Royal Cornwall Hospitals
NHS Trust

Oral Surgery Outpatients Department (OPD) Practice Standards Clinical Guideline

V1.0

December 2024

1. Aim/Purpose of this Guideline

1.1. The aim of this guideline is to outline the standards of care that must be delivered to each individual patient to ensure high quality of care is provided to patients receiving care in the Oral Surgery Out-patient department. Care Group management recognise that nationally, colleges, professional bodies and speciality associations may define workforce standards for specific clinical activities.

1.2. Within the Oral surgery department there is an out-patients general anaesthetic (OPGA) theatre and recovery suite as well as clinic rooms that provide orthodontic (non-invasive procedure) clinics, general out-patient clinics and Minor Oral Surgery (MOS) procedure clinics.

1.3. The standards described in this document are for the Oral surgery department as a whole and specifically the department clinic rooms. The OPGA theatre standards are as per the RCH theatre practice standards clinical guideline, therefore fall outside this clinical guideline.

1.4. All healthcare professionals have a duty to set a standard by which to practice. With a focus on clinical effectiveness and evidence-based care all staff must be able to demonstrate the ability to audit care and practice. The care that is delivered and improvements in practice must be based on evidence and best practice guidance.

1.5. All staff in the Care Group have a responsibility to ensure, where these exist or become available, it is appropriate to use these to inform these standards and should identify them to their line manager for escalation to the team responsible for ensuring the standards reflect current recommended practice.

1.6. This guideline should be read in conjunction with the following documents:

- Local Safety Standards (LocSSIPs) for the Oral Surgery Out-patient department. Safety Standards Minor Oral Surgery
- RCH conscious sedation in the Oral surgery (MOS) clinic. Conscious Sedation
- RCH Inclusion criteria for Out-patient General Anaesthetic (OPGA) in the oral surgery department. Inclusion Criteria for General Anaesthetic
- RCHT Five steps to safer surgery. 5 Steps to Safer Surgery
- RCHT Consent Policy. Consent Policy
- RCHT Uniform Policy. Uniform Policy
- RCHT Infection Prevention and Control Policy. Infection and Prevention
- RCHT Safe Handling and Disposal of Sharps. Safe Handling and Disposal of Sharps
- RCHT Decontamination Policy. Decontamination Policy

- DOH Infection Control in the Built Environment. Infection Prevention Control
- RCHT COSHH.COSHH
- RCHT ANTT Policy. ANTT Policy
- RCHT Theatre Practice Standards Clinical Guideline V4. Theatre \practice Standards
- RCHT Waste Management Policy. Waste Management
- PHE Guidance. PHE Guidance
- AfP Royal Marsden Manual of Clinical Nursing Procedures.
- Principles of Safe Practice within the Perioperative Environment.
- RCHT IT Policy. IT Policy
- RCHT Incident Reporting Policy. Incident Reporting Policy
- RCHT Policy and Procedure for being Open. Being Open Policy
- RCHT Disclosure and Barring Checks Policy.
- RCHT Management of Corporate and Local Induction. Management and Local Induction
- RCHT Core Training Policy. RCHT Core Training Policy
- RCHT Grievance and Disputes Policy. Grievance and Disputes Policy
- RCHT Whistleblowing Policy. Whistle Blowing
- RCHT Dignity at Work Policy. Dignity at Work Policy
- RCHT Positive Identification Policy and Procedure.Positive Identification Policy
- RCHT Fire Safety Policy. Fire Safety Policy
- RCHT Medical Devices Policy. Medical Devices
- RCHT Risk Management Policy. Risk Management Policy
- NMC Professional Registration. Professional Registration
- The Royal College of surgeons – Clinical Guidelines.

2. The Guidance

2.1. Departmental standard No 01: Preparation of personnel within the Oral Surgery Out-patient (OPD)

2.1.1 Standard Statement:

All members of staff working within the the Oral Surgery Out-patient department should present a professional appearance and always conduct themselves in a professional manner and should dress as per the RCHT dress code and uniform policy when in the clinical environment. Nursing staff will wear nurse uniforms appropriate to grade and medical staff will wear appropriate smart dress.

2.1.2 Refer to:

- RCHT Uniform policy. Uniform Policy
- RCH Infection Prevention and Control Policy. Infection Prevention Control
- PHE guidance. PHE Guidance

2.1.3 The Oral Surgery Department Clinic Room Attire.

2.1.3.1 Patient Safety

- Although there is no conclusive evidence that uniforms and work wear play a direct role in spreading infection, the clothes that staff wear should facilitate good practice and minimise any risk to patients.
- Uniforms and work wear should not impede effective hand hygiene and should not unintentionally encounter patients during direct patient care activity.
- Similarly, nothing should be worn that could compromise patient or staff safety during care, for example false nails, rings, earrings (other than studs), and necklaces. A plain band wedding ring is permitted.
- Trust ID Badges must be always kept on the individual. When moving about the hospital the Hospital ID badge must be on show. Lanyards should not be worn in any clinical area.
- Perfume and after shave may be worn but these should be light as many patients and staff are affected by strong perfumes.
- Minimal make-up may be worn in the Oral Surgery department.

2.1.3.2 Public Confidence

- Patients and the wider public should have complete confidence in the cleanliness and hygiene of their healthcare environment. The way staff dress is an important influence on people's overall perceptions of the standards of care they experience.

- Uniforms should always be clean, and professional in appearance. In addition, although there is no evidence that wearing uniforms outside work adds to infection risks, public attitudes indicate it is good practice for staff to change at work.

- Staff are not permitted to wear uniforms outside of the hospital grounds.

- Patients and visitors also like to know who in the care team is who. Uniforms and name badges can help with this identification. All staff in the Oral Surgery Out-patient department are required to wear an appropriate name badge.

2.1.3.3 Staff Comfort

- As far as possible, subject to the overriding requirements of patient safety and public confidence, staff should feel comfortable in their uniforms. This includes being able to dress in accordance with their cultural practices. For example, although exposure of the forearm is a necessary part of hand and wrist hygiene during direct patient care activity, the uniform code should allow for covering of the forearm at other non-clinical times.

- All staff who enter the clinic rooms, must don the appropriate PPE intended for use whilst delivering care in the specific clinic within the Oral Surgery department.

- Changing rooms are provided within the department with appropriate wash and shower facilities. All changing areas should be left clean, tidy, and dry after use.

- The Oral Surgery Out-patient department staff should wear:

    - In OPGA and recovery – as per RCH theatre practice standards.

    - In the MOS procedure clinics – RCH Theatre scrubs.

    - In general, out-patient clinics – The dental clinician/ medical staff should wear their own suitable clothing. Nursing staff should wear RCH registered nurse/ Registered dental nurse approved uniform.

- In orthodontic clinics - The dental clinician / medical staff should wear their own suitable clothing. Dental nurses/therapists should wear RCH dental nurse/therapist approved uniform.

- If carrying out a procedure in the MOS procedure room or undertaking, then the appropriate Procedural PPE must be worn:

  - Disposable apron.
  - Gloves (non-sterile / sterile as appropriate).
  - Surgical mask.
  - Eye Protection (In order to improve visibility, Eye protection may be removed whilst using the microscope for clinical assessment but should be immediately put back on when the microscope examination is completed).

2.1.3.5 **Technique to don PPE for Oral Surgery MOS Procedures:**

Hands must be washed before and after donning PPE

- Wash hands.
- Apply fluid resistant surgical face mask.
- Don apron, then eye protection.
- Lastly gloves (just prior to commencing procedure or touching any equipment).

2.1.3.6 **Laundering of Theatre Scrubs and Uniforms**

MOS Procedure Room Attire (Theatre scrubs)

All MOS procedure room attire must be sent to the RCH laundry to ensure laundering of clothing is in accordance with relevant standards. The home laundering of procedure room attire is not permitted.

General Clinic Attire

All uniforms to be washed and laundered as per RCH uniform policy instruction.

2.1.3.7 **Jewellery**

- Jewellery must be limited to a smooth wedding band only.
- All other jewellery should be removed before entering the clinical environment.

- All staff must be ‘bare below the elbow’ when in the clinical environment.

2.1.3.8 **Fingernails**

- Fingernails must be clean, short and free from nail varnish.

- False fingernails, including acrylic or gel coated, or fiberglass must not be worn, as these have been shown to harbor micro-organisms such as fungi and gram-negative bacteria even after hand washing; they can also inhibit effective hand washing.

2.1.3.9 **Footwear in the Oral surgery department (excluding OPGA)**

- It is each individual health worker’s responsibility to ensure that their footwear is decontaminated and fit for purpose intended.

- Footwear should not be left in a contaminated state or on changing room floors.

2.1.3.10 **Surgical Face Masks**

- Surgical Facemasks must be worn by the Oral Surgery Out-patient team during any examination / procedure.

- Additional protective face shields must be worn whenever activities place personnel at risk of splashes or aerosol contamination.

- Surgical masks must cover the nose and mouth, fitting the contour of the face and must be secure. They must be changed between patients.

- Surgical masks should not be touched once applied, if touched following application then it should be replaced.

- A used surgical mask must be handled by the tapes / elastics only and must be discarded into a yellow clinical waste bag for disposal after each case, or if soiled / contaminated.

- Surgical masks must not be worn around the neck or put into pockets for future use. Hands must be washed following mask removal.

2.1.3.11 When caring for patients with suspected or confirmed influenza, all healthcare workers need to, prior to any patient interaction, assess the infectious risk posed to themselves and wear the appropriate personal protective equipment (PPE) to minimise that risk: Face masks with shields - Surgical mask with intermediate filter (FFP3) to ensure high protection against bacterial contamination.

2.1.3.12 **Personal Hygiene**

- Personal hygiene should be of a high standard.
- Showers and towels are provided within the hospital, for staff accidentally contaminated with body fluids whilst on duty.

2.1.3.13 **Patient Attire in Procedure Clinics**

Patients in preparation for a minor examination / procedure must wear their own suitable clothing, a hospital patient gown is not considered necessary for procedures being carried out in any of the Oral Surgery Out-patient department clinic rooms.

2.1.3.14 **Visitors to the Oral Surgery Out-Patient Department**

- Relatives (in particular, parents) supporting patients, are permitted into the clinic room.
- Students (from various health professions) must comply with RCH uniform policy.
- Visiting professionals (surgeons etc.) must comply with RCH uniform policy.
- Allied health professionals (lab technicians, maintenance workers etc.) must comply with RCH uniform policy.
- Medical device representatives. Must comply with RCH uniform policy.

Compliance: 100%.

Exceptions: None.

