Patient Inclusion Criteria for Outpatient General Anaesthetic Procedure OPGA in the Oral Surgery Department at RCHT Standard Operating Procedure

V2.0

September 2025

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Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 is applicable to all staff; this includes those working as contractors and providers of services.

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Royal Cornwall Hospital Trust rch-tr.infogov@nhs.net

1. Introduction

This document outlines the general inclusion criteria for patients who can proceed to have their oral surgery procedure under a General anaesthetic (GA) in the Oral Surgery Out-patient Department. It is essential to streamline patients to the appropriate on-the-day pre-operative waiting area, theatre and recovery area in order to safely meet the patients' care needs.

The Oral surgery department has a limited pre-operative waiting area and therefore patients who require more than basic pre-op optimisation cannot be routinely accommodated. In addition, there is limited registered recovery nurses and an insufficient second stage recovery area to support extended or complex recovery needs.

This SOP is an appendix to the "Generic Theatre Practice Clinical Guideline" (February 2021).

1.1. To note this document does NOT apply to the Community Dental ('Smile Together') as the criteria for inclusion for this patient group is defined in "General Anesthetic Guidelines for OPGA Clinics".

1.2. These detailed criteria are designed to identify lower risk patients to which are suitable for higher turnover lists which for the Oral Surgery Department (OSD), is essential as there is limited first stage and second stage recovery areas.

1.3. Patients that fall outside of this SOP criteria could potentially still have a GA or sedation procedure in the OSD but would require early discussion and approval with the operating surgeon and with the attending anaesthetist.

1.4. If agreed to proceed with patients outside of this SOP then additional time would need to be allocated on the operating the list, to support operating time and recovery time. This may occur in times of extreme pressure or in response to RTT challenges.

1.5. This procedure should be read in conjunction with the following Trust documentation:

- Generic Theatre Practice Standards Clinical Guideline (February 2021).
- Procedural Sedation of Adult Patients Clinical Guidelines (December 2019).
- Theatre Pathway Guidelines for High/Medium/Low Covid-19 Patients (Aug 2020).

1.6. This version supersedes any previous versions of this document.

2. Purpose of this Policy/Procedure

2.1. The purpose of this document is to clearly articulate the standard inclusion criteria for patients to have their procedure under a GA in the RCH OSD.

2.2. To support the pre-operative assessment unit, theatre and booking teams to appropriately manage Oral surgery patients and their theatre pathway.

2.3. Ensure safe, efficient and effective practice for patients attending the OSD having a procedure under a GA.

3. Ownership and Responsibilities

The safe assessment, booking and admitting of patients to have their procedure under a GA in the RCH OSD is shared responsibility between OMF clinician, Pre-op assessment, the booking team, the specialty service manager, the attending Anaesthetist, the operating Surgeon and the Departmental Sister, each having their own distinct responsibilities to ensure the safest pathway for the patient.

3.1. Role of the Clinician in OMF Consultation:

- To determine if patient suitable for OPGA or main list theatre using the OPGA criteria included in this SOP.

- Refer on Maxims for booking to an OPGA list or main theatres list as appropriate.

3.2. Role of the Pre-op Assessment Staff

- To complete pre-op assessment and clarify correct patient pathway following that assessment.

3.3 Role of the Pre-op Admin and Booking staff

- Book patient to appropriate list as per pre-op assessment / clinician decision.

3.4. Role of the attending Anaesthetist

- Completes on the day clinical assessment to ensure patients meets OPGA criteria.

- Where OPGA criteria is not met – decision by anaesthetist as to continue on OPGA pathway or cancel and rebook to appropriate list.

3.5. Role of the Operating Surgeon

- Discussion with anaesthetist if any concerns that patient does not meet OPGA or concerns re proceeding with surgery.

3.6. Role of the Department Sister / Deputy

- Ensure the SOP is shared with all relevant stakeholders.

- Ensure SOP is followed and where patients are operated on outside of the SOP agreement then safety of patients' additional care needs to be considered and met.

4. Standards and Practice

4.1. General inclusion criteria for OPGA procedures in the OSD:

- Patient fit and healthy: ASA assessment defined as ASA1 or ASA 2.
- Body mass index (BMI): ≤ 35 and/or total body weight < 120kg.
- Rockwood Frailty Score: ≤3 (to note old age is not a contra-indication in itself).
- Lower age limit: Minimum 3 years of age.
- Surgical procedures with duration > 1 hour.
- Exclusions: high risk of bleeding, predicted excessive post-operative pain likely or prolonged post-operative immobility.

