FOI REF: 26/376

20th August 2026

East Sussex Healthcare NHS Trust

Eastbourne District General Hospital
Kings Drive
Eastbourne
East Sussex
BN21 2UD

Tel: 0300 131 4500
Website: www.esht.nhs.uk

Further to your recent request for information made under the Freedom of Information Act (FOIA) 2000, I now set out our answers to your specific questions, and any clarifications sought and provided, as follows:

Please could you provide the following information relating to the Oral & Maxillofacial Surgery, Oral Surgery, Hospital Dental Services or similar departments at EAST SUSSEX HEALTHCARE NHS TRUST.

Clarification was sought asking you to confirm if you wish us to include our Community Dental Service, who carry out treatment in the Day Surgery Unit, or just for Oral & Maxillofacial Surgery and confirmation was received that you require the following:

Could you include the community dental service as well OMFS please?

Part A – Clinical activity and patient safety data:

For each of the last three complete years, please provide:

1) The total number of procedures coded under the following OPCS-4 categories:

a) F09 – Surgical removal of tooth.

b) F10 – Simple extraction of tooth.

Year	F09 – Surgical Removal of Tooth (Inpatients)	F09 – Surgical Removal of Tooth (Outpatients)	F10 – Simple Extraction of Tooth (Inpatients)	F10 – Simple Extraction of Tooth (Outpatients)
2023	212	203	124	344
2024	232	167	119	314
2025	263	125	99	289

Unfortunately, following the clarification you provided, our Information Management Team advised that Community Dental activity is not coded using the OPCS-4 categories of F09 and F10, and therefore we cannot provide this data.

2) The number of recorded incidents relating to:

a) Wrong tooth extraction.

b) Wrong-site dental extraction procedures.

c) Relevant Never Events involving dental extraction procedures.

None.

- **Where possible, please provide annual totals only.**

  Not applicable.

- **I am not requesting patient-identifiable information.**

  Not applicable.

Part B – Policies, procedural guidance, and safety documentation:

Please provide copies of any current policies, protocols, procedural guidelines, checklists, LocSSIPs, or standard operating procedures relating to:

a) Tooth extraction procedures.

b) Prevention of wrong tooth extraction.

c) Prevention of wrong-site dental surgery.

d) Surgical safety processes within oral surgery / OMFS / hospital dental services.

Please see attached documents:

- LocSSIP Ref No: DENT/0311 – Procedure: General Dental Treatment Under General Anaesthetic for Patients Treated by the Special Care Dental Service.
- 00680-03 – LocSSIP Ref No & title: MFOP/0040 – Procedure: Dental Extractions Under Local Anaesthetic in the Outpatients Department.
- 01915 – LocSSIP Title & Ref: ESHT/0047 – Scrub Practitioner: Role and Responsibilities for Assisting During Basic Dental Procedures, Perioperative Period. Role Boundary for Dental Extractions Only.
- 01940 – LocSSIP Title & Ref No: THEB/0070 – Dental Cases: Basic Dental Extractions.

Please note that it is the Trust's FOI policy to only provide the names of staff that are graded at Band 8a or above (senior roles), and not to disclose the names of staff who are graded at Band 7 and below; these staff names have been redacted from the attached documents.

Please also note that we have redacted the names of the Trust's IT Systems and the names of staff that no longer work for the Trust and are applying Sections 31(1)(a) and 40(2) respectively. Please see below:

Section 31(1)(a)

Under Section 31(1)(a) of the Freedom of Information Act (FOIA), the Trust can confirm that it holds information relevant to your request, however, we are unable to disclose it for the reasons explained below.

Historically, we would disclose information relevant to the Trust's IT systems, infrastructure and software as part of our transparency agenda under the terms of the Freedom of Information Act (FOIA). However, in light of the recent cyber-attacks on NHS hospitals and the serious impact these have had on patient services and the loss of patient data, we are having to reconsider this approach. Please see several links to news articles about these recent cyber incidents provided below for your information.

- *NHS England — London » Synnovis Ransomware Cyber-Attack*
- *NHS England confirm patient data stolen in cyber attack - BBC News*
- *Merseyside: Three more hospitals hit by cyber attack - BBC News*

As a result of these attacks, thousands of hospital and GP appointments were disrupted, operations were cancelled, and confidential patient data was stolen which included patient names, dates of birth, NHS numbers and descriptions of blood tests.

When we respond to a Freedom of Information request, we are unable to establish the intent behind the request. Disclosure under the FOIA involves the release of information to the world at large, free from any duty of confidence. Providing information about our systems or security measures to one person is the same as publishing it for everyone. While most people are honest and have no intention of misusing information to cause damage, there are criminals who look for opportunities to exploit system weaknesses for financial gain or to cause disruption.

In the context of the FOIA, the term ''public interest'' does not refer to the private or commercial interests of a requestor; its meaning is for the "public good". The Trust receives a significant number of requests each year regarding our IT systems, infrastructure and cyber security measures. Most of these requests are commercially driven and serve no direct public interest. Information relevant to our IT portfolio is often requested by consultancy companies who then pass on this information to their client base. Many of these requests are submitted through the FOI portal whatdotheyknow.com who publish our responses, making this information available to an even wider audience.

As a large NHS Trust we hold extensive personal data relevant to our patients and staff, much of which is considered very sensitive. A lot of this information is held electronically on various administration and clinical systems. We have a duty under the Data Protection Act 2018 and the UK GDPR to protect this personal information and take all necessary steps to ensure this data is kept safe. This means not disclosing information that could allow criminals to gain unlawful access to our systems and infrastructure. The Trust can be heavily fined should it be found to have acted in a negligent way which results in a personal

data breach. We need to demonstrate that we comply with our legal obligations under data protection and freedom of information legislation, but we must be careful that too much transparency does not result in harm to our patients or staff, or cause disruption to our services.

Moreover, under the Network and Information Systems (NIS) Regulations Act 2018, operators of essential services such as NHS organisations like ours have a legal obligation to protect the security of our networks and information systems in order to safeguard our essential services. By releasing information that could increase the likelihood or severity of a cyber-attack, the Trust would fail to meet its security duties as stated in Section 10 of the Network and Information Systems Regulations 2018. Should we not comply with these requirements regulatory action can be taken against the Trust. Further information about the Network and Information Systems (NIS) Regulations Act 2018 can be found here – The Network and Information Systems Regulations 2018: guide for the health sector in England - GOV.UK

Your request asks for policy documents which unfortunately mention specific details regarding our IT Systems which, for the reasons explained above, would be inappropriate to release into the public domain. If disclosed, it is possible that patient data as well as other confidential information would be put at risk. Such disclosure could also impact on the security of our systems and result in serious disruption to the health services we deliver to the local community. Section 31(1)(a) of FOIA provides that information is exempt if its disclosure would, or would be likely to, prejudice (a) the prevention or detection of crime. In this case, disclosure would be likely to prejudice the prevention of crime by enabling or encouraging malicious acts which could compromise the Trust's IT systems and infrastructure. The Trust's capacity to defend itself from such acts relates to the purposes of crime prevention and therefore Section 31(a) exemption is applicable in these circumstances. For these reasons, the Trust considers disclosure of the information you are seeking to be exempt under Section 31(1)(a) [law enforcement] of the FOIA and the names of the IT systems within the policy is being withheld. The full wording of Section 31 can be found here: Freedom of Information Act 2000

Section 31 is a qualified exemption and therefore we must consider the prejudice or harm that may be caused by disclosure of the information you have requested, as well as apply a public interest test that weighs up the factors in maintaining the exemption against those in favour of disclosure.

In considering the prejudice or harm that disclosure may cause, as explained should the Trust release information into the public domain which draws attention to any weaknesses relevant to the security of our systems or those of a supplier, this information could be exploited by individuals with criminal intent. Increasing the likelihood of criminal activity in this way would be irresponsible and could encourage malicious acts which could compromise our IT systems or infrastructure, result in the loss of personal data and/or impact on the delivery of our patient services. We consider these concerns particularly relevant and valid considering the increasing number of cyber incidents affecting NHS systems in recent years and the view by government, the ICO and NHS leaders that the threat of cyber incidents to the public sector is real and increasing.

- *Organisations must do more to combat the growing threat of cyber attacks | ICO*

In the Government's Cyber Security Strategy 2022-2030, the Chancellor of the Duchy of Lancaster and Minister for the Cabinet Office states on page 7:

“Government organisations - and the functions and services they deliver - are the cornerstone of our society. It is their significance, however, that makes them an attractive target for an ever-expanding army of adversaries, often with the kind of powerful cyber capabilities which, not so long ago, would have been the sole preserve of nation states. Whether in the pursuit of government data for strategic advantage or in seeking the disruption of public services for financial or political gain, the threat faced by government is very real and present.

Government organisations are routinely and relentlessly targeted: of the 777 incidents managed by the National Cyber Security Centre between September 2020 and August 2021, around 40% were aimed at the public sector. This upward trend shows no signs of abating.”