References:

RCHT Uniform Policy (all policy links - see page 2 and 3).

RCHT Infection Prevention and Control Policies.

AfPP Principles of Safe Practice within the Perioperative Environment 2011.

2.2. **Oral Surgery Out-Patient Department Standard No 02 Documentation**

Refer to:

The NMC standards for documentation.

2.2.1. **Standard Statement**:

All staff are aware of the required standards for documentation and take responsibility for all their individual documentation of information. The Oral Surgery Out-patient department staff may document in a variety of

patient records, dependent on availability at the patient's appointment.

2.2.2. General Considerations

- Under the Public Records Act 1958 (National Archives, 2009), all NHS employees are responsible for any records that they create or use in the course of their duties. Thus, any records created by an employee of the NHS are public records and may be subject to both legal and professional obligations.

- The quality of record keeping reflects the standard of professional practice expected of professional practitioners (AfPP 2007).

- The record must be (NMC 2009):

  - Factual, consistent, and accurate.

  - Recorded/written as soon as possible after the event has occurred, providing current information on the care and condition of the patient.

  - Recorded/written clearly and in such a manner that the text cannot be erased, written in a manner that any alterations or additions are dated, timed, and signed such that the original can still be read clearly, with the signature printed alongside the first entry.

  - Not include abbreviations, jargon, meaningless phrases, and irrelevant speculation.

  - If written, recorded in black ink only, so that photocopies are readable.

2.2.3. Records must adhere to the General Caldicott Principles (HSC, 1998) on Confidentiality

- Justify the purpose(s).

- Do not use patient-identifiable information unless it is necessary.

- Use the minimum necessary patient identifiable information.

- Access to patient-identifiable information should be on a strict need-to-know basis.

- Everyone with access to patient-identifiable information should be aware of his or her responsibilities.

- Understand and comply with the law.

- All entries into the health record, including amendments, should be contemporaneous, clearly dated, timed, signed and the designation of the person making the entry should be clearly recorded.

- The Department sister/ charge nurse will retain copies of signatures of all healthcare professionals who make entries in healthcare records,

together with the professional's registration number (NMC or HPC). The register of signatures will be reviewed and updated annually.

- All electronic reporting will be traceable via the ‘login’ system.

2.2.4. **Swab, Instrument and Needle Count in MOS Clinics**

The swab, instrument and needle count must be recorded in the patient’s records as well as on the MOS clinic room white board.

2.2.5. **Surgical Instruments**

- There is a tracking and traceability system, which exists to allow traceability between instrument set and patient. This identifies which set was used for the patient and the decontamination process it has undergone, to trace back in the event of an adverse incident, such as sterilisation failure.

- Each instrument tray will contain an instrument checklist, which incorporates the information necessary for a recorded programme of use. The instruments on each set should be checked against this list, in accordance with the Swab, Instrument, Needle and Sharps Count Policy.

- All Oral Surgery department sterile instruments are, ID scribed to the Oral surgery department.

- If single-use instrument sets are used, then the tracing sticker will be removed from the external wrapping/label of the instrument set and placed in the patients’ paper record on the Green RCH Operation sheet (CHA 1297).

- The label will identify:

    - ID of the set.

    - UC number.

    - Expiry date.

    - Lot number.

- The instrument checklist must record the name of the scrub practitioner and the second checker and identify the patient through their NHS number only.

- Any discrepancies noted in any of the instrument sets would be recorded on the instrument checklist in addition to completing an incident report.

2.2.6. **Decontamination of Equipment prior to Service or Repair**

Anyone who inspects, services, repairs or transports medical, dental or laboratory equipment, either on hospital premises or elsewhere, has a right to expect that medical devices and other equipment have been

appropriately decontaminated; appropriate documentation will be provided to indicate the decontamination status of the item (DOH 1993).

Refer to: (all policy links - see page 2 and 3).

- RCH Decontamination Policy

2.2.7. Medical Equipment/Devices

- Staff will maintain relevant records that relate to equipment used in the Oral Surgery Out-patient department.
- These records may be linked with other departments such as Medical Physics, estates, medical device companies and SSD and include:
  - Record of purchase.
  - Any product trials information which may be held by the company.
  - dentification number for individual items for the purpose of tracking and locating.
  - Working history/maintenance records.
  - Capital assets register.
  - Maintenance contract.
  - Manufacturer's warranties.
  - Planned preventative maintenance.
  - Record of defective instruments sent to repair.
  - Calibration.
  - Lending of equipment.
  - Documentation and tracking of instruments used.
- An obligation arising from liability ends after ten years and up to one year is allowed for serving a writ. Equipment records of non-fixed equipment, including specification, test records, maintenance records and logs should therefore be retained for a minimum retention period of eleven years (DH 2006).
- The department sister/ charge nurse will hold / have access to documentation to demonstrate that staff have been adequately trained and authorised in the use of equipment and medical devices.
- All staff members using medical devices should do so only once adequately trained and competent to the level required for its use.
- All staff are responsible for maintaining their competence for medical devices.

2.2.8. **Accident/Incident Reporting and Statement Writing**.

Refer to: (all policy links - see page 2 and 3).

- RCH Incident and Serious Incident Policy.

2.2.9. **Recording of Electrosurgical Use and Settings**

- When electrosurgical equipment is used the following should be recorded in the patient's record:
    - Mode (Bipolar or Mono terminal).
    - Power setting in watts.
- This will safeguard the user in the situation where a patient may inadvertently experience an electrosurgical burn.

2.2.10. **Surgical Antiseptic Skin Preparation Solutions**

The chosen skin preparation/antiseptic solution will be documented in the patient's record to comply with the Consumer Protection Act (SI, 1987). This should include lot/batch number.

2.2.11. **Admission and Labelling Procedure**

Refer to:

- RCH Positive Identification Policy and Procedure

2.2.12. **The Procedure/Clinic Lists**

- For the MOS clinic, the clinician should refer and agree the procedure list order in advance (where possible).
- The clinician undertaking the procedure must take responsibility for compilation of the list in a recognised printed format; alternatively, by designating a member of their team (AfPP 2011). For MOS procedure clinics there will be a list printed from the Galaxy system. The list will include:
    - Surname, forename, NHS number, date of birth of the patient.
    - Procedure/Diagnosis.
    - Surgeon.
    - Session start-time.

To Note: The Galaxy system for MOS is not a live system (as it is for OPGA). The system for MOS is for booking and clinic list purposes only.

- All other clinics in the Oral Surgery Out-Patient department (except MOS and OPGA) will have patient clinic lists printed from the PAS system.
- The PAS clinic list will include:
    - Surname, forename and CR number.
    - Clinician / operator.
    - Session start-time.
    - Relevant comments for referred patients.
- Abbreviations must not be used.

Compliance: 100%.

Exceptions: None.

References:

RCH Medical Devices Policy.

AfPP Principles of Safe Practice in the Perioperative Environment 2011.

2.3. Oral Surgery Out-patient Department Standard No 03 – Safeguarding Patient Information

2.3.1. Standard Statement

Staff must protect and dispose of any confidential information, concerning a patient that is generated for any clinical use.

Refer to:

RCH Confidential Waste Policy.

RCH IT Policy.

2.3.2. Method

- Printed clinic lists must be disposed of in an appropriate manner at the end of the session in the RCH confidential waste receptacle.
- Printed clinic lists must be left face down and placed in the respective clinic room lockable notes trolley. The list is in the slide out drawer of the respective clinic notes trolley.
- Notes/x-rays remaining which pertains to patients must be removed and delivered to the appropriate area.
- Procedure Record books used in the MOS clinic only, must be closed at the end of each session. These are stored in the respective clinic notes trolley.

- Paper containing any patient details must be disposed of appropriately and must never be reused as scrap paper.

- All staff are responsible for logging out of the computer when moving away from it.

Compliance: 100%.

Exceptions: None.

References:

AfPP Principles of Safe Practice in the Perioperative Environment 2011.

RCHT Confidential Waste Policy.

2.4. Oral Surgery Out-patient Department Practice Standard No 04 - Infection Control

Standard Statement: All staff must utilise standard precautions in all aspects of practice to protect self, colleagues, and patients from the risk of health care acquired infection.

2.4.1. Standard Precautions in the Oral Surgery Out-patient Department

Management considerations:

- Protection and Precautions.
- Skin.
- Hand Hygiene.
- Gloves.
- Eyes and Mouth.
- Gowns and aprons.
- Sharps.
- Spillage of blood and body fluids.

See: Revised Healthcare Cleaning Manual

2.4.2. Accidental Exposure/Sharps Injury/Conjunctiva/Mucous Membrane Splash

All incidents must be reported on the RCH incident reporting system.

2.4.3. **Waste Disposal**

Refer to: (all policy links - see page 2 and 3).

- RCH Infection Prevention and Control Policies including:
  - RCH Hand Hygiene.
  - RCH Safe Handling and Disposal of Sharps.
  - RCH Decontamination Policy.
  - RCH Generic Waste Management Policy.
- RCH Incident reporting Policy.

2.4.4. **The Environment**

- Footfall is not routinely limited within the Oral Surgery Out-patient department during working hours; these areas include reception areas and clinics. Out-of-hours access is restricted by swipe card.
- Semi-restricted areas – Oral Surgery Out-patient department clinic room footfall is limited to authorised, correctly attired personnel and patients.

2.4.5. **Oral Surgery Out-Patient Department Clinic Rooms**

- Oral Surgery Out-patient department clinic room doors must always remain closed when a procedure is being undertaken.
- Footfall: The layout of the procedure room is designed to minimise, restrict, and contain bacterial and viral pathogens. In addition, footfall should be kept to a minimum.
- Traffic: The purpose of controlling Procedure room traffic (movement within the procedure rooms) is to minimise the movement of bacteria within the environment itself, personnel, and patients.

2.4.6. **Environment Cleaning**

Refer to: (all policy links - see page 2 and 3).

- RCH Cleaning Policy and standards.
- RCH COSHH Policy.
- Infection control in the built environment (DOH 2013).
- The environment and all working surfaces must be cleaned in accordance with the RCH infection prevention and control policy and cleaning guidelines (NHS cleaning manual, 2007) prior to use.
- The Department Sister/charge nurse will maintain records of cleaning schedules:

- Daily department staff cleaning records.
- Weekly departmental staff cleaning records and Domestic services weekly Procedure room audit.
- Monthly departmental staff cleaning records.
- Quarterly Domestic services departmental cleaning audit.
- 6 monthly Domestic services deep cleaning records.

