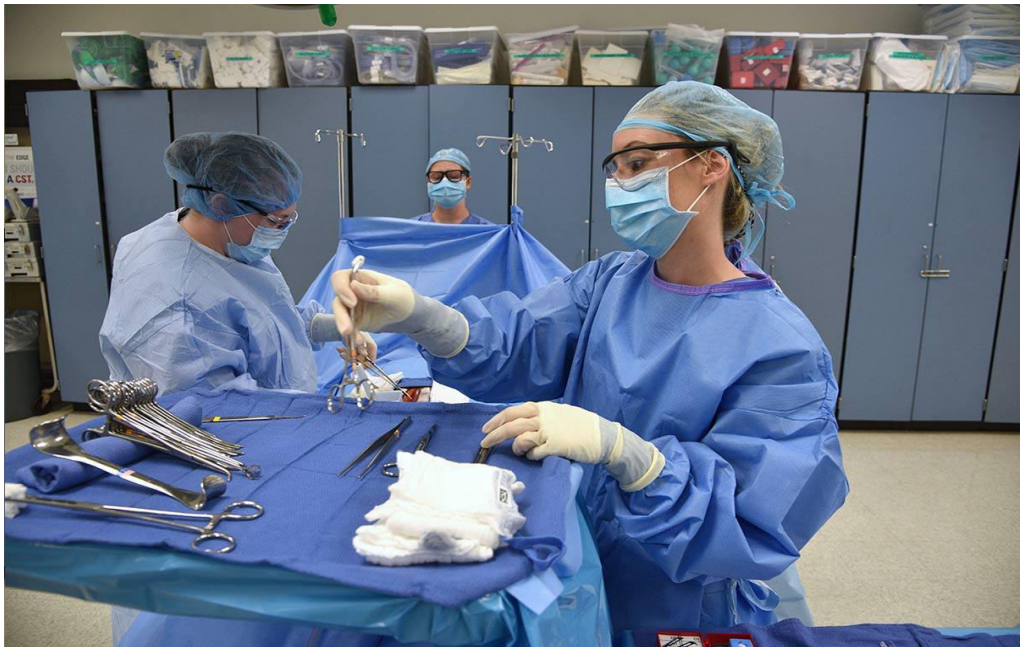
DEDER GENERAL HOSPITAL

SURGICAL SERVICE PROTOCOL



PREPARED BY: HSQU

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DEDER, EASTERN ETHIOPIA

PROTOCOL APPROVEAL SHEET

NAME OF PROTOCOL: SURGICAL SERVICE PROTOCOL

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THIS PROTOCOL IS EFFECTIVE FROM

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PURPOSE:

This protocol outlines the guidelines and procedures to ensure the safe and effective delivery of surgical services within the **Deder General Hospital**. It includes provisions for elective, urgent, and emergency surgeries, and emphasizes the importance of supervision and collaboration to ensure high-quality patient outcomes.

Scope of Surgical Services

Elective Surgeries: Scheduled, non-emergency surgeries that can be planned in advance.

Urgent Surgeries: Procedures required to treat conditions that, while not immediately life-threatening, should be performed to prevent serious complications.

Emergency Surgeries: Procedures performed immediately to save life, limb, or prevent significant health deterioration

Over view

The purposes of determining compliance with the hospital surgical services of Deder general hospital, with minor modification, upon the definition of surgery developed by WHO. Accordingly, the following definition is used to determine whether or not a procedure constitutes surgery and is subject to this.

Surgery is performed for the purpose of structurally altering the human body by the incision or destruction of tissues and is part of the practice of medicine. Surgery also is the diagnostic or therapeutic treatment of conditions or disease processes by any instruments causing localized alteration or transposition of live human tissue which include lasers, ultrasound, ionizing radiation, scalpels, probes, and needles. The tissue can be cut, burned, vaporized, frozen, sutured, probed, or manipulated by closed reductions for major dislocations or fractures, or otherwise altered by mechanical, thermal, light-based, electromagnetic, or chemical means. Injection of diagnostic or therapeutic substances into body cavities, internal organs, joints, sensory organs, and the central nervous system also is considered to be surgery (this does not include the administration by nursing personnel of some injections, subcutaneous, intramuscular, and intravenous, when ordered by a physician). All of these surgical procedures are invasive, including those that are performed

with lasers, and the risks of any surgical procedure are not eliminated by using a light knife or laser in place of a metal knife, or scalpel. Patient safety and quality of care are paramount and, therefore, patients should be assured that individuals who perform these types of surgery are licensed physicians (physicians as defined in WHO) who are working within their scope of practice, hospital privileges, and who meet appropriate professional standards.