With this in mind, we then considered the public interest test for and against disclosure. It should be noted that the public interest in this context refers to the public good, not what is ‘of interest’ to the public or the private or commercial interests of the requester. In this case we consider the public interest factors in favour of disclosure are:

- Evidences the Trust’s transparency and accountability
- Provides information relevant to the IT systems and applications the Trust uses
- Reassures the public and partners that the Trust procures these systems in line with Procurement legislation
- Reassures the public and partners that the Trust’s IT infrastructure and systems are secure

Factors in favour of withholding this information are:

- Public interest in crime prevention
- Public interest in avoiding disruption to our health services
- Public interest in maintaining the integrity and security of the Trust’s systems
- Public interest in the Trust avoiding the costs associated with any malicious acts (e.g. recovery, revenue, regulatory fines)
- Public interest in complying with our legal obligations to safeguard the sensitive confidential information we hold

In considering all of these factors, we have concluded that the balance of public interest lies in upholding the exemption and not releasing the information requested. Although disclosure would provide transparency about our software systems and IT infrastructure, this is outweighed by the harm that could be caused by people who wish to use this information to assess any vulnerabilities in our security measures and consequently use this information for unlawful purposes. Cybercrime can not only lead to major service disruption but can also result in significant financial losses. As a publicly funded organisation, we have a duty for ensuring our public funding is protected and spent responsibly. Moreover, as a public body the Trust must demonstrate that it keeps its confidential data and IT infrastructure safe and complies with relevant legislation, but at the same time we must be vigilant that

transparency does not provide an opportunity for individuals to act against the Trust. In considering the impact that recent cyber-attacks have had on NHS services, including the cancellation of thousands of patient appointments and procedures as well as the loss of confidential patient data, we consider the overriding public interest lies in withholding this information. The private or commercial interests of a requester should not outweigh the public interest in protecting the integrity of our systems and continuity of our essential patient services. Although we appreciate there may be legitimate intentions behind requesting this information, we must take a cautious approach to requests of this nature and appreciate your understanding in this matter.

Section 40(2)

I can confirm that we hold this information, but it is exempt under Section 40(2) of the Freedom of Information Act 2000 – Personal Information of third parties. This is because this information may allow the identification of individuals and disclosure would breach the principles of the Data Protection Act.

This is an absolute exemption and there is, therefore, no requirement to consider the public interest.

Part C – Departmental contact information:

Please provide the contact details (email addresses where available) for the following roles within relevant departments (Oral & Maxillofacial Surgery, Oral Surgery, Hospital Dental Service or similar).

a) Clinical Lead / Clinical Director.

Christian Surwald (Consultant – Maxillofacial)

Leona Toner (Head of Community Dental Services)

b) Service Manager.

Lisa Fuller (Service Manager for Head & Neck)

Jo Scott (Dental Clinical Services Manager – Community Dental Services)

c) Lead Nurse.

Matron

Senior Nurse

Senior Dental Nurse

Staff Nurse

As referenced in our response to Question 2, we do not disclose the names of staff graded below Band 8a. The posts of Matron, Senior Nurse, Senior Dental Nurse & Staff Nurse are below Band 8a and therefore we do not disclose their names.

We are unable to provide the contact details of staff as we consider this information to be exempt from release in accordance with Section 44 of the Freedom of Information Act (Prohibition on disclosure) and would refer to the Privacy and Electronic Communications EC Directive Regulations 2003 which provide specific rules on electronic communication services, including marketing (by phone, fax, email or text) and keeping communications services secure. We will not provide any information that could result in the transmission of unsolicited communications which may place an unacceptable risk to our email network and could also have a detrimental impact on patient care and treatment.

This is an absolute exemption and there is, therefore, no requirement to consider the public interest.

However, we can confirm the main telephone number for the Trust is 0300 131 4500.

d) Generic departmental contact email.

esht.communitydentalservice@nhs.net

I trust this information is helpful in its detail or explanation however, if you are dissatisfied with the response, then you have the right to request an internal review. If you wish to seek an internal review, please write to the Freedom of Information Team at esh-tr.foi@nhs.net quoting the above FOI reference number, within 40 working days. Please note the Trust is not obliged to accept a request for an internal review after this time period.

Yours faithfully

Freedom of Information (FOI) Team
East Sussex Healthcare NHS Trust
0300 131 4716
Core Hours of Business: Monday to Friday 9.00am to 4.00pm

East Sussex Healthcare NHS Trust

LocSSIP Ref No: DENT/0311

Procedure: General Dental Treatment Under General Anaesthetic for Patients Treated by the Special Care Dental Service.

Document control:

Author	Leona Toner Head of Community Dental Service
Version and ratified date	V1.0 10/2023
Review date	10/2026
Sign off by	Trust WHO and NatSSIPs Group
Areas relevant and any exclusions	Eastbourne Day Surgery Unit

Aims of the LocSSIP and key factors for consideration:

To optimise patient safety and the quality of general dental treatment provided under general anaesthetic (GA).

To ensure that all the information is available to support the consented treatment plan or to act in the patient's best interest if they lack capacity.

To ensure that all the instruments, materials and equipment is available to undertake the treatment required.

To define the key steps that the whole team need to engage in for effective team-working.

NatSSIP(s) addressed within this procedural LocSSIP:
NatSSIPs 2 (National Safety Standards for Invasive Procedures) and LocSSIPs (Local Safety Standards for Invasive Procedures) Policy Incorporates WHO Guidance and Site marking

8 Steps to Safer Surgical Interventions (Incorporating World Health Organisation Safety Checklist (WHO) & National Safety Standards for

Invasive Procedures (NatSSIPs)

SHARPS INCIDENTS, BLOOD & BODY FLUIDS (esht.nhs.uk)

LocSSIP: Minimising the Risk of Retained Throat packs

Other relevant/related organisational policies or LocSSIPs:

Health and Safety Management (esht.nhs.uk) Personal Protective Equipment Policy

An Organisation-Wide Policy & Procedure for the Management of Waste (esht.nhs.uk)

Decontamination of Surgical Instruments Policy

Consent to Treatment, Examination and Care

Surgical Instrument, Swab and Sharps Count

Policy for the Decontamination of Reusable

Overarching Policy for Infection Control (esht.nhs.uk)

Surgical Scrub, Gown and Glove procedure for

Policy-summary-sheet-spillage-of-bodily-fluids.pdf (esht.nhs.uk)

Medical Devices Training Policy and Procedure

Pre-operative Marking Correct Site Surgery

A Guide to Surgical Hand Antisepsis

Accountable items- swab, instrument, and sharps count

The National Safety Standards for Invasive Procedures (NatSSIPs) | Centre for Perioperative Care (cpoc.org.uk)

CPOC_NatSSIPs2_SequentialStandardsInfographic_2023.pdf

LocSSIP Details

General anaesthesia (GA) may be required to provide general dental care for patients treated by the Special Care Dental Service (SCDS). Patients who may need community dental services include:

- children with extensive untreated tooth decay who are particularly anxious or uncooperative.
- children with physical or learning disability or medical conditions.
- children referred for specific treatment.
- adults with complex needs who have a proven difficulty in accessing or accepting care in general dental services, including adults with moderate and severe learning and physical disabilities, severe autism, mental health problems and medical histories that limit the ability to cooperate.
- adults with medical conditions who need additional dental care.

All patients are treated in the Day Surgery Unit at Eastbourne District General Hospital.

Dental Community Clinic GA Planning

Each patient must have a comprehensive assessment to gather all the medical, dental, and social information before establishing a clear rationale that GA is the only way to provide the treatment required. GA should only be used when there is significant benefit to the patient which outweighs the risk of the GA itself.

Depending on the complexity of care needs the planning stage can often involve inter-professional collaboration to support the access, provision of care and any post-operative support.

Consideration is also given at this stage to other investigations or procedures pending under the care of other teams which could be undertaken at the same time.

Consideration is given to any known dental surgical complexity which requires a certain skill mix either within the team or supported by Maxillofacial colleagues.

The GA Pathway Pack should only proceed to the dental office when all the relevant information has been gathered and understood. This includes medical history, General Medical Practitioner report, results of any investigations, intra-oral radiographs, extra-oral images, FACE mental capacity assessment, consent form, minutes of best interest meetings, IMCA report, hospital passport and previous anaesthetic record if available.

Pre-assessment is carried out by the dental team GA coordinators and anaesthetists. When there are any other comorbidities any decision around day case suitability is made by a consultant anaesthetist.

Some patients' specific needs mean they are not able to cooperate for any level of pre-assessment.

Any reasonable adjustments required will have been planned for or indicated on the patient documentation and records.

The use of premedication, the type and method of application is specific to the needs of the patient.

In cases where intra-operative treatment decisions are being made, two dentists are present.

Start of the session
Dental staff will change into theatre attire wearing scrubs, shoes, and hat before entering the theatre space. Once entering the theatre standard hand hygiene should take place as per trust policy.

The dentist will log into the electronic patient record and take a test radiographic image. The dentist will review all patient information, the GA Pathway Pack and assess any available radiographs.