- All records will detail the standards of cleanliness required in each part of the unit including items and equipment, and that a schedule of cleaning frequency is available on request. Work schedules must be displayed work areas.

2.4.7. **The Department Sister/Charge Nurse will**:

- Determine who in the department should be responsible for each element on the cleaning schedule: cleaning staff, porters, or clinical staff.
- Routinely check that cleaning has taken place to a sufficient standard; highlight trends which indicate a downturn in the cleanliness provide investigation and an action plan for improvement, if necessary.
- Ensure that all cleaning and decontamination that takes place in the department is conducted according to the recommendations in the Revised Healthcare Cleaning Manual (NPSA, 2009).
- Agree the service level agreement with the Estates Department that ensures regular programme of maintenance to the Oral Surgery Out-patient department.
- Ensure that the Estates department responds to requests for repair to the structure of the unit in a timely manner and/or pursue where response has been overlooked.
- Maintain a transparent process for staff to report problems related to the structure of the Oral Surgery Out-patient department clinic rooms e.g. indicating areas of wall with peeling paint which must be repainted or covered with a new wall finish, and to record the outcomes of the reporting process.
- There must be available a cleaning work schedule for the domestic cleaning staff and a separate one for the clinical staff, clearly identifying: the tasks normally undertaken; the item; recommended method and frequency. Technical method statements can be found in the Revised NHS Cleaning Manual (NPSA, 2009).
- The RCH Decontamination Policy provides advice on methods of decontamination.
- The Department sister/charge nurse (or deputy) must undertake a

visual audit of the environment for cleanliness before the commencement of the clinics and act where appropriate. Results of this audit must be kept and be available for audit purposes.

- Disposable gloves must be worn for all cleaning tasks.
- Cleaning of the clinical environment must take place via a 'top to bottom', 'out to in' method.
- Damp cleaning of the ledges and shelves will take place prior to every clinic session.
- Cleaning of sterile store's room will take place monthly and include removal of all equipment, to facilitate cleaning of the floors. All portable equipment must be removed from this area. All racks must have equipment/packs/materials removed and be cleaned and replaced.

2.4.8. Cleaning between Patients in the Oral Surgery Clinic Rooms

- Surfaces that receive direct patient contact must be cleaned in accordance with the RCH Decontamination policy.
- Waste, laundry and instruments must be disposed of according to the RCHT Generic Waste Management Policy.
- Couches that are torn or damaged in any way must be reported immediately to the medical physics department for repair (not taped). If deemed beyond economical repair by medical physics staff then it should be decommissioned, removed from circulation, and disposed of by the waste collection team.

2.4.9. Terminal Daily Cleaning Procedures

- All equipment should be cleaned, and all portable equipment removed from rooms following cleaning.
- Windowsills, overhead lights, cabinets, waste receptacles, equipment and furniture should be cleaned with detergent solution and a disposable cloth.
- Sinks should be cleaned with detergent and water applied with a disposable sponge/cloth.
- Shelves should be emptied, wiped with detergent and water, and dried before replacing supplies.
- Suture storage boxes should be wiped with detergent and water and dried before being replaced on the shelves.

2.4.10. Management Consideration

- Surfaces must be kept free from visible dirt, and special attention must be paid to areas that are likely to become heavily contaminated (i.e. upward facing surfaces, including windowsill which must be kept free from clutter).
- Walls must not be allowed to become visibly dirty.
- Areas of wall with peeling paint must be repainted or covered with a new wall finish.
- For other surfaces, normal housekeeping methods are adequate (e.g. daily damp cleaning of ledges and shelves).
- Floors should be free of litter, dust, marks, water, or spillages.
- Floors should be free of floor polish build up.
- Specific spillages of blood or body fluids should be dealt with immediately.

2.4.11. Oral Surgery Department MOS/Orthodontic Procedure Rooms

- Before equipment is brought into the procedure rooms, it must be visually inspected for dust and cleaned in accordance with IPAC and manufacturer's instructions.
- The air changing ventilation system must be in operation in accordance with policy and best evidence-based practice.
- The temperature of the immediate environment ideally should be at a comfortable and static 21°C - 23°C and humidity between 30% - 70%.
- Only the number of personnel required to manage the proposed clinical procedure safely should be present in the clinic room.
- There should be a restriction on movement and talking within the clinic room when a procedure is being undertaken.
- All doors to the procedure room must remain closed to ensure effective ventilation of the area.
- As far as possible all potential equipment and supplies for the proposed clinical procedure should be available in procedure room prior to a clinical procedure commencing. This will then reduce the traffic in and out of theatre and therefore maximise the efficiency of the ventilation system.
- Storage of cardboard boxes in the procedure room must be discouraged as cardboard cannot be cleaned effectively.
- All stock items stored within the procedure rooms must be stored within a suitable cupboard with a functioning door.

- Any open containers used to keep items tidy e.g. suture boxes (when not containing sutures), Lin Bins, plastic trays, boxes etc. must be recorded on the cleaning schedule and emptied of contents, cleaned, and replaced, monthly.

- Where items are routinely stored in plastic boxes, drawers etc. these must be recorded on the cleaning schedule, the surface underneath must be cleaned, the box/drawer emptied of contents, cleaned, and replaced.

- Movable trolleys e.g. Care Carts, must be cleaned, including removing the contents from the drawers.

- The allocated staff member should undertake a visual audit of the environment for cleanliness before the commencement of the operating list and action taken to rectify any concerns where appropriate.

2.4.12. **Cleaning Equipment and Materials**

- All decontaminated equipment should be appropriately labelled with a label advising of its cleanliness status.

- Before equipment is brought into any of the Oral Surgery Out-patient department clinic rooms, it should be cleaned.

2.4.13. **Detergents and Disinfectants**

- Detergents and disinfectants should be used in accordance with the manufacturer's instructions.

- Disinfectants must be used in the correct concentration and mixed immediately prior to use. Personnel handling disinfectants or using them must be adequately trained and supervised.

- Disinfectants must be stored and labelled correctly according to COSHH Regulations.

2.4.14. **Spillage of Blood and Body Fluids**

(Extracted from the RCHT Decontamination Policy).

- The spill should be dealt with as soon as possible.

- The removal of blood and body fluid spills in clinical areas is the responsibility of the clinical staff in that department, not the cleaning staff. Outside clinical areas responsibility for cleaning should be identified locally and will depend on the size of the unit/hospital and the personnel available.

- Gloves and plastic aprons must be worn as a minimum when dealing with spill of blood or body fluids. If there is any risk of splashing, eye/face protection must be worn.

- Where the spillage may contain sharp material, forceps should be used

to remove the sharp material, placing it immediately in a sharps bin.

- If the spillage is large, soak up the excess fluid using paper towels and carefully place these in a clinical waste bag.
- Clean surface with warm water and detergent using a disposable cloth or mop.
- If the spill is on a carpeted area this should be disinfected following cleaning using a steam cleaner or wet extract carpet shampooer.
- Curtains or loose fabric covers should be laundered or dry cleaned.

Compliance: 100%.

Exceptions: None.

References:

RCH Infection Control Policies.

PHE Guidance.

ENF-GP Reprocessing Manual.

Tristel Sporicidal Wipe Cleaning Process.

2.5. Oral Surgery Out-patient Department Practice Standard No 5 – Aseptic Technique

2.5.1. Standard Statement:

Where applicable all staff will practice compliant aseptic technique in all aspects of practice to protect self, colleagues, and patients from the risk of health care acquired infection.

2.5.2. General Considerations

- Any staff member with infected lesions of the skin or bacterial infections of the upper respiratory system should not participate in any aseptic technique.
- All staff must be aware of differences between sterile items and non-sterile items and share responsibility for monitoring aseptic practice.
- All Staff must be aware of single use and reusable items.
- The environment and all working surfaces must be cleaned according to RCHT Decontamination Policy and the Cleaning Policy.
- All practitioners, staff and clinicians working, or who come to work in the Oral Surgery Out-patient department are expected to act as role models, demonstrating positive behaviours that actively promote best practice for infection prevention and control.

- A ‘zero’ tolerance for breaches to practice for infection prevention and control procedures must be fostered.
- All staff are responsible for maintaining their ANTT training and competence.

2.5.3. **Equipment and Medical Devices Safeguards**

- All pre-sterilised articles must be checked for evidence of sterilisation, damage, the integrity of packaging, and an expiry date, prior to use. Any packs found to be in an unsatisfactory condition must be discarded.
- Items used within a sterile field must be sterile. Any items that fall into an area of questionable cleanliness must be considered non-sterile.
- Where sterile drapes are used, they must be handled as little as possible. The drapes must be applied from the surgical site to the periphery, avoiding reaching over nonsterile areas. Once placed, drapes must not be repositioned to avoid contamination of the sterile field.

2.5.4. **Oral Surgery MOS Procedure Room Personnel**

- Staff participating in an aseptic procedure should present themselves as per the Principles of Safe Practice in the Perioperative Environment and the RCHT Uniform Policy.
- If gowns or gloves are contaminated, they must be changed as soon as is reasonably practicable.
- Personnel participating within sterile procedures should remain close to the sterile field and not leave the immediate area. If personnel leave the sterile field and exit the procedure room, they must re-scrub before returning to the sterile field. Leaving the sterile field increases the risk for potential contamination.
- Personnel participating within sterile procedures should stay within the sterile boundaries, and a wide margin of safety should be given between scrubbed and non-scrubbed persons.
- When changing positions or moving between sterile areas, scrubbed personnel should turn back-to-back or face to face to avoid contamination.
- Personnel participating within sterile procedures should always keep their arms and hands within the sterile field. Contamination may occur if hands are moved below the level of the sterile field.
- Personnel participating within sterile procedures should only be seated when the procedure is to be performed at that level.

- Any circulating or observing staff should not walk between the two sterile fields and should keep an adequate distance from the sterile field.

2.5.5. **Procedure Room Dressing Trolleys**

- To maintain asepsis, it is essential that all staff are aware of the correct method for opening different sterile packages to avoid the contamination of contents. Circulating persons must open wrapped sterile supplies by opening the wrapper furthest away from them first. The nearest wrapper must be opened last. Outer wrappers must be secured when presenting sterile items, to avoid contamination.

- Sterile fields should be prepared as close as possible to the time of use.

- If multi-dispensing antiseptic containers are used e.g., betadine, they must not be refilled and must be discarded at the end of the day.

- Do not prepare sterile trolleys in advance, even with the use of sterile sheets to cover them. The trolleys are subject to contamination over time and removal of sheets without contamination cannot be guaranteed. In addition, unless trolleys are continuously monitored, there is a potential for sterility to be compromised.