Deder general hospital is providing surgical services by organized and staffed in such a manner to ensure the health and safety of patients. Acceptable standards of practice include maintaining compliance with applicable Federal and State laws, regulations and guidelines governing surgical services or surgical service locations, as well as, any standards and recommendations promoted by or established by nationally recognized professional organizations.

Outpatient surgical services must be in compliance with our hospital. Outpatient surgical services must be provided in accordance with acceptable standards of practice. Additionally, the hospital's outpatient surgical services must be consistent in quality with the hospital's inpatient surgical services. Post-operative care planning, coordination for the provision of needed post-operative care and appropriate provisions for follow-up care of outpatient surgery patients must be consistent in quality with inpatient care in accordance with the complexity of the services offered and the needs of the patient

OUTPATIENT SURGICAL CLINIC SERVICES

- Most new cases in our Hospital shall be seen on that day.
- Some cases shall be seen by appointment in our hospital
- Date of appointment shall be determined by liaison officer after reviewing the referral letter.
- Based on the urgency of the case, patient may be seen on the same days
- Patients suspected of having malignancy should be given an early appointment (within 2 weeks). The management of these cases should be specialist-led.

- There should be a system in place to trace patients with malignancy who defaults. Patients deemed not requiring specialist care can be discharged to a Primary Care Clinic/non-specialist hospital.

INPATIENT SURGICAL SERVICES

- The overall care of patients in the surgical wards shall be under the responsibility of specialist.
- A specialist should review and be involved in the management of all critically ill patients.
- Specialist should engage with family members of critically ill patients to update on the progress and care plan of the patients.
- Appointment for follow up should be given upon discharge, and in the event where this is not feasible, the staff should call the patient and inform the appointment date.

SURGERY

ELECTIVE SURGERY:

(A) ELECTIVE: INPATIENT

- ✓ **All elective surgery should be done in the presence of specialist (surgeon, Gynecologist) .**
- ✓ An operation list for elective surgery shall be made available at least one day prior to surgery.
- ✓ The minimum data set in an operation list should include:
  - ✓ The name of the operating surgeon must be stated for each procedure.
  - ✓ The name of the consultant/surgeon in charge of the theatre must be specified in the list. He shall determine the sequence of the cases and their respective theatres.
- ✓ All elective cases must be reviewed pre-and post-operatively by the operating surgeon.
- ✓ All cases posted for elective surgery shall be optimized and referred to anesthetics prior to listing.

- ✓ Postponed cases should be given priority preferably on the next available list.
- ✓ Scheduling of elective cases should be based on the Guideline of Prioritization of Cases for Emergency and Elective Surgery
- ✓ Negotiated List: Is an elective list that has been agreed upon by anesthesiologists and the surgeons within a stipulated time. It is meant to reduce cancellation of cases. Refer to excerpts of minutes of the meeting

(B) DAY CARE SURGERY

- Hospitals with specialists shall consider Day Care Surgery as of high priority for simple uncomplicated cases.
- To ensure good utilization of Day Care Surgery, hospitals with specialists shall identify index surgeries to be done as Day Care.
- Utilization of this service shall be monitored as per existing guidelines.

(C). EMERGENCY SURGERY

- **As our hospital emergency surgery should be given by specialist surgeon and IESO or in the presence of surgeon**
- The prioritization of surgery for emergency cases is as follows:

(A) Acute Emergency

- Patient's condition, which requires immediate operation (i,e. life threatening situation, failing which life/limb will be lost.
- Surgery may proceed without baseline investigation/patient being fasted.

(B) Emergency

- Patient's condition, who are haemodynamically stable that require operative procedure to be carried out, otherwise life is threatened or morbidity increased.

