**Oral Surgery Safety Checklist**

Name................................................................

DOB.................................................................

Address   …………………………………….…

Time into surgery………………….…….

Time of discharge………………………..

**(adopted from Somerset NHS Trust)**

Date....................................................................................

1. Intended procedure: Extraction of (write full notation, e.g.

lower right first permanent molar)………………………….

…………………………………………………………………

…………………………………………………………………

…………………………………………………………………

Teeth to be extracted    \_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

/

Complicating factors. Please specify …………………………………………..…………………………………….

**TIME OUT**

1. Team members introduced themselves by name and role
2. Patient/parent/carer confirmed their/the patient’s identity
3. Treatment site confirmed and viewed by both clinician and nurse
4. Relevant radiographs present  Yes N/A
5. Checked with treatment plan     Yes N/A
6. Consent confirmed                      Verbal? Written?
7. Consent form visible and accessible and legible
8. Relevant medical history …………………………………………………………………………………….…………
9. Does the patient have a known allergy? Yes No
10. **CHECK OUT**

* Mouth checked for retained foreign object (count out dental rolls/gauze/swabs)
* Swabs, sharps and instrument count correct
* Correct teeth extracted recorded in the notes

Debrief carried out, inc. equipment or staffing issues. Please specify………………….............................................

…………………………………………………………………………………………………………………………………...

Name and Signature of Dental Nurse ........................................ ……………………………………….......................

Name and Signature of Clinician................................................ ………………………………………..................