2.5.6. **Procedure Room Practice**

- The following practices will support infection prevention and control for patients undergoing interventional procedures:

  - Do not routinely remove hair. If hair must be removed from the operative area, electric clippers are available.

  - Prepare the skin at the surgical site immediately before incision using an antiseptic preparation (Chloraprep).

  - Cover surgical incisions with an appropriate dressing (if required) at the end of the procedure.

Compliance: 100%.

Exceptions: None.

References:

AfPP Principles of Safe Practice in the Perioperative Environment 2011.

RCH Trust Decontamination Policy.

RCH Cleaning Policy Generic Theatre Standard 01.

2.6. Oral Surgery Out-Patient Department Practice Standard No 06 - Management of Patients with known Infections or Carriers of Infectious Agents

2.6.1. Standard Statement:

All Oral surgery department staff will have knowledge of the requirements for caring for patients with known Infections or carriers of Infectious Agents in the Oral surgery department to protect self, colleagues, and patients from the risk of health care acquired infection.

Refer to:

- RCH Infection control policy. (all policy links - see page 2 and 3).

2.6.2. General Considerations.

2.6.2.1. **Training**: all staff involved in the care of the patient must be aware of the specific precautions and have received adequate training.

2.6.2.2. **Daily Safety Huddle**: should include a quick check to ensure all staff are aware of the specific precautions and patient's clinic appointment time. Sufficient environment/equipment cleaning time should also be highlighted and discussed.

2.6.2.3. **Communication**: is essential.

2.6.2.4. **Flow**: The essence of this is maintaining adherence with infection control policy but also maintaining flow through the Oral Surgery Out-patient department. Sensible and thoughtful application with discussion between all care givers will allow for better flow.

2.6.2.5. To limit accidental exposure good clinic room practice/technique includes keeping staff to a minimum, trying to reduce unnecessary movement of personnel from one room to another, raising awareness and keeping only the equipment/items relevant for the current patient. Standard precautions must be adhered to. Clinic room doors must be kept closed to aid the efficiency of the ventilation systems. As far as possible all personnel, equipment and sundries must be sourced prior to the case being undertaken.

2.6.2.6. **Waste**: Contaminated PPE and clinical waste disposed of into yellow bags for incineration. Contaminated clothing and reusable bedding disposed into red bags for infected laundering. Safety gel/granules to be applied to spillages or when carrying possibly infected bodily fluids from theatre to sluice and when disposing, to prevent splash back.

Compliance: 100%.

Exceptions: None.

References:

Generic Theatre Practice Standards for specific guidance on infectious agents in the procedure/clinical rooms.

AfPP Principles of Safe Practice in the Perioperative Environment 2011.

RCH ANTT Policy.

RCH Decontamination Policy.

2.7. Oral Surgery Out-patient Department Practice Standard No 07 – Fire Prevention

- Fire Precautions: (all policy links - see page 2 and 3).
- Refer to:
- RCHT Fire Safety Policy.

2.7.1. General Considerations

2.7.1.1. Alcohol Skin Preparation

- Alcohol-based skin preparations are known to be flammable.
- Risk Assessment must be undertaken for their use and application. Alcohol-based skin preparations can be absorbed into body hair or can pool on the body surface.

2.7.1.2. Alcohol flames are difficult to see under the lights.

- The quantity of flammable fluid used to prepare the skin should be kept to a minimum to avoid run-off and pooling, either on or around the patient. Precautions should be taken to prevent pooling underneath drapes or in the patient's umbilicus.
- Any run-off that occurs must be contained by absorbent material placed around the patient, which is removed before the drapes are applied.
- Time must be allowed for the alcohol to evaporate and disperse prior to applying the drapes.
- Care must be taken in using sprays with flammable propellants such as butane when electro surgery is planned.

2.7.1.3. Oral Surgery Out-patient Department - Electro surgery in the Clinic Rooms

- In electro surgery, the active electrode is in the surgical site.
- Electro surgery units use a high frequency alternating electrical current for cutting and coagulation. They are the

main potential ignition source for a fire.

- Electro surgery can produce a high temperature electrical arc if carbonised tissue is allowed to build up on the tip of the electro surgery device. It is essential that an electrocautery tip cleaner be applied to remove the build-up of carbonised tissue.
- The power setting for the electro surgery unit will be confirmed verbally between the operator and the user prior to activation.
- The active electrode must always be stored securely in a non-conductive container when not in use.
- The active electrode must only be activated by the person holding the device.
- Active electrodes must not be used in the presence of flammable substances, including anti-microbial skin preparations, and tinctures.

2.7.1.4. **Staff responsibilities**

- All staff must be aware of the trust fire evacuation policy.
- All staff must have attended mandatory yearly updates.
- All staff must be aware of location of fire escape routes and firefighting equipment in all areas of work.
- A local fire Warden will be on duty each day in each clinical area - these individuals will have received additional training on what actions to take in the event of a fire occurring in the Oral Surgery Out-patient department.
- All staff have a responsibility not to block fire exists or escape corridors with equipment.
- Each area should be checked each day to ensure that fire exit routes are clear, and fire doors are not wedged open. Doors left open during the day must be closed at the end of the day before the department is closed.

Compliance: 100%.

Exceptions: None.

References:

RCH Fire Safety Policy.

2.8. Oral Surgery Out-patient Department Standard No 08 – Management of Hazardous Materials

Refer to:

- RCH Infection Prevention and Control policies; including Hand Hygiene and Safe Handling and Disposal of Sharps.

2.8.1. Standard Statement:

All staff in the department must be aware of the measures that need to be taken in the event of the spillage of a hazardous substance. Spillages will be dealt with as soon as possible. The Oral Surgery Out-patient department must ensure that the equipment to deal with spillage is readily available.

2.8.2. Hazardous Spillages Method:

- All staff must adhere to COSHH regulations and be conversant with the Trust COSHH policy for dealing with spillages.
- Staff will be conversant with the substances used in the Oral Surgery Out-patient department that are considered a risk by COSHH.
- All staff handling hazardous substances must receive training appropriate to their role and responsibility.
- COSHH training is mandatory on appointment to the Trust, and it is recommended that updates are received every two years.
- Staff must wear protective clothing, in adherence with the trust policy, when dealing with disposal of contaminated waste.
- Staff will be aware of the measures to be taken in the event of a spillage, regarding appropriate protective clothing, evacuation requirements etc.
- All identified hazardous substances will be handled with care and compliance to manufacturer’s instructions adhered to.
- Handling of identified hazardous substances will be kept to a minimum.
- Any untoward occurrences involving hazardous substances must be reported, with referral to the Occupational Health Department as necessary.

2.8.3. Non-Hazardous Spillages

Method:

- All staff handling waste or spillage of fluids must receive training appropriate to their role and responsibilities.

- Staff will familiarise themselves with the Trust policy on spillages.
- Wearing protective clothing i.e., gloves, aprons, mask. Substances will be mopped up using paper roll/towels and discarded into a yellow clinical waste bag. Care must be taken not to contaminate the outside of the bag.
- The surface must be cleaned using detergent and water and dried. Staff must dispose of gloves as clinical waste and wash hands.

Compliance: 100%.

Exceptions: None.

References: (all policy links - see page 2 and 3).

- Generic Theatre Practice Standards Clinical Guideline V3.0.
- RCH Infection Prevention and Control.
- RCH COSHH Policy.
- RCH Disposal of Waste.
- RCH AfPP Principles of Safe Practice in the Perioperative Environment 2011.

2.9. Oral Surgery Out-patient Department standard No 09 - Collection of specimens in the MOS clinic and transportation to the laboratory standard.

2.9.1. **Standard Statement**: In the Oral Surgery Out-patient Department MOS clinic, specimens are taken during some procedures. It is essential that every specimen reaches the pathology, bacteriology, histology, or cytology department without undue delay and in optimum condition, to facilitate the survival and identification of organisms.

Method:

RCH Standard for Collection of a Sample - Classification of Specimens.

2.9.1.1 **Specimens fall into three categories**:

- Transfusion specimens.
- Retrievable specimens.
- Irretrievable specimens.

2.9.1.2 **RCHT Pathology has classified irretrievable specimens as**:

- Cerebrospinal fluids (CSFs).
- Specified dynamic function tests and specific test requirements.

- Bone Marrow specimens.
- Amniotic Fluids.
- Histological and Cytological samples (excluding voided urines and sputa).
- Some samples from post-mortems.
- Certain forensic samples under the auspices of a Pathologist.
- Clinical Microbiology - Sterile fluids, Outbreak samples other than faeces, specimens from temporary residents, specimens from the operating theatre.
- All other specimens are considered retrievable, ie able to be repeated.

2.9.1.3 **Documentation Requirements: Recording of Specimens**

- All entries into any health record, including amendments, must be clearly dated, timed, signed and the designation of the person making the entry must be clearly recorded.
- It is the responsibility of the Oral clinician to ensure that the specimen(s) are present, labelled correctly and signed before the sample is taken directly to the specimen collection box.
- The transportation of the specimen to the histology collection box in the Oral Surgery Out-patient department is routinely carried out by the assisting registered nurse / Dental nurse.
- It is the responsibility of the Oral clinician to sign the request form and state what investigations are required. This should generally be the operator. Whoever provides the detail must supply all information, including clear identification of who they are, their grade, and their contact details.

2.9.1.4 **Specimen Identification**

- Specimen identification must begin at the time the specimen is removed from the patient. The operator removing the specimen must clarify what the specimen is, including site if relevant.
- One of the ‘primary assisting’, or ‘secondary assisting’ members of staff (registered nurse or Registered Dental nurse) must determine the nature and site of the specimen that is being taken by verifying with the operator, the specimen and site of removal. This information will then guide the assisting member of staff to the actions that are required for the specific type of specimen being collected.

- The assisting staff member (registered nurse or Registered Dental nurse) must check with the operator whether the sample should be placed in a container containing preservative or other transport medium, or whether it should be a dry specimen.

- Action must be taken to prevent drying out of specimens. Specimens and cultures should be placed in the sample pot as soon as they are taken.

2.9.1.5 Specimen Labelling

- After checking the patient's records, the following details must be recorded on the specimen pot label:

  - Patient's full name, identification number and date of birth.
  - Ward, hospital, theatre.
  - Nature of the specimen.
  - Date/time specimen was taken.
  - Nature of fixative.
  - Consultant's name.

- ID labels must be printed from the specimen request form from Maxims and then attached to the body of the specimen container.

- These same details must also be evident on the maxims request form, along with the following:

  - Medical practitioner's name, clearly and legibly detailed.
  - Medical practitioner's signature.
  - Details of who the report should be submitted to.