Theatre staff will input patient details, times, and specific details on [redacted] (computer system for recording patients' operative data).

The dentist will write on the white board the patient's name, date of birth, age, unit record number and any allergy details. If a provisional treatment plan is provided this will be cross checked with the patient's pathway and electronic dental record before being written on the white board.

The dental nurse will check all required supplementary dental instruments, materials and equipment are available. Specific checks will take place around the dental unit water line, and any treatment specific materials required for the individual cases.

The sensory room is prepared for patients who may struggle with the waiting area.

The delivery of safe care by a multi-disciplinary team requires everyone to be patient focussed, have strong communication and be engaged in the key safer surgery steps.

The order of the sequential steps is specific to the Special Care/GA pathway due to the patient base as detailed below:

Step 1- WHO Surgical Safety Pre-Operative Team Brief.
A briefing must take place at the start of a session before any staff member meets the patient. The reason for this is that some patients present with challenging behaviour that requires awareness and careful management. Other reasons are due to sensory, social, or mental health triggers that may affect the patients' behaviour and engagement.

Staff must introduce themselves stating their name and role before having a comprehensive case discussion for each patient. It is also important that if reasonable adjustments have been planned that these are understood by the whole team.

A multi-disciplinary meeting allows for all members of the team to discuss and clarify any issues of the patient journey, any safety issues, or any additional matters.

For complex cases a member of the patient's support team may be part of the discussion to help with the planning. Discussion can also take place around any premedication and or clinical holding required.

Other key points of discussion about the special care dental patients will include additional patient support, communication needs, premedication, airway management and the use of throat packs.

Throat packs are not recommended for routine insertion. If a throat pack is going to be used it should be clearly communicated that the anaesthetist will insert it and be responsible for removing it.

Any additional equipment required is identified and any other instructions completed on the WHO Surgical Safety Checklist form. The WHO SSC must be signed on behalf of the team to confirm that it has been fully implemented.

Step 2-WHO Surgical Safety Sign In
Checking in the patient is undertaken by the ODP/anaesthetic practitioner with the anaesthetist present. The patient's wristband and notes are checked with verbal confirmation of the patients' details. Allergy check is carried and a patient

with no allergy is given a white wristband. If a patient has an allergy, they are given a red wristband.
The patients care pathway and pre-op details are checked following the checklist and once completed, signed, and dated. Confirmation of the correct consent form with the patient/carer/family before induction requiring staff signature.

Step 3- Consent and Procedural Verification
The dentists also meet with the patient and the accompanying support to confirm the planned approach to treatment or examination under anaesthesia, the consent, or the key outcomes of a best interest's decision. It is also an opportunity to reiterate risks and benefits, possible outcomes, materials and allow further questions to be asked from the patient or the accompanying support.

Consent & procedural verification, with the consent signed by the operator DAS Governance – LocSSIPs and NatSSIPs & trust policy.

When the proposed treatment plan differs significantly from what was anticipated further discussion should take place with the patients advocates. [If the treatment plan is only known when the patient has been anaesthetised further discussion can still be supported by a dentist removing surgical attire and communicating with the patients accompanying support during the procedure.]

Scrubbing: gowning & donning of sterile gown & gloves
Staff have access to a range of face masks, visors, FFP3 as well as hoods.

The dental staff operating should carry out a surgical hand antisepsis using an aqueous antimicrobial solution.

They then don a surgical gown and gloves using the closed method as per AfPP guidelines and Trust policy.

Preparation of Surgical Instruments Dental Cart and Trolley
The integrity of the outer packaging of all the surgical trays is checked for any damage by the circulating dental nurse and the identifying indicators of sterility for the sets used, including the expiry dates of the packs.

Once sterile trays/sets are opened, check the tray list is consistent with the contents, and the sterility indicators are checked.

The instruments must be checked with two competent practitioners before and after use, one of which must be a registered practitioner.

The tray list of instruments must be verbally checked out loud and once completed signed with the names of the scrub practitioner and circulating practitioner who checked the set with the date and patient hospital number for traceability purposes.

The count should include any item that enters the mouth, including throat pack (Raytec gauze), swabs, sharps, disposable items, instruments, and their constituent parts. A pre-procedure count should be performed prior to

commencing treatment and items detailed on the count board. The count marks should be easily visible and legible. The count should take place by two dental staff who have had a count competency carried out.

Airway Management

Airway management of each patient should be carefully considered by the anaesthetist on an individual patient basis, after discussion with the dentist and review of the patient. A secure airway and the patient safety is the priority for the anaesthetist and will be reflected in the choice of airway.

Throat packs are not recommended for routine insertion.

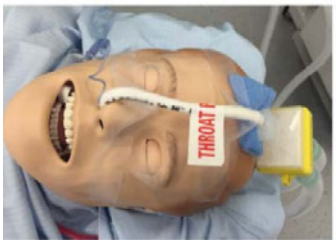
When there is substantial debris from dental treatment such as drilling out old amalgam fillings and scaling, a throat pack may be considered by the anaesthetist on a case-by-case basis. The risk of substantial debris should be documented as part of the justification for throat pack use on the anaesthetic chart, WHO form and, in the patients' dental notes.

When it is an exam under anaesthetic the anaesthetist may wish to wait until a definitive treatment plan is established before placing a throat pack.

After anaesthesia has been induced and an appropriate airway secured the anaesthetic team will ask the scrub or circulating dental nurse for a throat pack. They will issue this to the anaesthetic team whilst adding this to the count. This action should be vocalised to the whole team and repeated while being added to the count board.

While inserted a 'pack' label must be placed on the patient's forehead and only removed once the pack is out as below:

The tag of the throat pack must remain in full view always hanging out of the mouth. All packs must have radiology tapes and should not be cut shorter once they are in the mouth.



Difficult Airway

Difficult airway from history or assessment requires access to the difficult airway trolley, fibreoptic scope, extra anaesthetic support and CMAC. Having good records and communication through an airway alert letter should take place with the patient, carer, GMP and onto [redacted] by the anaesthetist.

Preparation of the Patient

Once the patient has been anaesthetised the positioning for the head and any physical needs lying supine should be provided. Other patient supportive measures are specific to the age and procedure being carried out for example calf compressors and warming.

The team must wait until the anaesthetist is clinically satisfied with the patient and all monitoring is connected.

All other equipment can then be positioned such as the dental cart, mobile x-ray unit, dental suction, scaler, and surgical drill.

Step 4-WHO Surgical Safety Time Out.
This is where all team members **pause to participate** and **listen** to the correct patient, provisional dental treatment plan if known, allergy, and gaining confirmation that everyone is happy to continue.

During Surgery
The patient is draped in sterile surgical single use drapes. If radiographic imaging is required, this is taken and processed by the circulating dental nurse while scaling and the clinical dental exam is taking place.

Particularly for patients who have not had a preoperative dental assessment a thorough exam under anaesthesia is required. This includes extra-oral and intra-oral examination of the soft and hard tissues. Where applicable any periodontal, orthodontic, any disease or anomalies including full dental charting is recorded.

When intra-operative treatment decisions are being made by two dentists there must be an agreed definitive plan that is in the best interests of the patient.

After scaling, radiographs and an exam has taken place a definitive plan is determined and written on the whiteboard. The decision making around the final plan should aim to ensure that the patient is going to be symptom-free and dentally stable. The aim is to complete all dental treatment required in a single episode of care.

An intra-procedure count should be performed when there have been any additional items used as part of the procedure or when there is a change in staff.

Range of dental treatment that can be provided
Restorative treatment should take into consideration the longevity and predictability of success in the size and choice of filling material.

Oral surgery is required for all unrestorable teeth or teeth with associated pathology. Local anaesthetic should be used prior to extractions; however, consideration should be given to patients with sensory issues who may bite their lip or tongue in the recovery stage. Sutures and haemostatic agents should be used when haemostasis has not been achieved or when there are concerns around patient access post operatively due to limited patient cooperation.

Periodontal treatment requires Basic Periodontal Exam, periodontal disease classification and plaque/calculus removal. Where there is significant loss of

periodontal support the decision making should consider the various risk factors in the long-term prognosis of the tooth/teeth.
Endodontic treatment is only carried out in strategic anterior teeth that are carefully case selected.

Mucosal lesions that are suspicious should have a biopsy or a second opinion provided by a Maxillofacial colleague.
Preventive treatment should be provided as appropriate to the dental status and oral health risk.
In cases where there is the potential for a dental clearance due to significant disease or a failed dentition this expectation should have been covered as part of the work up around possible treatment outcomes.

At the completion of dental treatment there is visual and verbal check by the dental team confirming the treatment plan being carried out matches the definitive plan.

Step 5-Reconciliation of items in the prevention of retained foreign objects.

What should be counted?
The final count should include any item that has entered the mouth as detailed on the count board from the pre-procedure count and the intra-procedure count.

Who should carry out the count?
Two dental staff should carry out the count, a dentist, and a dental nurse.