4.2. Social Circumstance inclusion criteria for OPGA procedures in the OSD:

- Patient must have a pre-agreed accompanying adult to take them home (by car or taxi) to a dwelling where there is a telephone and a named adult providing overnight care.
- Patient must have a pre-agreed friend or relative to stay with them for 24hours post operatively.
- Exclusions: Anyone who does not meet the social criteria.

4.3. Medical Exclusion criteria for OPGA procedures in the OSD:

- Uncontrolled hypertension to include a Blood Pressure more than systolic 180 mmHg and/or diastolic > 100 mmHg.
- Unstable angina to include chest pain at rest or regular use of GTN.
- Uncontrolled AF to include a heart rate > 100 BPM.
- History of a Myocardial infarction (MI) to include MI within 6 months / and/or stents < 1 year / and/or CABG < 6 months.
- Pacemaker.
- Implantable cardioverter defibrillator (ICD).
- Uncontrolled heart failure to include ejection fraction < 50% or unable to lie flat or climb stairs without extreme shortness of breath.
- Congenital heart disease.
- Anaemia to include HB < 100 (needs investigation to appraise Acute or Chronic), if investigated and chronic and > 80 okay to proceed.

- Sickle cell disease.
- Severe asthma or COPD (or recent exacerbation/steroid treatment/PEFR 250 L/min).
- Baseline resting Sp02 < 94%.
- Obstructive sleep apnoea (confirmed or suspected).
- Known difficult airway/intubation to include > grade 3 laryngoscopy.
- Limited mouth opening to include < 3 fingers.
- Unstable epilepsy to include increasing seizures.
- Stroke to include within 6 months.
- Neuromuscular disease to include Parkinson’s disease, multiple sclerosis, muscular dystrophy and motor neurone disease.
- Psychiatric to include patients taking lithium.
- Alcohol or heavy drug dependence.
- Late-stage dementia.
- Poorly controlled diabetes to include HbA1c >69. (Diabetic patients should be first on the operating list (am or pm)).
- Chronic renal failure to include eGFR < 60.
- Uncontrolled thyroid disease.
- Cholestatic liver disease caused by bile obstruction.
- Ankylosing spondylitis to include marked scoliosis and cardiac/pulmonary involvement.
- Malignant hyperpyrexia.

4.4. **For reference - Rockwood Frailty Score**

CLINICAL FRAILTY SCALE

	Category	Description
1	VERY FIT	People who are robust, active, energetic and motivated. They tend to exercise regularly and are among the fittest for their age.
2	FIT	People who have **no active disease symptoms** but are less fit than category 1. Often, they exercise or are very **active occasionally**, e.g., seasonally.
3	MANAGING WELL	People whose **medical problems are well controlled,** even if occasionally symptomatic, but often are **not regularly active** beyond routine walking.
4	LIVING WITH VERY MILD FRAILTY	Previously "vulnerable," this category marks early transition from complete independence. While **not dependent** on others for daily help, often **symptoms limit activities.** A common complaint is being "slowed up" and/or being tired during the day.
5	LIVING WITH MILD FRAILTY	People who often have **more evident slowing,** and need help with **high order instrumental activities of daily living** (finances, transportation, heavy housework). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation, medications and begins to restrict light housework.
6	LIVING WITH MODERATE FRAILTY	People who need help with **all outside activities** and with **keeping house.** Inside, they often have problems with stairs and need **help with bathing** and might need minimal assistance (cuing, standby) with dressing.
7	LIVING WITH SEVERE FRAILTY	**Completely dependent for personal care,** from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~6 months).
8	LIVING WITH VERY SEVERE FRAILTY	Completely dependent for personal care and approaching end of life. Typically, they could not recover even from a minor illness.
9	TERMINALLY ILL	Approaching the end of life. This category applies to people with a **life expectancy <6 months,** who are **not otherwise living with severe frailty.** (Many terminally ill people can still exercise until very close to death.)

SCORING FRAILTY IN PEOPLE WITH DEMENTIA

The degree of frailty generally corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia,** recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia,** they cannot do personal care without help.

In **very severe dementia** they are often bedfast. Many are virtually mute.

DALHOUSIE UNIVERSITY

Clinical Frailty Scale ©2005–2020 Rockwood, Version 2.0 (EN). All rights reserved. For permission: www.geriatricmedicineresearch.ca

Rockwood K et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489-495.

5. Dissemination and Implementation

5.1. This policy will be available on the RCHT Oral surgery Department shared folder. There will also be a hard copy available to view within the Oral surgery Department.

5.2. The SOP will be shared at specialty Business and Governance meeting and will be shared with the relevant governance leads for their onward sharing with their specialties.

5.3. The Departmental Sister will be responsible for ensuring that all relevant departmental staff are aware of this SOP.