- Security and labelling of any specimen is the operator's and therefore they should label the specimen container. This must be done after the details have been provided but before the specimen is placed in the container. To reduce confusion, the label must not be placed on the lid of the container.

- The information on the investigation request form must correspond with the details on the specimen container and the patient's records. It must also contain relevant clinical information to assist the laboratory staff.

- It is vital that all information is checked and accurate before the specimen leaves the clinic room. The specimen must be

accompanied by the documentation.

- Routine Specimens - are placed in the Oral Surgery Out-patient department sample collection box, directly after sample taken, to wait collection from the portering service. If not collected by the end of the am or pm session (that specimen was taken), then nursing staff should call the help desk to expedite portering to collect.

- Urgent Specimens - the laboratory staff must be notified (Royal College of Pathologists 2005).

2.9.1.6 **Handling Specimens**

- Care must be taken when selecting an appropriate specimen container, in relation to its size and purpose. For histopathology specimens, the container must be large enough to ensure that the specimen floats freely, is completely covered by appropriate fixative and is sealed for transportation.

- The operator must follow standard precautions when placing the specimen in the container. Precautions must be taken to prevent any contamination of the outside of the specimen container.

- All staff must adhere to COSHH regulations and Trust policies for treatment of splash injuries from specimen fixative or body fluids.

- All specimens for microbiology must be placed in a specified biohazard bag which is sealed before dispatch.

- All staff must adhere to Trust standard precautions when handling specimens in accordance with local policy.

- The specimen must be removed from the clinic room before the next scheduled patient arrives.

2.9.1.7 **Traceability**

- There must be a central point for specimens and specimen forms to be taken to following procedure. In the Oral Surgery Out-patient department, this is the specimen collection box.

- Tracking information is responsible for ensuring that the patient labels on both specimen and specimen form tally, that the operator has signed the specimen form, and that formalin is added if appropriate.

- Both the specimen and specimen form must then be placed in the collecting box provided.

- The collecting box will be collected from this central point on

a regular basis during the day by the portering service; the last collection in the afternoon will be while the lab is still open.

2.9.1.8 **Staff Responsibility**

- All staff will receive training before undertaking handling of specimens and will achieve the required levels of competency before undertaking this task.

- The ‘primary assisting’ members of staff (registered nurse) will confirm with the operator the nature of the specimen, the site the specimen was taken from, and the analysis required. The necessary form will be completed in a clear and concise way.

- The ‘primary assisting’, (registered nurse) must follow Universal Precautions when handling the specimen/placing in its container.

- All staff must adhere to COSHH regulations and be conversant with Trust COSHH policy for treatment in respect of splash injuries from specimen fixative or body fluids.

- All specimens must be handled with care to avoid crushing or distortion to anatomical detail.

- Specimen containers of sufficient size and strength must be provided for each specimen.

- In the event of several specimens, each container must be clearly numbered, and these numbers duplicated onto the specimen form.

- The ‘primary assisting’, (registered nurse) must ascertain, from the operator, whether a fixing medium (Formalin) is required or not.

- The Oral surgery clinician must assure all details are checked with the patient’s records. All parts of the label must be completed as fully as possible.

- The label must be placed on the container, not the lid, prior to placing the specimen inside. The details on the container can then be shown to the ‘primary assisting’, (registered nurse) prior to the specimen being placed inside.

- Any specimen held in a fixative must be labelled with an appropriate hazard label.

- The ‘primary assisting’, (registered nurse) must not discard of any tissue or fluid until it has been ascertained that it is not required for the laboratory.

- Completed specimens and forms must be placed in a sealed bag.
- Urgent specimens must be placed in a bag labelled as such and given directly to the ‘primary assisting’, (registered nurse) for immediate dispatch to the sample collection box.
- Where formalin is used, it must cover the entire specimen plus one third.

Compliance: 100%.

Exceptions: None.

References:

Generic Theatre Practice Standards Clinical Guideline.

AfPP Principles of Safe Practice in the Perioperative Environment 2011.

The Royal Marsden Hospital Manual of Clinical Nursing Procedures.

2.10. Oral Surgery Out-patient Department standard No 10 - Latex Allergy

2.10.1. **Statement**: All staff are required to have knowledge and understanding of the requirements for the care of patients with latex allergy. The local practice standards will be included in the induction program for new staff.

2.10.2. Communication Processes

- Please refer to the RCHT Guidelines: Procedure for Allergies or Idiosyncrasies to Medicines and Food.
- The allergy status must be clearly documented in the medical notes, in the allergy box on the drug chart and on any outpatient prescription.
- In addition to recording the allergy category, the healthcare professional must also document:
    - The name of the drug or food that caused the reaction.
    - The nature of the reaction e.g. rash, swollen lips etc.
    - Confirm that this is a ‘true allergy’ and not a side-effect e.g. nausea.
    - When the reaction occurred e.g. as a child.
    - Where the information regarding allergy status came from e.g. confirmed with patient, confirmed in medical notes.
    - The healthcare professional must sign and date the entry.

- It is important that information on patient allergies is communicated to the department at the earliest opportunity to allow provisions to be made.

- Short notice notification of latex allergy may result in a delay to the patient being treated while the appropriate actions are taken.

2.10.3. **Intra Procedural:**

- The key is to avoid contact with latex on the skin, intravenously, by inhalation and particularly by contact with mucous membranes, peritoneum, and serosa surfaces.
- All staff must be aware of the need to maintain a latex free environment.
- The single most important precaution is to avoid any member of staff wearing latex containing gloves.

2.10.4. **What precautions should be taken with NRL-Sensitive Staff?**

- Staff who consider that they have a possible hypersensitivity should be referred to Occupational Health for screening.
- All general staff equipment, gloves, masks etc. used in the Eye Unit are latex free, and any replacement products considered must also be confirmed latex free before purchase.
- Staff with known latex sensitivity must have regular review with their line manager and Occupational Health, documented in their personal file.

Compliance: 100%.

Exceptions: None.

2.11. Oral Surgery Out-patient Department standard No 11 - Application of the 5 Steps to Safer Surgery including WHO Surgical Safety Checklist (SSC) in the Oral Surgery MOS Clinics

2.11.1. **Standard:** Application of the 5 Steps to Safer Surgery including WHO Surgical Safety Checklist (SSC) in all Procedure Rooms.

2.11.2. **Standard Statement:** All procedures performed in Oral surgery procedure rooms will have the correct and full application of the WHO SSC process completed and documented by the team. Patient safety is paramount all staff are expected to raise concerns if at any point they feel that this process is not being fully supported.

2.11.3. **Method**:

2.11.3.1. **MOS Pre-Briefing**

- The MOS pre-brief is carried out prior to the commencement of the procedure list.

- Participation is required by all members of the MOS clinic room team.
- The briefing is a verbal discussion, led by a designated member of the team and recorded on the 'Oral surgery LA procedure briefing' form.
- Silent cockpit" principles should be observed, and all elements of the form must be considered and recorded against. Any specific equipment or patient-related requirements should be discussed prior to the procedure being carried out.
- Staff must introduce themselves to each other by name and role. This information will also be recorded on the procedure room white board.
- The nurse /practitioner designated "in charge" of the list must be clearly identified on the procedure room whiteboard.
- Any changes to the published Galaxy list must be discussed, understood and agreed by all members of the procedure room team. If changes include laterality or change of procedure, then the list should be amended and reprinted.
- Any issues related to the organisation of the list must be discussed.
- All staff are given the opportunity to raise any concerns of any nature prior to the procedure being carried out. The procedure should not proceed until any concerns have been addressed to the satisfaction of the whole team.

2.11.4. WHO Surgical Safety Checklist (MOS procedure rooms only)

- All steps will be read out loud though steps relating to aspiration/airway risks and blood loss may be treated with discretion.
- "Silent cockpit" principles should be adopted during all steps, all team members must show respect for the process, be present and fully participate in all steps of the check procedure.
- The Oral surgery out-patient department MOS clinic will utilise the 'Oral surgery Local anaesthetic procedures only' WHO form (CHA4557).

2.11.4.1. **Sign In – as patient enters the MOS Procedure Room**

- All members of the team must introduce themselves and observe "silent cockpit," whilst a designated member of the team performs the WHO "sign in." out loud.

  This includes:

  - Patient identity check.
  - Patient confirmation of their identity, site, intended procedure and consent.
  - laterality will be identified (if relevant) with each patient following their assessment. Marking will then be completed with patient involvement and agreement (if relevant).
  - Local anaesthetic and medication checks.
  - Questions regarding allergy status.
  - Risk factors for bleeding, including any anticoagulation medication.
  - Any further concerns.

- The nominated person (must be a registered nurse or Doctor), will clearly mark the checklist in the appropriate place to confirm the check has taken place and will clearly print their name and Sign to confirm completion of the sign in check.
- The nominated person (must be a registered nurse or Doctor), will confirm that the correct patient details are completed on the dermatology WHO Surgical Safety Checklist (a patient identity label may be used).

2.11.4.2. **Time Out – Before start of Procedure including Skin Preparation**

- To be completed by the Oral Surgery Out-patient department MOS procedure room team - the operator retains the accountability to ensure that this check is fully completed. All relevant staff should be present.
- A delegated member of the clinic room team will confirm all team members are present and initiate the checklist by reading out loud all points contained in the timeout section of the checklist. Discretion may be used for questions relating to blood loss if the patient has a local or regional anaesthetic.

- If at any point during completion of the checklist a member of the team is required to leave the MOS procedure room, the checklist should be suspended and recommenced when all are present.

- If at any point during completion of the checklist the team is interrupted by an individual external to the team, the checklist should be suspended and recommenced when all team members can pay full attention to the process.

- Any concerns or queries raised by any team member must be resolved before procedure commences.

- If at any point any member of the team feels the process is not safe, they are expected and will be supported to say STOP.

- The delegated team member will clearly mark the checklist in the appropriate place to indicate the point has been discussed.

- The delegated team member leading the WHO SSC must print their name and sign to confirm the 'Time-Out' check is complete.

- If at any point during the procedure a member of the team is replaced or a further member of staff joins the team they will be introduced by name and designation and be briefed on the procedure, given any necessary information and have sight of the consent form.

- A delegated member of the team will ensure team members are present and initiate the checklist by reading out loud all points contained in the sign out section of the checklist.

- Any concerns or issues that have arisen during the procedure must be reported on the electronic incident reporting system where necessary.

- The team formally acknowledges any concerns for recovery and postoperative care of the patient.