When should the count be carried out?
A final count should be performed when there is still access to the mouth.

Even when patients are having other procedures the count should take place at the end of the dental procedure.

How should the count take place?
Staff should count when the theatre is quiet and there are no distractions.

If the count is interrupted, it should restart from the point of the interruption. When there has been a failed reconciliation the count must be repeated until the item is located.

Throat packs placed by the anaesthetist must be in the count. Confirmation requires an audible shout from the anaesthetist to trigger the whole team to stop and visibly see the pack. Only the anaesthetist who places the pack should remove the pack. This applies even when two anaesthetists are present. If there is a change of anaesthetist, the responsibility of throat pack removal should be handed over.

Following the removal of the pack the anaesthetist must perform laryngoscopy to check that the larynx is clear of dental debris and that the pack has been removed. This action should be vocalised to the whole team and repeated while the final count is taking place. The notes should also record pack removed. This should also be on the anaesthetic chart as it is inserted by the anaesthetist. There is also a custom screen in the patients' dental record for confirmation that the throat pack has been seen and the time the throat pack was removed.

Also counted at this stage is the number of extracted teeth and roots.

All items should be visually inspected to ensure they are intact after removal.
Details must be written on the care pathway and the operating register, ensuring all data is recorded correctly and signed by the appropriate staff.
Swabs should be counted in and out in a bundle of five.

If a specimen is obtained by the surgeon, complete relevant specimen form as per trust policy.

Step 6- WHO Surgical Safety Sign Out.
A specific question is asked to confirm that the treatment carried out matches the written information on the white board, form completed signed and dated.

Another key aspect to this step is to identify patient, equipment, staff, or process concerns that need addressing.

Transfer to Recover
Safe transfer of patient to recovery is carried out and a handover to the recovery staff, by the anaesthetist to the designated recovery practitioner.

Theatre must be cleaned between cases using Clinell wipes. All blood or body fluids (with the exception of urine) should be cleaned with a sodium hypochlorite solution (1 tablet to 100ml of cold water) as per ESHT policy.

Disposal of waste and dirty trays/sets: all are taken to the dirty room/disposal room.

All the rubbish bags, sharps bins, used instrument trays are stored in this room and the different departments will collect and remove i.e., HSDU will collect the dirty instruments trays for cleaning and sterilisation.

Planned/Unplanned Admission
Planned overnight admissions are rare and organised through the GA Coordinators. When patients are admitted even when it is not due to a dental reason the on-call OMFS consultant QVH should be informed. The treatment plan, drugs chart and planned discharge letter are to be written up on handover to the ward on conversion from a day case to overnight stay by anaesthetics, theatre and ESHT surgical team.

The community dentist will call the QVH trauma co-ordinator to advise that SCDS patient has converted to an overnight stay. The QVH trauma coordinator phone number can be sourced through switchboard. The hospital at night team will manage the patient on the ward, requesting input from appropriate specialities. The following morning OMFS team discharge the patient as appropriate unless a ward plan is in place.

Step 7-WHO Surgical Safety Team Debrief.
The operating session is discussed, including any incidents both positive and negative that have arisen during the list, a nominated practitioner must investigate any concerns that have arisen.

Ensure that a WHO Surgical Safety debriefing form is completed, these are placed in a folder in theatre and kept in the administration office, which is part of the monthly team brief audits.

Dental Follow Up
A follow up call is carried out the next day by the dental team. A clinical dental review can also be arranged if required.

Training Requirements
The dental staff are GDC registered professionals. One to one induction is carried out to working in a theatre environment and lists can be run with two dentists in attendance.

Registered Practitioners must hold either: Registered General Nurse (RGN) or Operating Department Practitioner (ODP) qualification.

Staff need to understand and read any policies related to this procedure (as described at the start of LocSSIP) as well as:

Understand and have training on all the equipment needed and used for the procedure.

Operating Theatre set up for the procedure.

Attend multi-disciplinary meetings when provided.

Documentation and audit processes:

Include LocSSIP's on the Trust WHO & NatSSIPs group meeting.

Ratify these policies at Trust WHO & NatSSIPs group meeting.

Review yearly locally and re-ratify every three years via the Trust WHO and NatSSIPs steering group.

All changes to be sent back to matrons/DAS Governance for the future ratification.

Documentation and audit processes:

[redacted]
Operating Register
Care Pathway
WHO Surgical Safety checklist

All incidents must be recorded on the [redacted] incident form (Trust incident reporting system).

Any changes to LocSSIP sent back to WHO and NatSSIPs steering group for future ratification – updated locally every year and within the WHO and LocSSIP group every three years.

References:

CPOC_NatSSIPs2_SequentialStandardsInfographic_2023.pdf

The National Safety Standards for Invasive Procedures (NatSSIPs) | Centre for Perioperative Care (cpoc.org.uk)

A clinical guideline from the British Society of Special Care Dentistry in the use of GA

Meanings & Abbreviations:

AfPP: The Association for Perioperative Practice.

Bair hugger/forced air warmer: Warming blanket system.

Calf compressor/machine & sleeves: Sleeves put pressure on the veins around the calf, speeds up blood flow, Leg Compression machines or Intermittent Pneumatic Compression (IPC) devices are used for the prevention of clotting of blood in the lower extremities of the body like the calves and thighs.

[redacted]: Trust incident reporting system.

EDGH: Eastbourne District General Hospital

ESHT:East Sussex Healthcare Trust.

[redacted]: Trust patient documentation system.

FACE: FACE mental capacity assessment

GA: General Anaesthetic.

GDC: General Dental Council

GMP: General Medical Practitioner

HSDU: Hospital Sterilisation and Disinfection Unit.

IMCA: Independent Mental Capacity Advocate

LocSSIP: Local Safety Standards for Invasive Procedures.

NatSSIP: National Safety Standards for Invasive Procedure.

ODP: Operating Department Practitioner.

OMFS: Oral & Maxillofacial Surgery

QVC: Queen Victoria Hospital

SCDS: Special Care Dental Service.

SSC: Surgical Safety Checklist

STP: Specialist Theatre Practitioner.

[redacted]: Computer system for recording patient's operative data.

WHO: World Health Organisation.

All LocSSIPs are kept for information and are available via the Extranet.

Details of patient involvement
As far as possible an explanation of the process is to be given to all patients/carers/family as and when necessary, i.e., staff introduction, review of consent and procedure, transit to area, checking in, monitoring, cannulation etc.

Particular attention must be given to the additional needs of the individual patient and any reasonable adjustments implemented by all staff providing care.

East Sussex Healthcare NHS Trust

LocSSIP Ref No & title: MFOP/0040

Procedure:

DENTAL EXTRACTIONS UNDER LOCAL ANAESTHETIC IN THE OUTPATIENTS DEPARTMENT

Document control:

Author	[redacted] Dental Nurse, Sister Maxillofacial
Version and ratified date	V3.0 03/2025
Review date	03/2028
Sign off by	Trust WHO & NatSSIPs Steering Group
Areas relevant and any exclusions	Trustwide Maxillofacial OPD

Aims of the LocSSIP and key factors for consideration:

To ensure staff are able to follow and with the correct training understand the process named above to optimise patient safety.

NatSSIP(s) addressed within this procedural LocSSIP:

NatSSIPs 2(National Safety Standards for Invasive Procedures) and LocSSIPs (Local Safety Standards for Invasive Procedures) Policy Incorporates WHO Guidance and Site marking

8 Steps to Safer Surgical Interventions (Incorporating World Health Organisation Safety Checklist (WHO) & National Safety Standards for Invasive Procedures (NatSSIPs)

Other relevant / related organisational policies or LocSSIPs:

National infection prevention and control manual for England

Management of Linen – please refer to the National Infection Prevention and Control Manual (section 1.7)

Sharps – please refer to the National Infection Prevention and Control Manual (section 1.9 and section 1.10)

Aseptic Non-Touch Technique (ANTT) Policy

Health and Safety Management Personal Protective Equipment Policy Arrangements

Policy and Procedure for Consent

Pre-operative Marking Correct Site Surgery Policy and Procedures

Policy for Surgical Scrub, Gown and Glove Procedure for Surgical and Invasive Procedures

Surgical Instrument, Swab and Sharps Count Policy

Decontamination of Surgical Instruments Policy (HSDU)

Policy for the Decontamination of Reusable Equipment

Policy and Procedure for the Management of Medical Devices

Medical Devices Training Policy and Procedure

Body Fluid Exposure policy

Management of blood and body Fluid Spillages

Policy and Procedure for the Management of Waste

Hand Hygiene Policy

Environmental Cleaning Policy

CPOC_NatSSIPs2_SequentialStandardsInfographic_2023.

The National Safety Standards for Invasive Procedures (NatSSIPs) | Centre for Perioperative Care (cpoc.org.uk)

LocSSIP details:

Dental Extractions: A dental extraction (also referred to as tooth extraction, exodontia, and exodontics) is the removal of teeth from the dental alveolus (socket) in the alveolar bone. Extractions are performed for a wide variety of reasons, but most commonly to remove teeth which have become unrestorable through tooth decay, periodontal disease, or dental trauma.