1. Trauma (<6 Hours): Non-life threatening condition but if the operation is carried out after 6 hours, it will increase patient morbidity and mortality risk.
2. Non-trauma (<8 Hours): Non-life-threatening condition but if the operation is carried out after 8 hours, it will increase patient morbidity and mortality risk.
3. ii. In the event of overwhelming number of emergency cases, elective surgeries may be postponed accommodating them (responsibility of the HOD).

4. Information about long emergency list not brought to the attention of the surgical/anesthesiology HOD to reprioritize the utilization of operation theatre.
5. Absence of a contingency plan to clear long emergency list especially after hours and during public holidays.

(C) URGENT

- Patient's condition, which requires operative procedure within 24-hours otherwise there is increase in morbidity.

(D) SEMI-URGENT

- Patient's condition which requires operative procedure within 1/52 otherwise there may be increase in morbidity.

CLINICAL ISSUES (CI)

- Management of patient with peripheral vascular complication requiring amputation.
- May vary due to local limitation or practice

OPERATION THEATRE

- The attire to be worn in the operating theatre should follow the local hospital guideline.
- Staff who leaves the theatre complex with the OT attire should change on returning.
- All surgeons should follow the "Safe Surgery Saves Lives" guideline.

INFORMED CONSENT

- Informed consent should be obtained for all surgical procedures
- All consent must be taken by the MO or specialist using the appropriate consent form as per Appendix 10, 11 & 12.[14] & [15]
- The use of information leaflet is encouraged.
- Validity and duration:
    - Consent will remain valid until it is withdrawn by the patient or if there is a material change in the circumstances. Refer to existing directive. [10]
- Eligibility and age:

- ✓ In life saving situation, where all efforts to trace the relatives and next of kin have failed, two clinical specialists, one of whom is from the related discipline can give consent for the clinical procedure to be carried out.
- ✓ The consent taken, and the efforts made to trace the next of kin must be documented in the case notes.

REFERRAL SYSTEM

✓ Referrals to a General Surgical Department shall follow the existing FMOH guidelines.

Quality assurance

- ✓ Reporting of perioperative mortalities via e-POMR shall be monitored.
- ✓ All surgical departments with specialist services should conduct clinical audit.
- ✓ Comply with "Safe Surgery Saves Lives" initiative.
- ✓ KPI indicators shall be reported as per policy

Special General Surgery that should be done in our hospital

- ✓ The recognized specialties under General Surgery are Breast and Endocrine, Vascular, Colorectal, Hepatopancreatobiliary, Upper Gastrointestinal, Thoracic and Trauma & Burns Surgery.
- ✓ The development and delivery of each subspecialty of General Surgical Services shall be coordinated and integrated within the General Surgical Services.
- ✓ List of surgical procedures that should be provided by the surgeon is tabulated as per Section V.

1. BREAST AND ENDOCRINE SURGERY (B&E)

- The subspecialty field of B&E Surgery generally covers diseases of the breast and almost all endocrine glands in the body. These include thyroid, parathyroid glands, pancreas and adrenal glands.
- Breast cancer patients, where feasible should be managed through MDT.

- local excisions are required to monitor their performance Using KPI for B&E. Refer to Appendix 13. [13]
- The scope of B&E Surgery is as per General Surgical Services.

2. VASCULAR SURGERY

- The subspecialty field of Vascular Surgery generally covers disease affecting all parts of the vascular system except the heart and the brain. This includes the diseases of the aorta and peripheral arteries, which are the domains of a vascular surgeon. It also includes varicose veins and vascular access for haemodialysis, which can also be managed by general surgeon with adequate training and exposure.
- Other vascular conditions such as vascular malformations and trauma can also be managed by other surgical disciplines with adequate exposure and training.
- The scope of Vascular Surgery is as per General Surgical Services and include non-invasive vascular laboratory.
- Appointments and referrals: Non-urgent cases are seen in the outpatient clinic on an appointment basis. Referrals can be sent in via fax and appointment will be given on the next available slot. Cases that need urgent vascular attention can be referred to the on-call team and will be discussed with the vascular consultant.