- The WHO Surgical safety Checklist must be signed by the team member leading the check and the Oral clinician.

2.11.4.3. **Sign-Out**

- Should be performed by a designated member of the operating team at the end of the procedure but before the patient or any of the team leaves the procedure room.

- "Silent cockpit" must be observed.

- Verbal confirmation that the name and site of the procedure have been accurately recorded.
- That any specimens have been labelled correctly.
- That instrument and swab counts are correct.
- Post procedure instructions have been given and understood by the patient.

2.11.4.4. **List Debriefing**

- The list de-brief should be recorded on the ‘Oral surgery LA procedure briefing’ form.
- The whole MOS team debrief at a suitable interval to review the procedures undertaken on the procedure list.
- The list de-brief should be recorded on the standard template and when complete saved to the shared governance file for audit.
- The clinic room team acknowledges:
    - What went well?
    - Any challenges or concerns about the list.
    - Communication, skill-mix, issues outside theatre, timing issues.
    - Any specific equipment issues that needed to be addressed before the next list.
    - Anything that could have been done to make the list safer.
    - Anything that could have been done to make the list more productive.
- Any issues should be reported to the Departmental sister or nominated deputy, and an incident report raised if necessary.
- Any issues of shared learning must be included for the following days departmental “safety huddle”.

Compliance: 100%.

Exceptions: None.

References:

RCH Five steps to safer surgery.

AfPP Principles of Safe Practice in the Perioperative Environment 2016.

2.12. Oral Surgery Department Standard No 12 - Application of the 5 Steps to Safer Surgery (including the Oral surgery unit specific) WHO Surgical Safety Checklist (SSC) in all Procedure Rooms

2.12.1. **Standard Statement:** All operative procedures performed in the dermatology procedure rooms will have the correct and full application of the Oral surgery LA procedure, WHO SSC process completed and documented by the MOS procedure room team.

2.12.2. **Method:**

- Audit of Compliance with 5 Steps to Safer Surgery, including dermatology WHO SSC.
- 100% compliance is expected with application of the 5 Steps to Safer Surgery - this will be monitored by:
- Departmental Safety Huddle.
    - The department "Safety Huddle" will be completed daily by all RCH departments and incorporates the principles of Team review.
    - All staff on-duty (except those staff whose clinical session has commenced early) are expected to attend - the Department sister or Nurse-in-charge leading the huddle is expected to ensure that all available staff are present. (Unavailable staff are expected to retrospectively review the huddle details when their session has completed).
    - The safety huddle discussion will be documented on the standard OPD template provided and will include any issues identified for learning from the previous days.
    - The practitioner leading the safety huddle will ensure that all staff are given the opportunity to raise concerns for the days planned activity.
    - Any issues raised will be documented and held for any staff commencing duty later to enable them to be briefed.
    - The completed record will be returned to the department sister's office and held in the Departmental safety huddle folder.
    - The completed record will within 7 days, be saved to the shared governance file for evidence.

2.12.3. **Operating List Briefing – Step 1 of 5 Safer Surgery**

- Each procedure list will have a Pre-briefing before the start of the session.
- The procedure list briefing will be structured following the standard

template.

- The procedure list briefing may be led by any member of the team, but the operating surgeon must be present.
- All team members must be involved in the discussion and able to raise any concerns regarding the planned activity.
- All individual cases must be discussed, and any specific requirements or anticipated problems documented on the briefing sheet.
- The briefing sheet will be retained in the procedure room for the briefing of staff joining the team, new information may be added during the session.
- The completed record will within 7 days, be saved to the shared governance file for evidence.

2.12.4. **WHO Surgical Safety Checklist - Steps 2, 3 and 4 of 5 steps to Safer Surgery**

- Every patient undergoing an invasive procedure will have a fully completed Oral surgery WHO SSC.
- The Oral surgery LA procedures WHO SSC is retained in the medical notes and forms part of the procedure record.
- Incomplete WHO SSC will need to be fully completed before the patient leaves the MOS procedure room.

2.12.5. **WHO Surgical Safety Checklist - Steps 2, 3 and 4 of 5 Steps to Safer Surgery Audit of Quality**

- The process for completion of the Oral surgery LA procedures WHO SSC is detailed in the MOS Procedure Room Practice Standard within this document.
- The quality of the WHO process will be directly observed and assessed as per the audit tool for application, engagement, and completion at each stage of the WHO.
- For one week in each month every procedure room will complete a direct observational assessment of every WHO process for each patient.
- Completed assessment forms will be returned to the divisional governance office before the final day of each month for entry to the WHO SSC database and compilation of the monthly specialty and location report.
- Departmental assessments will be supported by senior team assessment and peer assessments from other skilled and competent department sisters / charge nurses.

- All completed assessment forms will be entered into the WHO SSC database for inclusion in the monthly report.
- The monthly report will report compliance by site, procedure room and specialty.
- Individual reports related to clinicians can be provided.

2.12.6. **Debriefing - Step 5 of 5 Steps to Safer Surgery**

- Each list will have an operating list debriefing at the end of the session and before team members leave the procedure room.
- The debriefing will be structured using the Oral surgery standard template.
- The debriefing may be led by any member of the MOS team, but the Operator must be present.
- The debriefing may begin at any time agreed suitable by the team.
- All team members must be involved in the discussion and able to raise any concerns regarding the session's activity.
- All issues raised at debrief must be discussed and any suggestions for improvement, escalation or resolution recorded.
- The debriefing sheet will be returned to the department Sisters office for inclusion of any learning in the following days safety huddle.
- Within 7 days the briefing / debriefing document will be saved to the shared drive and its entry recorded in the summary sheet to enable auditing.
- Completion of:
    - Safety huddle.
    - Procedure list briefing.
    - Procedure list debriefing Will be included in the monthly report for 5 Steps to Safer Surgery by department and specialty.

2.12.7. Monthly Compliance Reports will be reported at Specialty Business and Governance Meeting, Care Group Governance Board meeting and shared with all Surgical Specialties.

Compliance: 100%.

Exceptions: None.

References:

RCH 5 Steps to Safer Surgery.

AfPP Principles of Safe Practice in the Perioperative Environment 2016.

2.13. Oral Surgery Out-patient Department Standard No 13 - Stocking up of Clinic Rooms

2.13.1. **Standard Statement**: All staff are responsible for ensuring that the clinic rooms are always stocked, ensuring correct stock rotation.

2.13.2. Method:

- All staff must ensure that the clinic rooms are left stocked ready for use at the end of each operating session. All areas should be checked including cupboards and shelves in preparation rooms. If this is not achievable because of pressure of work, the Nurse-In-Charge (NIC) of the shift must be informed, so other staff can be directed to fulfil this requirement during any other quieter periods.
- Staff must ensure that when placing new stock, older stock is brought forward to ensure it is used in date order.
- All expiry dates must be checked prior to the stock being placed into areas and again before use.
- Each area has required stock levels for each item they hold, and these should not be exceeded.
- Staff should ensure that stock items are stored neatly to reduce damage to items. If a final item is removed from a box, staff must ensure the box is disposed of and that there is a new box of the item available for use.
- Any items noted to be in short supply, must be notified to the Department Sister or deputy.
- Regarding reduced levels, any increased usage in a particular item that will be sustained, should be notified to the Department sister.
- Items that are unwanted or unused must be returned to their appropriate storage area.
- Staff should only use other clinic room stock as a last resort, if the item required is out of stock, within the department.
- Any labels on stock items must be attached to the patient notes for traceability purposes.

Compliance: 100%.

Exceptions: None.

2.14. Oral Surgery Out-patient Department Standard No 14 – Values and Behaviours

2.14.1. **Standard Statement:** All staff will endeavour to always maintain a professional demeanour within the department, treat their colleagues

with courtesy and respect, and provide the best possible care for all patients who enter the department. Fundamentally we will reflect the RCH trust values and behaviour standards.

2.14.2. **Method:**

- All staff are expected to be changed and ready for duty at their allocated start time.
- Talking outside of the clinic and procedure rooms must be kept to a minimum to avoid disruption.
- Staff must familiarise themselves and comply with the Trust standard regarding the use of mobile phones.
- Staff must be familiar with and adhere to the Trust Values and Behaviours.
- Staff must be familiar with and adhere to the Trust Uniform Policy.
- Staff must ensure that entitlement to lunch and rest breaks are not exceeded.
- It is expected that when a change of team occurs, an informal handover will take place.
- Smoking is not allowed on any RCHT site. Staff wishing to smoke during their allocated break times must change and leave the trust site. These staff must ensure that they do not return late from break times as this is discourteous to colleagues. Help and support is available from Occupational Health for staff members who wish to give up smoking.
- Staff should address members of the team by their appropriate title unless invited to do otherwise, especially in front of patients.
- Patients should be addressed by their preferred title, as requested. If no specific title or name requested, then they should be addressed by Mr/Mrs/Ms/Miss (except for paediatric patients).
- Staff must be familiar with the trust values and demonstrate behaviour that is consistent with these. Any member of staff demonstrating behaviour that is not consistent with these values will be challenged and action taken if behaviour is not redressed.

Compliance: 100%.

Exceptions: None.

References:

RCH Values and Behaviours.

2.15. **Oral Surgery Out-patient Department standard No 15 - Use of Mobile**

Phones

2.15.1. **Standard Statement:** The inappropriate use of mobile phones in the Oral Surgery department is strictly prohibited.

2.15.2. **Method:**

- Staff must be familiar with the trust policy regarding the use of mobile phones in the hospital.
- The use of RCH mobile phones is restricted for essential and appropriate clinical communication only.
- Personal phones must not be used except in exceptional circumstances.
- Staff may use their personal mobile phones in the coffee room whilst on their designated breaks. Medical staff may use their personal telephones for essential Trust business use but taking of images is strictly forbidden with personal devices.
- Mobile phones must be switched off or on silent mode in the procedure rooms. Procedure rooms and consultation rooms.
- Sending text messages and receiving calls whilst in the procedure rooms is strictly prohibited unless considered essential / critical to the current patient being operated on or if the surgeon is on call and unable to divert emergency calls whist operating.
- Sending text messages and receiving calls whilst in clinical areas must be clinically indicated and for trust business and communications only.
- The Trust accepts no responsibility for loss, damage to, or breakage of personal mobile phones.
- The use of picture phones, by any staff member or visitor, is strictly prohibited in clinical areas.

Compliance: 100%.

Exceptions: None.