Patient admission:

Welcome the patient to the clinic, staff to introduce themselves by name and introduce the rest of the staff.

Patients name confirmed verbally & ask the patient to verbally confirm the procedure that they are having.

If paper consent form present and signed the information documented must be confirmed verbally by the patient and signed confirmation by the clinician, as per Trust policy.

If the consent is on [redacted] (patient medical notes electronic computer system) then patient to confirm on the screen.

If the consent form is not available then clinician to consent the patient, as per Trust policy.

WHO surgical safety check list to be completed allergies and medication to be recorded and confirmed with the patient.

Pre-operative surgical safety team brief:

During the WHO Surgical Safety team brief, Step 2 of the 8 steps to safer surgery DAS Governance – LocSSIPs and NatSSIPs) team introduces themselves and discusses all aspects of the surgical procedures. The team will also communicate the availability of the sterile equipment.

WHO surgical safety check list to be completed with the team documenting any changes or alerts, form signed & dated.

Before starting the procedure:

Ask the patient to rinse with chlorohexidine 0.2% mouthwash.

Provide safety glasses and disposable bib for the patient.

Ensure that good lighting is available and in good working order.

Handwritten OPD notes available using the [redacted] notes (electronic notes system used throughout the trust).

Preparation of the patient as per biopsy.

Ensure correct teeth for extraction are identified taking into account broken teeth/small teeth/buried teeth prior to surgery using the Palmer notation system (system used to identify teeth used by dental professionals).

Clinician to write on the “white board” in OPD surgery patient’s hospital number and which teeth are to be extracted-this is to be agreed at the WHO surgical safety team brief with x-rays available.

Preparation of surgical instruments:

Check the outer wrapping of all surgical instruments to be used to insure in date and not damaged and that their integrity is intact and in date.

HSDU (Hospital sterilisation & disinfection unit) traceability sticker to be added to the patient WHO surgical safety check list.

WHO Surgical Safety checklist Step 4 of 8; Time Out., completed before commencement of procedure. This is where all team members ‘pause’ to participate and listen to the correct patient, correct site and correct side making all aware and discuss any other issues to be divulged at this moment, and that section of the WHO surgical safety form is signed & dated DAS Governance – LocSSIPs and NatSSIPs.

Commencement of surgical procedure:

Open up the dental procedure pack using the aseptic technique.

Open dental syringe small dental needle and local anaesthetic (lidocaine 2% adrenaline 1:80,000, Articaine 1: 100,000 or Mepivacaine 3%) as directed by the clinician and add to the dental pack.

Add suture and haemostat as required.

During the procedure, the operations register to be completed.

Batch and expiry date of the local anaesthetic to be recorded on the patents WHO surgical safety checklist and also in the operations book.

.

A WHO Surgical Safety Step 7 of 8; ‘Sign out’ is performed where the team ‘pause’ to take part in the WHO checklist acknowledging correct surgery, counts correct this is prior to surgeon leaving theatres, any equipment problems identified correct section of the form signed & dated.

General rubbish disposed & sharps are disposed in Sharps bins as per Trust policy.

The procedure room and any equipment used should be cleaned in line with Environmental Cleaning Policy

End of the procedure:

Check that the patient is feeling ok and not faint or shaky.

Verbally go over the post-op instruction and give the patient post-op instruction leaflet to take home.

Arrange follow up appointment if required or discharge as per clinician’s instruction.

Any incidents that have arisen during the list must be discussed; if an action plan is required a staff member must be nominated to ensure the action plan is completed to a successful outcome and results feedback to all the staff members.

Consider if a [redacted] incident report needs to be submitted

Training requirements:

Registered Practitioners must hold either GDP (general dental practitioner) RGN (registered general nurse) or RDN (registered dental nurse) qualification or another appropriate registered healthcare professional with recognised surgical care practitioner's course for extended practise.

Documentation and audit processes:

Include LocSSIP's on the Trust WHO & NatSSIPs group meeting.

Ratify these policies at Trust WHO & NatSSIPs group meeting.

Review yearly locally and re-ratify every three years via the Trust WHO and NatSSIPs steering group.

All changes to be sent back to Matrons/DAS Governance for future ratification- updated locally every year and within the Trust WHO & LocSSIP group every 3 years.

References: all kept in Local LocSSIPs folder for information

CPOC_NatSSIPs2_SequentialStandardsInfographic_2023.

The National Safety Standards for Invasive Procedures (NatSSIPs) | Centre for Perioperative Care (cpoc.org.uk)

Meanings & Abbreviations:

A dental extraction: Also referred to as tooth extraction, exodontia, exodontics) is the removal of teeth from the dental alveolus (socket) in the alveolar bone. Extractions are performed for a wide variety of reasons, but most commonly to remove teeth which have become unrestorable through tooth decay, periodontal disease, or dental trauma

[redacted] Trust incident reporting system

[redacted]**:** Trust documentation system/ Electronic document management EDM

Palmer notation system: Dental notation is a nomenclature for numbering and naming of teeth, primarily used in the United Kingdom.

Abbreviations:

DAS: Diagnostics, Anaesthetics and Surgery

EDM: Electronic Document Management

GPD: General Dental Practitioner

HSDU: Hospital Sterilisation and Disinfection Unit

LocSSIP: Local Safety Standards for Invasive procedures

NatSSIP: National Safety Standards for Invasive procedures

NHS: National Health Service

NMC: Nursing & Midwifery Council

OPD: Outpatients Department

RDN: Registered Dental Nurse

RGN: Registered General Nurse

WHO: World Health Organisation

All LocSSIPs are kept for information and are available from Management team or via the Extranet.

Development credits:

N/A

Details of patient involvement:

Patient agrees to procedure verbally and by signing consent form with the clinician, as per Trust policy.

East Sussex Healthcare NHS Trust

LocSSIP title & Ref: ESHT/0047

SCRUB PRACTITIONER: ROLES AND REPONSIBILTIES FOR ASSISTING DURING BASIC DENTAL PROCEDURES, PERIOPERATIVE PERIOD

ROLE BOUNDARY FOR DENTAL EXTRACTIONS ONLY

Document control:

Author	[redacted]; LocSSIP Facilitator Matron [redacted]
Version and ratified date	V3.0 03/2024
Review date	03/2027
Sign off by	Trust WHO and NatSSIPs Steering Group
Areas relevant and any exclusions	All areas of the Trust with a requirement for non-medical assistance during surgical procedures.

Aims of the LocSSIP and key factors for consideration:

To ensure that staff can follow the correct and safe procedures for the Role boundary for Dental Extractions

To provide documented instruction and a detailed process to provide the correct training to optimise patient safety.

To provide the Healthcare Practitioner with the scope of the role that is covered by East Sussex Healthcare NHS Trust under vicarious Liability.

NatSSIP(s) addressed within this procedural LocSSIP:

NatSSIPs 2 (National Safety Standards for Invasive Procedures) and LocSSIPs (Local Safety Standards for Invasive Procedures) Policy Incorporates WHO Guidance and Site marking

8 Steps to Safer Surgical Interventions (Incorporating World Health Organisation Safety Checklist (WHO) & National Safety Standards for Invasive Procedures (NatSSIPs)

NHS Indemnity: Arrangements for Clinical Negligence Claims in the NHS
NHS-Indemnity.pdf

Other relevant / related organisational policies or LocSSIPs:

Pre-operative Marking Correct Site Surgery Policy and Procedures

Overarching Policy for Infection Prevention and Control Main Theatres Eastbourne DGH and Conquest Hospitals, Uckfield Day Surgery Units

Policy and Procedure for Consent

Surgical Instrument, Swab and Sharps Count Policy

Policy for the Decontamination of Reusable Equipment

Policy for Surgical Scrub, Gown and Glove Procedure for Surgical and Invasive Procedures

Policy and Procedure for the Management of Waste

The Perioperative Care Collaborative, Position Statement Surgical First Assistant /PCC Surgical First Assistant, sfa-position-statement-final-april-2018.pdf (afpp.org.uk)

Competency documents need to be completed for each member of Staff; a Competency register of named Staff kept locally with the Matrons.

LocSSIP Details:

The purpose of this LocSSIP is to define the key elements that a Scrub Practitioner can undertake for assisting during surgery; with the knowledge that the Trust provides vicarious liability to all staff members working within the scope of this LocSSIP.

Practitioners not adhering to the guidelines of this policy, who continue to undertake additional duties other than Scrub practitioner, will be liable to prosecution, without the Trusts protection under the 'vicarious liability' framework.

The East Sussex Healthcare NHS Trust will only accept that a dual role is necessary due to the lack of a medical assistant to undertake the role. Practitioners must not undertake the role of assistant until the individual concerned has the relevant learning experience, competences and skills to undertake this role.

The boundaries of the Scrub practitioner role with regards to assisting and the basis for safe effective practice will be agreed with the individual, their immediate manager and measured against agreed competencies and practices.

