for example, Polish.

3. Level of Impact

If you have indicated that there is a negative impact, is that impact:			
		YES	NO
Legal (it is not discriminatory under anti-discriminatory law)			
Intended			

If the negative impact is possibly discriminatory and not intended and/or of high impact then please complete a thorough assessment after completing the rest of this form.

3.1 Could you minimise or remove any negative impact that is of low significance? Explain how below:
3.2 Could you improve the strategy, function or policy positive impact? Explain how below:
3.3 If there is no evidence that this strategy, function or policy promotes equality of opportunity or

improves relations – could it be adapted so it does? How? If not why not?	
Scheduled for Full Impact Assessment	Date:
Name of persons/group completing the full assessment.	
Date Initial Screening completed	13.2.19

Uncontrolled when printed