2.16. Oral Surgery Out-patient Department standard No 16 - Consent and Refusal of Consent

2.16.1. **Standard Statement:** All staff should be familiar with the RCH policy for consent to examination and treatment. Any patient refusing or expressing concerns after giving consent must be allowed time to discuss the concerns fully before submitting to treatment. Concerns regarding consent must be brought to the attention of the senior doctor immediately.

Refer to: RCH Consent to Examination or Treatment Policy.

2.16.2. **Children and Consent**

Refer to: RCH Consent to Examination or Treatment Policy.

2.16.3. **Consent to Photography and Recording**

- Staff will ensure that prior to any photographs being taken or video equipment is used, the appropriate consent has been obtained from the patient.
- Patients have the right to refuse permission for any photographs to be taken, or any video equipment to be used during their procedure.
- It is essential that anyone wishing to use photographic, or video equipment has obtained the necessary permission from the patient prior to their use.
- Any photographs taken of patients are the copyright of the Secretary of State for Health and may only be used subsequently if further permission is gained from the patient. When outside agencies have been given permission to film or photograph within the operating department, staff should be reminded of their role in patient advocacy and standards of professional conduct.
- When outside agencies have been given permission to film or photograph within the operating department, staff should be reminded of their role in patient advocacy and standards of professional conduct.
- Media personnel should not be permitted into the Perioperative Environment without the Trust Executive permission.
- The use of personal devices for recording patient images is strictly forbidden.

Compliance: 100%.

Exceptions: None.

References:

RCH Recordings and Photography Policy.

RCH Consent to Examination or Treatment Policy.

2.17. Oral Surgery Out-patient Department standard No 17 - Managing Accidents and Incidents

2.17.1. **Standard Statement:** All staff members are responsible for the identification and documentation of accidents and incidents within the department.

2.17.2. All staff will refer to the following RCHT policies on the reporting and management of incidents:

- Incident Reporting and Management Policy and Procedure.
- Reporting of Injuries, Diseases and Dangerous Occurrences (RIDDOR) Policy.
- Serious Incident management Policy and Procedure.
- A Policy and Procedure for Being Open.

2.17.3. **Method:** All staff will receive training on the responsibilities of the employer and the employee in relation to health and safety, and be familiar with the following policies:

- Health and Safety and Environmental Policy (Introduction and Responsibilities for Health and Safety).
- Policy for Risk and Incident Management.
- Serious Adverse Incident Policy and Procedure.

2.17.4. All accidents to, or all incidents involving staff/and or equipment/ adverse incidents/breaches of protocol or any issues pertaining to patient care and the running of the theatre lists must be reported to the co-ordinator and a report completed via the trust incident reporting system.

Compliance: 100%.

Exceptions: None.

References:

RCH Incident Reporting Policy.

2.18. Oral Surgery Out-patient Department Standards No 18 – Visitors to the Department

2.18.1. Statement**:** Staff will ensure that only visitors, who have obtained the relevant permission for definitive supportive and / or educational purposes, are present in the clinical area or procedure rooms.

2.18.2. **Method:**

- Patients have the right to confidentiality unless they have consented to have information divulged. Patients have the right to refuse the presence of visitors during their appointment.
- The number of visitors permitted in the perioperative environment must be kept to a minimum.
- All visitors must have gained appropriate consent prior to arrival.
- All visitors must be provided with the appropriate apparel and instruction given as to their use.

- All visitors to the procedure room or clinics, must be made aware that all procedures carried out within the department are confidential in nature, and that any information, discussions, technical data or documentation must be treated in confidence.

- All visitors must be made aware of department etiquette, and they should be introduced to all staff working in the area they will be attending.

- It is essential that visitors be always chaperoned during their visit.

- Visitors must be made aware that should they feel faint or unwell during their stay then they should immediately inform a member of staff.

- All medical, nursing, and technical personnel who are not employees of the trust but intend to participate in patient care during their visit, must have their professional qualifications verified prior to admission to the department.

Compliance: 100%.

Exceptions: None.

2.19. Oral Surgery Out-Patient Department Standard No 19 - Mandatory Training

2.19.1. **Standard statement:** All staff to attend and take responsibility for their individual mandatory training needs.

2.19.2. **Method:**

- Staff to take individual responsibility for keeping up to date with mandatory requirements.

- Evidence can be provided for all training compliance in the following areas:

  - COSHH.
  - Fire.
  - BLS/ILS/PBLS.
  - Manual Handling.
  - Infection Control.
  - Health and Safety.
  - Risk Management.
  - Conflict Resolution.
  - Information Governance.

- Child Safeguarding (Level 1,2 and 3).
- WHO.
- Human Factors.

➢ All staff will have an annual Individual performance Appraisal (PDR) with their line manager where they will be able to identify individual learning and development needs.

➢ The departmental sister will collate data to inform the department annual trading needs analysis, to support allocation of funding and planning of staff development.

Compliance: 100%.

Exceptions: None.

References:

RCH Mandatory Training Policy.

2.20. Oral Surgery Out-patient (OPD) Standards No 20 - Expectant Mothers (Staff) Working in the Department

2.20.1. **Standard Statement**: Expectant Mothers (Staff) Working in the Oral Surgery Out-Patient Department.

2.20.2. **Duty of Employee:**

The Employee who is an expectant mother: as soon as is reasonably practicable, the employee has a duty to inform her line manager and the occupational health department. This must be confirmed in writing so that the line manager can make provision for maternity leave and arrange for a risk assessment to take place.

2.20.3. **Duty of Employer:**

- Departmental sister has a responsibility to ensure that potential hazards are assessed by a risk assessment for nursing staff and the Specialty Service Manager for Medical staff.
- Ensure that all members of their staff have received information, instruction, and training appropriate to their job responsibilities.
- Health and Safety Services: To provide advice and guidance to managers and individual employees on the health and safety aspects of hazards and risks associated with pregnancy and breastfeeding.
- To liaise with managers across departmental boundaries in the provision of advice and guidance that may facilitate the resolution of any outstanding hazards/risks identified.
- To monitor and audit the effectiveness of the policy and risk

assessment system.

- Occupational Health Department: To provide advice and guidance to employees on occupational health issues that they may encounter at work when a new, expectant, or breast-feeding mother.

2.20.4. Management of Risk

- Potential hazards for the expectant mother in the clinical environment must be assessed by a risk assessment. Once the risks are identified, a plan of action must be formulated to ensure that the expectant mother is not exposed to any unnecessary risks within the workplace. The action plan must be reviewed at regular intervals to ensure that the working environment is safe. This is a legal requirement (HMSO, 1994).

- If this is beyond the remit or authority of their managers/supervisors, they are to undertake the management of the task of risk elimination or reduction themselves or pass it onto an appropriate level of authority for implementation.

- Up to date written records of all the risk assessments, action plans and reviews must be kept for the expectant mother.

- All significant risks must be recorded onto the appropriate Risk Register, and this is kept up to date.

- The risk assessment must be specific to the workplace environment where the expectant mother is required to work.

- The risk assessment must identify any concerns about potential hazards to which the expectant mother may be exposed.

- Advice should be obtained from the local Control of Substances Hazardous to Health (COSHH) advisor as this person will have a record of manufacturing safety data sheets.

2.20.5. Risk Assessment Guidance

Explanations (Hazards)	Consider The Risk	Risk Avoidance
Violence and Aggression	Could the individual be exposed to clients/patients, even visitors that could cause physical harm to an expectant mother.	Review/exposure working with violent and aggressive client groups. Consider work areas with alternative client groups.
Shocks, Vibration and Movement	Regular shocks, low frequency vibration or movement pose a risk of miscarriage.	Avoid whole body vibration work, or where the stomach is exposed to jolts.

Explanations (Hazards)	Consider The Risk	Risk Avoidance
Manual Handling (Where loads risk injury)	Hormonal changes make pregnant workers susceptible to injury and obviously as pregnancy progresses. Posture/spaces/manoeuvrability become issues.	Apply normal manual handling rules. Avoid lifting / mechanise / use handling aids. Assessment / Risk reduction / training. Reduce the amount of physical work and ensure it is within their capabilities.
Driving	Arrest by seat belt/collision whilst driving a vehicle may cause injury to mother and unborn child.	Any concerns about the ability to drive, consult. GP/Occupational Health.
Noise	No specific risk - loud noise over prolonged periods may raise blood pressure.	Adhere with current legislation concerning noise.
Strong Smells	Nausea/discomfort.	Report any unusual odours. Identify and remove if possible. Avoid exposure.
Ionising Radiation X-Ray Gamma Rays Alpha and Beta Particles	Large doses are harmful. Exposure limits set for course of pregnancy. Exposure risk/radioactive liquids/dusts for nursing mothers (especially skin Ingestion/inhalation risk to unborn child).	Comply with statute exposure rates for pregnant women. Avoid employment of nursing mothers in areas of high radioactive contamination. Safe systems of work to avoid accidental exposure. Inform Occupational Health Radiation Protection. Advisor on confirmation of pregnancy.
Non Ionising Radiation Ultra Violet Infra-red	At no more risk than other workers. (N.B. Extreme overexposure to radio frequency radiation could raise body temperature).	Ensure exposure to electric and magnetic fields is within exposure limit.

Compliance: 100%.

Exceptions: None.

References:

RCH Risk Management Policy.

2.21. Oral Surgery Out-patient Department Standard No 21 - Human Resource Management

- Refer to: RCHT Disclosure and Barring Checks Policy.
- RCHT Management of Corporate and Local Induction Policy.

- RCHT Core Training Policy.

- All new staff to the RCH are required to have a current enhance DBS check before commencing employment.

- Staff transferring to new roles within the trust will also require enhanced DBS checks before commencing in post.

- Staff are required to inform their line manager at the earliest opportunity of any cautions / convictions received during their employment. Each case will be considered individually and will not necessarily impact on any aspects of employment with the Trust.

- Registered staff are also required to inform their professional body.

2.21.1. Grievance Procedures

- All staff have the right to raise any issue that they believe has adversely affected them and have it investigated.

- Staff should speak to their line manage in the first instance or if this is not possible the Clinical Matron, Head of Nursing or HR team.

- The trust has several Independent Listeners (freedom-to-speak-up Guardians) available who will support any member of staff contactable via switchboard.

- RCHT Grievance and Disputes Policy and Procedure.

2.21.2. Nurses and Registered Staff Responsibility

- All registered staff are responsible for maintaining their own professional registration.

- Registered nursing staff are required to revalidate every 3 years. Staff who allow their professional registration to expire will not be allowed to work in a registered capacity until proof of registration is received. Salary will be adjusted for the time they have been unregistered.

- Refer to: RCHT Professional Registration Policy.

2.21.3. Whistle Blowing

- Refer to: RCHT Raising Concerns in The Public Interest (Whistleblowing) Policy.