Be mindful of their accountability and code of their specific professional conduct; practice only if they are deemed to be confident and competent to do so in any given context of care.

No pressure or coercion may be placed on any member of the theatre team to act in this role.

The Practitioner will need to consider the following issues:

The complexity of the surgical procedure being undertaken and their previous experience.

Previous training in the tasks which he/she is to undertake.

Possession of an appropriate level of knowledge of the procedure in which he/she is to participate.

Potential risks to the patient by practicing as an assistant: i.e., tissue damage from retraction; damage to structures/ organs from in appropriate handling of instrumentation.

The Healthcare professional acting as Scrub Practitioner must focus upon the management of the intraoperative care of the patient and therefore must not assume the additional duties of a Surgical First assistant.

The Roles and Responsibilities for the Scrub Practitioner: in relation to assisting during the perioperative period are as follows:

Enhancing the communication link between operating surgeon, scrub practitioner and the senior practitioner in charge of the operating session.

Involved in the team completion of the WHO Surgical Safety Checklist for all surgical interventions as part of the Eight Steps to Safer Surgery; including the team brief and debrief.

Pre-operative: WHO Surgical Safety Pre-List team brief:

A pre-op WHO Surgical Safety Pre-team briefing is undertaken with all staff present: in line with the WHO Surgical Safety 8 Step to Safer Surgery

All staff to introduce themselves.

The operating list is discussed by the multidisciplinary team in order by each patient; all issues/points discussed to be documented.

Any changes to the order must be documented and the Co-ordinator for the department and the Ward need to be informed, and a new listed with the changes of order printed. All old lists need to be collected and placed in the Confidential Waste bin.

Any additional equipment required is identified and any other instructions written on the WHO Surgical Safety briefing form.

Ensure WHO Surgical Safety briefing form is completed, signed and dated.

Scrubbing: gowning & donning of sterile gown & gloves:

Nice (2019) recommends prior to the first procedure hands are decontaminated by hand scrub using an aqueous antiseptic.

The first scrub & subsequent scrubs to follow the AfPP guidelines & Trust policy and completed to AfPP guidelines poster, situated in the scrub up area of theatre. Surgical Hand Antisepsis (poster) Sept 2017

Don gown and gloves using closed method as per AfPP guidelines and as per Trust policy.

Assisting roles covered by this LocSSIP:

The scrub practitioner must work under the operating surgeon at all times. They must not undertake any task that could be classified as an operative manoeuvre except in the areas below as 'recognised duties.

Skin disinfection and preparation and draping prior to the commencement of surgery. (LocSSIP, AfPP Standards and trust Policy)

Use of suction within the mouth; during basic dental extractions only. This is supervised/instructed by the surgeon; the area being suctioned must be visible to the scrub practitioner; there should be no deep suctioning within the mouth or back of the throat.

Superficial skin and tissue retraction; only when the practitioner can see the area of retraction. (If area is not visible then the practitioner should not retract).

Cutting of superficial sutures e.g., skin sutures; or where the practitioner can see the whole suture and not damage any surrounding tissues with the scissors.

Cleaning of wound and application of dressings.

Transfer to Post Anaesthetic Care Unit (PACU):

Assist in the safe transfer of the patient to, Post-operative anaesthetic care unit, PACU ensuring a full handover is given to the PACU staff by the Anaesthetist and Scrub practitioner to the designated PACU Practitioner
At the end of the list a WHO Surgical Safety Step 8 of 8: Team Post-Debrief:

The operating session is discussed, including any incidents both positive and negative that have arisen during the list, any incidents that require the completion of a [redacted] needs to be completed.

Ensure a WHO Surgical Safety debriefing form is completed, signed & dated, these are placed in a folder in Theatre and audited regularly.

Considerations:

If due to unforeseen circumstances (i.e., a member of the medical team is taken ill at the table; surgical complications occurring during surgery, requiring immediate first assistant in order to maintain patient safety), a need may arise for theatre practitioners to provide assistance.

It is the senior practitioner in charge of the operating session's responsibility to ensure that the scrubbed practitioner is competent to provide any assistance required; it may require another member of the surgical theatre team to scrub.

The senior practitioner on duty must be consulted, where they will consider the following issues:

Can a member of the medical team be located to assist?

Do the theatre team require senior support?

Training requirements:

Practitioners' Responsibilities:

Registered Practitioners must hold either: Registered General Nurse (RGN) or Operating Department Practitioner (ODP) qualification and therefore be registered with the Nursing and Midwifery Council (NMC) or the Health and Care Professions Council (HCPC)

Their registrant details must be listed on their competences sheet and register of competent staff held locally.

Staff need to understand and read any trust and nationally related policies related to this procedure.

Principles that relate directly to development of practice for all members of the health care team can be summarised as follows:

Always put the needs of patients first.

Update and develop your knowledge, skills and competencies.

Recognise your limitations in your personal knowledge and skill and take action to address deficiencies.

Ensure that you do not compromise existing standards of care with the taking on of new responsibilities.

Acknowledge your own professional accountability.

Management Responsibilities:

Managers initiating or responding to requests for developments from individuals to enhance/expand their scope of practice or for developments in the service which requires this additional scope must:

Decide if the development/enhancement is in the best interest of patients and is line with the divisional plan.

Define the criteria for the practice development including the aims and objectives.

Identify the competencies to be achieved and facilitate the accessing of appropriate education and training.

Monitor practice through the audit process, appraisal and supervision of practice.

Ensure a database of practitioners able to achieve this LocSSIP is maintained.

Forward a copy of the database to the DAS divisional team and advise of any updates as and when they happen. This will be held within the division in a secure drive for compliance purposes only.

East Sussex Healthcare NHS Trust under vicarious liability.

Pages 3,5 & 10
Executive summary, Page 3
"Circumstances Covered- NHS Indemnity covers negligent harm caused to patients or healthy volunteers in the following circumstances: whenever they are receiving an established treatment, whether or not in accordance with an agreed guideline or protocol; whenever they are receiving a novel or unusual treatment which, in the judgement of the health care professional, is appropriate for that particular patient; whenever they are subjects as patients or healthy volunteers of clinical research aimed at benefitting patients now or in the future."

Page 5
"Who is covered, 7. NHS Indemnity covers the actions of staff in the course of their NHS employment. It also covers people in certain other categories whenever the NHS body owes a duty of care to the person harmed, including, for example, locums, medical s academic taff with honorary contracts, students, those conducting clinical trials, charitable volunteers and people undergoing further professional education, training and examinations. This includes staff working on income generation projects. GPs or dentists who are directly employed by the Health Authorities, e.g., as Public Health doctors (including port medical officers and medical inspectors of immigrants at UK air/sea port), are covered."

Page 10.18
"Would health care professionals be covered if they were working other than in accordance with the duties of their post? Health care professionals would be covered by NHS Indemnity for actions in the course of NHS employment, and this should be interpreted liberally. For work not covered in this way health care professionals may have a civil, or even, in extreme circumstances, criminal liability for their actions."

Consultant Solicitor

Documentation and audit processes:

All incidents should be recorded on the [redacted] incident form.

Any changes to LocSSIP sent back to WHO and NatSSIPs steering group for future ratification- updated locally every year and within the WHO and LocSSIP group every three years.

References:

All kept in LocSSIPs folder for information in the Theatre admin Office EB DGH

The Association for Perioperative Practice (AfPP) Standards and Recommendations for Safe Perioperative Practice (5th Edition) is kept in the Matrons Office (Theatres EDGH)

Meanings & Abbreviations:

A role boundary: Is a clear definition of the duties, rights, and limitations.

[redacted] Trust incident reporting system

[redacted] Computer system for recording patient's operative data

Abbreviations:

AfPP: The Association for Perioperative Practice

ESHT:East Sussex Healthcare Trust

HCPC: Health Care Professions Council

I.E: That is to say.

LocSSIP: Local Safety Standards for Invasive Procedures

NA: Not Applicable

NatSSIP: National Safety Standards for Invasive Procedure

NHS: National Health Service

NMC: Nursing and Midwifery Council

ODP: Operating Department Practitioner

PACU: Post Anaesthetic Care Unit

PCC: Perioperative Care Collaboration

RGN: Registered General Nurse

SFA: Surgical First Assistant

STP: Specialist Theatre Practitioner

WHO: World Health Origination

NHS Indemnity: Arrangements for Clinical Negligence Claims in the NHS (Copy in the LocSSIP folder, theatre admin office EDGH)

PCC Surgical First Assistant, sfa-position-statement-final-april-2018.pdf (afpp.org.uk)

All LocSSIPs are kept for information and are available from Management team or via the Extranet

Development credits

N/A

Details of patient involvement

N/A

East Sussex Healthcare NHS Trust

LocSSIP title & Ref No: THEB/0070

DENTAL CASES:
BASIC DENTAL EXTRACTIONS

Document control:

Author	[redacted] LocSSIP Facilitator
Version and ratified date	V3.0 07/2024
Review date	07/2027
Sign off by	Trust WHO & NatSSIPs group
Areas relevant and any exclusions	Theatre department

Aims of the LocSSIP and key factors for consideration:

To ensure that Staff can follow the correct and safe procedures for Dental Extractions

To provide documented instruction and a detailed process to provide the correct training to optimise patient safety.