6. Monitoring compliance and effectiveness

Information Category	Detail of process and methodology for monitoring compliance
Element to be monitored	All the policy to be monitored.
Lead	Oral surgery department Sister, OPGA anaesthetic lead, Oral surgery Governance lead.
Tool	Any incidents will be monitored via Datix incidents.
Frequency	Monitoring will be an ongoing practice within the department.
Reporting arrangements	Any concerns regarding the ongoing implementation of this procedure should be reported to the Oral Surgery Department Sister who will investigate and report back to relevant staff.
Acting on recommendations and Lead(s)	Any recommendations/changes to this process will be reported at the specialty Business and Governance meetings and changes implemented.
Change in practice and lessons to be shared	Required changes to practice will be identified and actioned immediately. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders.

7. Updating and Review

This procedure will be reviewed every 3 years.

8. Equality and Diversity

8.1. 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.

8.2. Equality Impact Assessment

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

Appendix 1. Governance Information

Information Category	Detailed Information
Document Title:	Patient Inclusion Criteria for Outpatient General Anaesthetic Procedure OPGA in the Oral Surgery Department at RCHT Standard Operating Procedure V2.0.
This document replaces (exact title of previous version):	Patient Inclusion Criteria for Outpatient General Anaesthetic Procedure OPGA in the Oral Surgery Department at RCHT Standard Operating Procedure V1.0.
Date Issued/Approved:	September 2025.
Date Valid From:	September 2025.
Date Valid To:	September 2028.
Author/Owner:	Lucie Baker – Departmental Sister.
Contact details:	01872 254915.
Brief summary of contents:	Inclusion criteria for OPGA on oral surgery department.
Suggested Keywords:	OPGA, inclusion criteria, Oral surgery.
Target Audience:	**RCHT:** Yes **CFT:** No **CIOS ICB:** No
Executive Director responsible for Policy:	Chief Medical Officer.
Approval route for consultation and ratification:	Speciality, SSS Senior Management Team Governance meeting, SSS Care Board.
Manager confirming approval processes:	Ian Moyle-Browning Head of Nursing (HoN).
Name of Governance Lead confirming consultation and ratification:	Michele Reed.
Links to key external standards:	None required.
Related Documents:	As listed in section 1.
Training Need Identified:	No.

Information Category	Detailed Information
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet and Intranet
Document Library Folder/Sub Folder:	Clinical / Oral Surgery

Version Control Table

Date	Version Number	Summary of Changes	Changes Made by
December 2021	V1.0	Initial issue	Paulette Hunkin, Clinical Matron, Oral Surgery, Specialist Services and Surgery (SSS).
July 2025	V2.0	Full review – no changes.	Paulette Hunkin, Clinical Matron, Oral Surgery, Specialist Services and Surgery (SSS).

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 particular 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:	Patient Inclusion Criteria for Outpatient General Anaesthetic Procedure OPGA in the Oral Surgery Department at RCHT Standard Operating Procedure V2.0.
Department and Service Area:	Specialist Services and Surgery.
Is this a new or existing document?	Existing Document.
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 523416.

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)	Define inclusion criteria for OPGA in the oral surgery department.
2. **Policy Objectives**	To share these criteria with all relevant stakeholders that assess, book or refer into this service.
3. **Policy Intended Outcomes**	To ensure the correct patients are referred to the OPGA service and that where exceptions exist then they are assessed individually on the day for inclusion by the relevant staff providing care to the OPGA patient.
4. **How will you measure each outcome?**	To ensure the correct patients are referred to the OPGA service and that where exceptions exist then they are assessed individually on the day for inclusion by the relevant staff providing care to the OPGA patient.

Information Category	Detailed Information
5. Who is intended to benefit from the policy?	All staff involved in any part of a the OPGA in oral surgery pathway.
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
6b. Please list the individuals/groups who have been consulted about this policy.	Specialty – Clinicians, nursing staff, clinical matron, lead anaesthetist for OPGA, governance lead / surgeon for Oral surgery.
6c. What was the outcome of the consultation?	Policy written and approved.
6d. Have you used any of the following to assist your assessment?	**National or local statistics, audits, activity reports, process maps, complaints, staff, or patient surveys:** 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	Yes	
Sex (male or female)	Yes	
Gender reassignment (Transgender, non-binary, gender fluid etc.)	Yes	
Race	Yes	
Disability (e.g. physical or cognitive impairment, mental health, long term conditions etc.)	Yes	

Protected Characteristic	(Yes or No)	Rationale
Religion or belief	Yes	
Marriage and civil partnership	Yes	
Pregnancy and maternity	Yes	
Sexual orientation (e.g. gay, straight, bisexual, lesbian etc.)	Yes	

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 – Clinical Matron, SSS.

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