2.21.4. Complaints

- Refer to: RCHT Compliments, comments, concerns, and complaints (the 4C’s) policy and related procedures.

- All staff are encouraged to foster an open and honest culture and addressing where possible, any informal concerns and complaints at the earliest opportunity to avoid formal complaints.

- All staff are responsible for seeking service user / patient feedback – this is obtained with the encouragement of Friends and family feedback and Care opinion.

2.21.5. **Harassment and Bullying**

- Refer to: Dignity at Work Policy Procedure and Guidance.

2.21.6. **Educational Support:**

- Refer to: Management of Corporate and Local Induction Policy.
- Core Training Policy.
- Medical Devices Training Policy
- Preceptorship Guidance and Framework Policy.
- Induction All Staff: All newly appointed staff will receive a local induction / orientation program that facilitates their integration into the Oral surgery department.
- Induction Non-Substantive Staff: The Trust Policy: 'A policy for the induction of temporary workers' must be adhered to when new agency, bank or otherwise non substantive staff are employed by the Department sister and the supervising clinician.
- The department sister must ensure the allocation of staff to clinical duties must reflect a risk- managed mix of substantive (or familiar and experienced staff) and non-substantive staff.

2.21.7. **Staff Competence in the Oral Surgery Out-Patient Department at RCHT**

- All staff in the Oral Surgery Out-patient Department will be required to complete and maintain the relevant skills to their banding and clinical role.
- Individuals who have completed the relevant skills and competence to perform a task or role will be supported to do this following formal agreement and sign off by the department sister. This will be in line with the registered/ unregistered banding framework.
- Achieving competence in a skill at a higher level will not guarantee a higher banded role. This can only be considered when suitable vacancy exists, and a fair and equitable recruitment process is followed.
- Any concerns regarding individual's competence will be addressed informally with the individual in the first instance. Appropriate

training and development programs will be agreed and supported.

- Staff Responsibility:
  - The nurse must comply with the NMC Code of: Professional Standards of Practice and Behaviour for Nurses and Midwives.
  - Preserve Safety: 13 Recognise and work within the limits of your competence.
  - The HCA must comply with the Skills for Health: Code of Conduct for Healthcare Support Workers and Adult Social Care Workers in England: 1. Be accountable by making sure you can answer for your actions or omissions.

2.21.8. **RCHT Capability Policy and Procedure**

- It is not assumed that experienced staff have the skills or knowledge required when transferring to a new area of care. Careful assessment of basic skills and a period of orientation are essential before competence can be achieved.
- Experienced staff (registered for more than one year) should be expected to undertake relevant and recognised courses on teaching and assessing in the clinical areas that will meet the needs of all learners in that area.
- Assessors and candidates must be aware of the requirements of an individual assessment before it is undertaken. Reference should be made to the assessment systems of individual courses.

2.21.9. **Professional Development**

- All members of the workforce must receive regular updates and training as per job role. The department sister is responsible for ensuring staff have specific time rostered for regular updates and CPD activity, as identified through their clinical need/activity and yearly appraisal.
- Staff are responsible for identifying gaps in their knowledge and skills, bringing this to the attention of the department sister and working with them to seek a reasonable resolution.
- Requests for supported development i.e. funding or time out of the clinical area must be supported by the individuals line manager and be in line with service need.
- Requests must then be submitted to the Clinical Matron and then the HON for review and allocation of funding / time if deemed appropriate.
- Time out of the clinical areas for learning will be allocated by the line managers and will support service need requirements, individuals

should be aware that time out of the clinical areas cannot be guaranteed in all cases and may be cancelled at short notice to support service need and patient safety.

- Degree courses are routinely supported 50/50 – 50% in employee's time and 50% at Trust time.

- Individuals are encouraged to seek alternative routes for development i.e. secondment to other areas /shadowing. All requests should be made to the line manager who will endeavor to facilitate these requests whenever possible.

Compliance: 100%.

Exceptions: None.

3. Monitoring Compliance and Effectiveness

Information Category	Detail of process and methodology for monitoring compliance
Element to be monitored	Practice compliance against all Oral Surgery Out-patient Department clinic room practice standards will be monitored.
Lead	Oral Surgery Outpatient Department Sister Paulette Hunkin, Clinical Matron, Specialist Services and Surgery.
Tools	The revised RCH WHO safety audit tool will be used to monitor compliance monthly. Each senior auditor will assess practice observed at each audit.
Frequency	The Oral surgery department team will audit 10 WHO observations of practice in the MOS clinic each month. The observations will be submitted to the Governance Lead for Specialist Services and Surgery by the 2nd of the following month for collation and reporting at the Care Group Huddle. Compliance with the Oral Surgery Out-patient LA procedures WHO SSC will be reported monthly to the management team.
Reporting arrangements	At monthly governance meetings. Responses and actions agreed will be recorded in meeting minutes.
Acting on recommendations and Lead(s)	It will be the responsibility of the Head of Nursing to action any recommendations from the report and report back to General Manager.
Change in practice and lessons to be shared	This document consolidates and defines current practice, no changes to current practice are required. The documentation implementation will be led by the Department sister. All staff will have discussions on the local practice standards at yearly PDR and will complete yearly online WHO training. Any shortfalls by individuals identified will be dealt with by the appropriate manager in line with trust policy. Lessons learned will be shared with all stakeholders at Unit safety briefings and Specialist Services and Surgery meetings

4. Equality and Diversity

4.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the Equality Diversity And Inclusion Policy or the Equality and Diversity website.

4.2. Equality Impact Assessment

The Initial Equality Impact Assessment Screening Form is at Appendix 2.

Appendix 1. Governance Information

Information Category	Detailed Information
Document Title:	The Oral surgery outpatient department Practice Standards Clinical Guideline V1.0.
This document replaces (exact title of previous version):	New Document.
Date Issued/Approved:	May 2024.
Date Valid From:	December 2024.
Date Valid To:	December 2027.
Directorate / Department responsible (author/owner):	Paulette Hunkin. Specialist Services and Surgery.
Contact Details:	01872 253416.
Brief Summary of Contents:	Defined standards expected within the Oral Surgery Out-patient (OPD).
Suggested Keywords:	Procedure Rooms, Surgical Equipment, Standards, Clinical Standards, Clinical Practice, Oral surgery, Max Fax, Dental, Orthodontist, Clinic Rooms, MOS, LA Procedures Clinic.
Target Audience:	**RCHT:** Yes **CFT:** No **CIOS ICB:** No
Executive Director responsible for Policy:	Chief Medical Officer.
Approval route for consultation and ratification:	Care Group Governance Meeting, Medicine Practice Committee, Information Governance Group.
Manager confirming approval processes:	Roz Davies, General Manager for Specialist Services and Surgery.
Name of Governance Lead confirming consultation and ratification:	Michele Reed, Governance Manager.
Links to key external standards:	None required.
Related Documents:	None.

Information Category	Detailed Information
Training Need Identified?	Yes – WHO Training.
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet and Intranet
Document Library Folder/Sub Folder:	Oral/Surgery.

Version Control Table

Date	Version Number	Summary of Changes	Changes Made by
December 2024.	V1.0	Initial issue.	Paulette Hunkin, Clinical Matron.

All or part of this document can be released under the Freedom of Information Act 2000.

All Policies, Strategies and Operating Procedures, including Business Plans, are to be kept for the lifetime of the organisation plus 6 years.

This document is only valid on the day of printing.

Controlled Document.

This document has been created following the Royal Cornwall Hospitals NHS Trust The Policy on Policies (Development and Management of Knowledge Procedural and Web Documents Policy). It should not be altered in any way without the express permission of the author or their Line Manager.

Appendix 2. Equality Impact Assessment

Section 1: Equality Impact Assessment (EIA) Form

The EIA process allows the Trust to identify where a policy or service may have a negative impact on an individual or group of people.

For guidance, please refer to the Equality Impact Assessment Policy (available from the document library) or contact the Equality, Diversity, and Inclusion Team rcht.inclusion@nhs.net

Information Category	Detailed Information
Name of the strategy / policy / proposal / service function to be assessed:	New.
Directorate and service area:	Specialist Services and Surgery.
Is this a new or existing Policy?	New.
Name of individual completing EIA (Should be completed by an individual with a good understanding of the Service/Policy):	Paulette Hunkin Clinical Matron.
Contact details:	01872 253416.

Information Category	Detailed Information
1. Policy Aim - Who is the Policy aimed at? (The Policy is the Strategy, Policy, Proposal or Service Change to be assessed)	The aim of this policy is to outline the standards of care that must be delivered while caring for patients and managing the staff in the Oral Surgery Out-patient (OPD).
2. Policy Objectives	To standardise care and practice. To standardise expectations.
3. Policy Intended Outcomes	Standardisation of care and practice. Standardise expectations.
4. How will you measure each outcome?	WHO Audit. Spot checking.
5. Who is intended to benefit from the policy?	Patients and Staff.
6a. Who did you consult with? (Please select Yes or No for each category)	• Workforce: Yes • Patients/ visitors: No • Local groups/ system partners: No • External organisations: No • Other: No

Information Category	Detailed Information
6b. Please list the individuals/groups who have been consulted about this policy.	**Please record specific names of individuals/ groups:** Oral Surgery Out-patient (OPD) medical and nursing staff.
6c. What was the outcome of the consultation?	Acceptance.
6d. Have you used any of the following to assist your assessment?	No

7. The Impact

Following consultation with key groups, has a negative impact been identified for any protected characteristic? Please note that a rationale is required for each one.

Where a negative impact is identified without rationale, the key groups will need to be consulted again.

Protected Characteristic	(Yes or No)	Rationale
Age	No	
Sex (male or female)	No	
Gender reassignment (Transgender, non-binary, gender fluid etc.)	No	
Race	No	
Disability (e.g. physical or cognitive impairment, mental health, long term conditions etc.)	No	
Religion or belief	No	
Marriage and civil partnership	No	
Pregnancy and maternity	No	
Sexual orientation (e.g. gay, straight, bisexual, lesbian etc.)	No	

A robust rationale must be in place for all protected characteristics. If a negative impact has been identified, please complete section 2. If no negative impact has been

identified and if this is not a major service change, you can end the assessment here.

I am confident that section 2 of this EIA does not need completing as there are no highlighted risks of negative impact occurring because of this policy.

Name of person confirming result of initial impact assessment: **Paulette Hunkin**

If a negative impact has been identified above OR this is a major service change, you will need to complete section 2 of the EIA form available here:
Section 2. Full Equality Analysis