Instrumentation and equipment required to undertake the above procedures, Decontamination, Sterility of Instrument trays and extras

NatSSIP(s) addressed within this procedural LocSSIP:

ESHT NatSSIPs & LocSSIPs Policy, incorporates WHO Guidance & Site Marking

NatSSIPs 2 (National Safety Standards for Invasive Procedures) and LocSSIPs (Local Safety Standards for Invasive Procedures) Policy Incorporates WHO Guidance and Site marking

8 Steps to Safer Surgical Interventions (Incorporating World Health Organisation Safety Checklist (WHO) & National Safety Standards for Invasive Procedures (NatSSIPs)

Other relevant / related organisational policies or LocSSIPs:

Overarching Policy for Infection Prevention and Control Main Theatres Eastbourne DGH and Conquest Hospitals, Uckfield Day Surgery Units

Health and Safety Management Personal Protective Equipment Policy Arrangements

Policy and Procedure for Consent

Policy for Surgical Scrub, Gown and Glove Procedure for Surgical and Invasive Procedures

Surgical Instrument, Swab and Sharps Count Policy

Decontamination of Surgical Instruments Policy (HSDU)

Policy for the Decontamination of Reusable Equipment

Policy and Procedure for the Management of Waste

Environmental Cleaning Policy

LocSSIPs:

Minimising the Risk of Retained Throat Packs

Scrub Practitioner, Roles and Responsibilities for assisting during Basic Dental procedures, perioperative period. Role boundary for Dental Extractions only

CPOC_NatSSIPs2_SequentialStandardsInfographic_2023.

The National Safety Standards for Invasive Procedures (NatSSIPs) | Centre for Perioperative Care (cpoc.org.uk)

LocSSIP Details:

Dental Extractions: Tooth extraction **is** the removal of a tooth from its socket in the bone.

Equipment:
The day prior to surgery a daily tray ordering form is completed for all the trays required for the next day's operating list.

The equipment is sourced and prepared, with any missing sets of instruments requested as fast track from HSDU (Hospital sterilisation and disinfection unit). These required sets of instruments are checked for holes/abrasions/in the sterile wrapping, sterility and tracking labels then placed on a trolley with a

procedure pack. (A pre-made pack containing drapes, sutures blades and swabs etc.)

Start of the list:
Additional Equipment:

All equipment for Dental extraction needs to be checked and ready for use:

Dental drill and all additional equipment needed is working.
Basic Extraction Instrument tray
Oral pack

Dental Tooth pots available

The theatre team need to ensure that all equipment required for individual procedures is available in addition to back up emergency equipment and their sterile integrity is intact and the use by date has not expired.

Single use items which may be required during surgery are also checked at this time by the Theatre staff to ensure that a full range of sterile equipment is available for use.

There are new steps which have been added to the patients checks which are additional to the WHO safety checklist in line with new National guidance, NatSSIPs 2. January 2023.
CPOC_NatSSIPs2_SequentialStandardsInfographic_2023.

The Surgeon will see the patient on the ward/pre-operative clinical area before surgery, and a WHO Surgical Safety/NatSSIPs 2 sequential Step 1 of the 8 steps to safer surgery is completed; Consent & procedural verification, with the consent signed by the operator DAS Governance – LocSSIPs and NatSSIPs & trust policy

ON WARD: The Operating surgeon must check that the notes, the patient, the X-ray and the consent form all match the procedure to be performed.

The patient is marked with a surgical skin marking pen to identify correct side, Mark the Quadrant (extra orally) or the side (if not teeth)

Pre-operative: WHO Surgical Safety Pre-List team brief:

During the WHO Surgical Safety team brief, Step 2 of the 8 steps to safer surgery DAS Governance – LocSSIPs and NatSSIPs) team introduces themselves and discusses all aspects of the surgical procedures. The team will also communicate the availability of the sterile equipment.

The operating list is discussed regarding patient individually.

Any changes to the order must be documented and the Co-ordinator for the department and the ward need to be informed, and a new list with the changes of order printed and all other lists to be collected and placed into the confidential waste bin.

Any additional equipment required is identified and any other instructions written on the WHO Surgical Safety briefing form.

Ensure WHO Surgical Safety briefing form is completed.

Anaesthetic room

Checking in the patient:

In the anaesthetic room a WHO Surgical Safety Step 3 of 8; Sign In, is completed by the anaesthetic practitioner & anaesthetist with patient, Checks including consent with patient is carried out and that section of the WHO surgical safety form is signed & dated.

This is undertaken by the ODP/Anaesthetic Practitioner with the Anaesthetist present.

The practitioner introduces themselves by name to the patient and states what they need to check.

The first check is the patient's wristband and then verbally confirming the patients details on the wristband with the patient and notes.

The patients Care pathway and pre-op details are checked following the checklist and once completed, signed and dated.

Consent form:

Check the correct consent form has been used as per Trust policy and clearly states the procedure (side and site) that the patient is fully aware and understands.

Check the consent form with the information printed on the designated Theatres Operating list, check the procedure(s) match. (If they do not match a [redacted] form must be completed)

If paper consent form is present, the information documented must be confirmed verbally with the patient and check it has been completed with all signatures that are required, as per Trust Policy.

If consent form is on [redacted] (Trust patient record documentation system) this must be shown to the patient via an I-Pad and checked and documented on the patients Care pathway

Allergies:

White wristband no allergies, RED wristband allergies (written on the white board inside Theatre) by the Surgical team and checked at the WHO Surgical Safety Time Out

Ask the patient to confirm verbally the side of the operation and visibly see where the surgeon has marked the site/side.

In the anaesthetic room a WHO Surgical Safety Step 3 of 8; Sign In, is completed by the anaesthetic practitioner & anaesthetist with patient, Checks including consent with patient is carried out and that section of the WHO surgical safety form is signed & dated.

WHO Surgical Safety check list:
Sign in (before induction of Anaesthesia) is completed, signed, and dated.

Throat Pack

If a throat pack is inserted by the Anaesthetist, a sticker stating a throat pack has been put in and time of insertion is placed on the patient's forehead, the details are put on the white board where it states time pack in and time pack out (removed) and on the Anaesthetist anaesthetic chart. If the throat pack is inserted by the Anaesthetist, it is removed by the Anaesthetist. The information is recorded on the patients care pathway.

Throat packs should be gauze with a raytec strip throughout and a tape on one end. See fig 1.

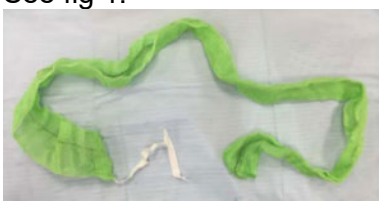


Figure 1. Raytec gauze with tape at one end for use as throat pack.

To reduce the risk of a retained throat pack, the pack will be added to the scrub team's swab and instrument count.

As such throat packs **should not** be stored in the anaesthetic rooms.

The surgeon will sometimes insert a throat pack and the same details apply as seen above.

Throat pack sticker.

The sticker is applied to the patient's forehead because once the sterile drapes are removed it can be seen clearly as a reminder, as long as the patient has no known allergies.

Please refer to: Minimising the Risk of Retained Throat Packs

Scrubbing: gowning & donning of sterile gown & gloves

Nice (2019) recommends prior to the first procedure hands are decontaminated by hand scrub using an aqueous antiseptic.

The first scrub & subsequent scrubs to follow the AfPP guidelines & Trust policy and completed to AfPP, Standards & Guidance.

Don gown and gloves using closed method as per AfPP guidelines and trust policy.

Preparation of surgical instruments and Trolley

Checking Instruments; visually check the integrity of the outer wrapper /packaging of all the sets for any damage and the identifying indicators of

sterility for the sets used for Dental extractions, including the expiry dates of the packs.

Ensure Trolley is clean to lay up packs for the following procedure.

Once sterile trays/sets are opened the tray list is consistent with the contents, the list is checked for sterility indicators.

The instruments must be checked with two competent practitioners before and after use, one of which must be a registered practitioner, the tray list of instruments must be verbally checked out loud and once completed signed with the names of the scrub practitioner and circulating practitioner who checked the set with the date and patient hospital number for traceably purposes.

The trolley should be prepared in line with the specific procedure being undertaken and any Surgeon specific instruments and preferences.

Ensure swab counts, needle & blades are checked and counted, verbally out loud in a systematic manner involving the circulating practitioner and clearly written on the white board. The count is recorded on the Theatre white board and visible for the Theatre team to see – as per; NatSSIPs 2 (National Safety Standards for Invasive Procedures) and LocSSIPs (Local Safety Standards for Invasive Procedures) Policy Incorporates WHO Guidance and Site marking and Surgical Instrument, Swab and Sharps Count Policy

White board will have the patients name, Unit Record Number and any allergy written down and the procedure being undertaken making sure to check the laminated sheet: (for all Dental cases, copy in LocSSIP folder)

Dental cases
In Theatre: Make sure the patient is marked.
Print the name, Unit Record Number, and patient DOB on the white board.