3. COLORECTAL SURGERY

- The subspecialty field of Colorectal Surgery generally covers diseases of the small bowel, colon, rectum and anal canal.
- The scope of Colorectal Surgery is as per General Surgical Services; include Endoanal/rectal ultrasound, anal manometry, pudendal nerve latency tests and biofeedback services. The Colorectal unit is involved in training and education of nurses/AMOs, HOs, MOs, specialist and colorectal trainees.

4. HEPATOPANCREATOBILIARY SURGERY (HPB)

- HPB Surgery in the MOH is a dedicated tertiary care service, which provides comprehensive clinical care to patients with diseases of the liver, pancreas and biliary system.

- General surgeons should be able to do damage control surgery for HPB trauma especially liver trauma, which includes perihepatic packing, and haemorrhage control. Subsequently, management should be discussed together with the nearest HPB surgeon, based on the hemodynamic stability of the patient.
- General surgeons performing ERCP need to be trained and credentialed at a high-volume centre.

5. UPPER GASTROINTESTINAL SURGERY

- The Upper GI surgery covers the field of benign and malignant diseases of oesophagus, stomach and duodenum. Surgical management of morbid obesity and clinical nutrition are also a component of this subspecialty.
- The scope of Upper GI Surgery is as per general surgical services, including Bariatric Programme and GI laboratory to study motility disorder & reflux diseases.

6. THORACIC SURGERY

- The Thoracic Surgery Services manage surgical problems related to the disease of the chest wall, lungs, pleura, mediastinum, trachea, bronchus, oesophagus and diaphragm.
- The scope of Thoracic Surgery Service is as per General

7. TRAUMA AND BURNS

- Trauma & Burns care is provided in MOH hospitals.
- The management of trauma will follow ATLS principle.
- Provision of trauma care services shall be as per National Trauma Policy when available.
- Burns care maybe provided by the general or plastic surgeon.

8. PAEDIATRIC SURGERY

- It is an extremely general field as it is determined by age rather than organ specific.
- There exist many similarities between General Surgery in adults and children, but there are also specific differences especially in the field of Neonatal Surgery.

- It must be appreciated that surgeon caring for surgical children must work closely with the Pediatricians, and much of the referrals would come from them.
- Currently Pediatric Surgical Specialist is only present in the following MOH hospitals.
- Provision of services where Pediatric Surgery is available on site is the areas of responsibility of a Pediatric Surgeon which includes General Pediatric Surgical wards, clinic, operation theatres, neonatal ICU (in collaboration with Neonatologists).
- It would be expected that the Pediatric Surgery Services would take overall care of the surgical needs of the children, including neonates. Given adequate numbers of Pediatric Surgeons, this should not pose a major problem.
- There should be provision for rotation amongst the general surgery trainees and junior specialists so that they are more exposed to the differences in handling surgical children.

9. Common conditions that will be seen by general surgeons in these Hospital include.

(a) Appendicitis

(b) Intussusception

(c) Inguinal Hernia

(a) Appendicitis

- Manage and undertake surgery for most children more than 7 years old. If anesthesia support, facilities and OT staff are available, this should be carried out in the facility.
- As this condition is relatively uncommon in those below that age, discussion with the nearest Pediatric Surgical Unit would be prudent in the management and may require transfer to those centres.

(b) Intussusception

- Hydrostatic Reduction is the preferred modality of treatment for intussusception, failing which surgery should be offered.

- There should be an audit mechanism to look at the success rate of hydrostatic reduction and corrective actions should be taken if it falls below the National Standards.

(c) Inguinal Hernia

- This typically occurs in infants and can lead to unnecessary transfers after hours. Ideally, all hernias in premature babies and under 1 year old should be done as quickly as possible to lessen this risk.
- All Inguinal hernia cases under 2 years old should be done by paediatric surgeon and cases above 2 years old can be done by general surgeon.
- The practice of waiting to do herniotomies until certain weight (e.g. 10kg) is not ideal and may lead to being incarcerated. Attempts at manual reduction, if done correctly, should be successful in about 99% and should only be attempted by experienced personnel.

9. UROLOGY

- Management of urological condition:
- In hospital without Urologist:
  - ☞ General Surgeons are expected to provide basic
- Urology Services. In whatever scope it is provided, the surgeon must provide appropriate care and must have undergone some form of training