Surgeon: Write the teeth to be removed (or the procedure) on the white board.
Check the Consent form.
Go through THE WHO SURGICAL SAFETY CHECKLIST, identify patient, operation and site.

Safe transfer is carried out of patient from the Anaesthetic room into Theatre and onto the Operating table in the supine position, should then take place.

When the operating theatre trolleys are used surgery will take place on the patient on the trolley

Wait until anaesthetist is clinically satisfied with the patient and all monitoring is connected.

Then the surgeon will place a head ring, horseshoe or sandbag under the patients' shoulders depending on the required position of the patient's head for the dental surgery being performed.

Surgical Aids are applied**,** diathermy plate, Deep Vein Thrombosis prevention boots or leggings, support aids, gel pads to pressure areas and Forced Air Warming blankets to prevent hypothermia (to name some but this is not an exhaustive list).

Equipment is then positioned for use by the procedure team. This includes diathermy machine, calf compressor device, pedal for the dental drill and suction machine.

The equipment is placed at the end of the operating table (patients feet end) and the anaesthetic machine is to the side this is to allow access to the patient's head during surgery, with the operating table placed with the head end nearest the Anaesthetic room doors.

Scrub practitioner is shown consent form confirming the side and site of procedure and checks this against the patients care pathway.

WHO Surgical Safety checklist Step 4 of 8; Time Out. This is where all team members 'pause' to participate and listen to the correct patient, correct site and correct side making all aware and discuss any other issues to be divulged at this moment, and that section of the WHO surgical safety form is signed & dated DAS Governance – LocSSIPs and NatSSIPs.

Commencement of surgical procedure

The patient is draped in sterile single use drapes (as per AfPP Standards) with a turban/head drape and drapes from oral pack.

Surgery is then Commenced.

Scrub practitioner must follow the LocSSIP on Role Boundary for assisting for Dental extractions only.

During Surgery

Computer:
Patient details, times and specific details are recorded on [redacted].

(A WHO Surgical Safety/NatSSIPs 2 sequential Step 5 of 8; implant check if required).

A WHO Surgical Safety/NatSSIPs 2 sequential Step 6 of 8; Equipment reconciliation is carried out: Nothing unintended left behind • Count of constituent parts • Count at every cavity closure, the scrub practitioner should verbalise loudly to the Operating Surgeon when this is complete, and all is accounted for and receive an audible response.

On completion of surgery

Ensure all surgical swabs and instrument counts and suture needles are completed and documented, as per AfPP guidelines and Trust policy/LocSSIP.

Details must be written on the care pathway and the Operating register, input correct information onto the computer [redacted]) ensuring all Data is recorded correctly and signed by the appropriate staff.

End of procedure

A WHO Surgical Safety Step 7 of 8; 'Sign out' is performed where the team 'pause' to take part in the WHO checklist acknowledging correct surgery, counts correct, the prosthesis used and any concerns to pass on to recovery/PACU (Post Anaesthetic Care Unit), this is prior to surgeon leaving theatres correct section of the form signed & dated.

The scrub practitioner must document the procedure/skin closure/dressing and any drains and add any concerns to care plan. Noting pressure areas and the patient's temperature recorded in accordance with Nice guidance CG65

Patient should have fresh linen on their bed/trolley to maintain dignity and to uphold temperature.

Patient pressure areas and cleanliness checked and recorded in the patients care pathway, and all surgical aids removed such as surgical diathermy plate, DVT boots/leggings.

Transfer to Post Anaesthetic Care Unit (PACU)

Safe Transfer of patient to PACU is carried out and a handover to the PACU Staff, by the Anaesthetist and Scrub practitioner must be performed to the designated PACU Practitioner

Disposal of waste and dirty trays/sets: all are taken to the dirty room/disposal room. The rubbish bags have been labelled including date, number of the operating theatre and case number. An anatomical waste box is used for human tissue and disposed as per Trust policy Anatomical Leak proof containers – should be used for all anatomical clinical waste/tissue from theatres as it requires incineration different departments will collect and remove i.e., HSDU will collect the dirty instruments trays for cleaning and sterilisation.

Specially supplied Dental pots (stock from HSDU) are required for all teeth and amalgam fillings to be disposed in the correct manor, a special bin in the Dirty room is allocated for these pots' disposal.

Theatre must be cleaned between cases using Clinell wipes. All blood or body fluids (with the exception of urine) should be cleaned with a sodium hypochlorite solution (1 tablet to 100ml cold water) as per ESHT policy.

WHO Surgical Safety Step 8 of 8: Team Post-Debrief:

At the end of the list a WHO Surgical Safety Team Debrief is carried out:

The operating session is discussed, including any incidents both positive and negative that have arisen during the list, a nominated Practitioner must investigate any concerns that have arisen and a [redacted] completed, if necessary, form signed & dated

Ensure that a WHO Surgical Safety debriefing form is completed, these are placed in a folder in Theatre and kept in the Admin office, which is part of the monthly team brief Audits.

Training requirements:

Registered Practitioners must hold either: Registered General Nurse (RGN) or Operating Department Practitioner (ODP) qualification.

Staff need to understand and read any policies related to this procedure (as described at the start of this LocSSIP) as well as:

Patient positioning
Staff training on all the equipment needed and used for the procedure.

Staff training on related LocSSIPs i.e., specimens

Registered staff training on the LocSSIP, Scrub Practitioner, Role and Responsibilities for assisting during basic Dental procedures, Role boundary for Dental Extractions only and completion of the competencies required for this role

Documentation and audit processes:

[redacted] (computer system for recording patients' operative data)
Operating Register
Care Pathway
WHO Surgical Safety checklists

All incidents should be recorded on the [redacted] incident form (Trust incident reporting system)

Any changes to LocSSIP sent back to WHO and NatSSIPs steering group for future ratification- reviewed locally yearly and by the WHO LocSSIPs group every 3 years

References:

The Association for Perioperative Practice (AfPP) Standards and Recommendations for Safe Perioperative Practice (5th Edition) is kept in the Matrons Office (Theatres EDGH)

CPOC_NatSSIPs2_SequentialStandardsInfographic_2023.

The National Safety Standards for Invasive Procedures (NatSSIPs) | Centre for Perioperative Care (cpoc.org.uk)

Meanings & Abbreviations

Calf compressor/machine & sleeves: Sleeves put pressure on the veins around the calf, speeds up blood flow, *Leg Compression machines or Intermittent Pneumatic Compression (IPC) devices are used for the prevention of clotting of blood in the lower extremities of the body like the calves and thighs.*

[redacted] Trust incident reporting system

Dental Extraction(s): Removal of a tooth/teeth from the mouth

[redacted] Trust patent documentation system

Diathermy: Surgical diathermy, electrocoagulation with an electrocautery of high frequency used for sealing blood vessels or stopping bleeding of incised vessels

Suction machine: consists of a vacuum pump, a vacuum regulator and gauge, a collection canister, a bacterial filter. Plastic tubing is used to continuously draw fluid into the collection canister. (Suction machine used to remove bodily fluids from a patient)

[redacted] Computer system for recording patient's operative data

Throat packs: Have traditionally been placed to collect shed blood, bodily or external fluids and other material that may collect in the oropharynx during nose, **throat**, oral and maxillofacial surgery.

Abbreviations:

AfPP: The Association for Perioperative Practice

ESHT: East Sussex Healthcare Trust

HSDU: Hospital Sterilisation and Disinfection Unit

LocSSIP: Local Safety Standards for Invasive procedures

NatSSIP: National Safety Standards for Invasive Procedure

Nb: Nota Bene, which means 'Please note'

ODP: Operating Department Practitioner

PACU: Post Anaesthetic Care Unit

PAS: Patient Administration System

RGN: Registered General Nurse

STP: Specialist Theatre Practitioner

WHO: World Health Origination

All LocSSIPs are kept for information and are available from Management team or via the Extranet

Development credits

N/A

Details of patient involvement

For those receiving regional anaesthesia with little or no sedation acceptance of the patient's awake status must be considered by all staff. Involvement of the patient at WHO Surgical Safety steps to be included.

Noise, movement and interruptions should be minimised in all circumstances but more so when patient is alert.

As far as possible an explanation of the process is to be given to all patients undergoing this procedure as and when necessary, i.e., staff introduction, transit to area, checking in, monitoring, cannulation etc. Patient involvement during sign in to be maximised by staff.

Within the operating procedure area, if undergoing a general anaesthetic or sedation, direct patient involvement will be minimal.

For those receiving regional anaesthesia with little or no sedation acceptance of the patient's awake status must be considered by all staff. Involvement of the patient at WHO surgical safety steps to be included.

Noise, movement and interruptions should be minimised in all circumstances but more so when patient is alert.