1.0 PURPOSE: Procedure for defining surgical care, Anesthesia guidelines and safety guidelines to avoid adverse events during the day care surgical process

2.0 SCOPE: The operative procedure is only one part of the total surgical care of the patient. Total surgical care includes establishing or confirming the diagnosis, preoperative preparation, the operative procedure, and postoperative care

3.0 RESPONSIBILITY

3.1 Surgeons

3.2 Nursing Staff

3.3 Paramedical staffs

3.4 Medical Administrators

4.0 ABBREVIATIONS

4.1 NABH: National Accreditation Board For Hospitals and Healthcare providers

4.2 COP: Care of Patients

4.3 OT: Operation Theatre

5.0 PROCEDURE FOR SURGICAL CARE:

5.1 All surgical procedures shall be undertaken by the surgeons as per the list of surgical procedures prepared by the OT in-charge in consultation with the surgeons and based on the list received from the concerned wards on daycare basis only

5.2 All patients undergoing daycare surgical procedure (either routine or emergency) shall have an assessment done preoperatively and a provisional diagnosis and that should be documented.

5.3 The pre-operative assessment shall be done by the surgeon performing the surgery or a credentialed doctor from the team.

5.4 All patients planned for daycare surgical procedure are to get admitted at least 2 hours in advance on the day of surgery to monitor their vitals, medical fitness and preparation for procedure by the ward staff. This period is considered as necessary to make available the OT and required staff assisting the surgery

5.5 The concerned surgeon or a doctor member of his team shall obtain an informed consent for surgery from the patient/relative prior to the procedure. The consent shall be sought after proper explanation of the benefits, risks and complications involved performing the said procedure. In case, the operative plan is changed intra-operatively, a fresh consent shall be sought from the patient/relative.

5.6 All patients undergoing surgical procedure shall be properly identified through MRD number and name and preoperative checklist should be verified by the Pre-OP in charge / OT Incharge.

5.7 Site of surgery on patient shall be marked by surgeon prior to surgery. Preoperative note shall explain the procedure to be performed and should be documented prior to surgery

5.8 Only Doctors qualified by law shall be permitted to perform the procedures. Such doctors shall be credentialed and given privileges to conduct the said procedures in this hospital. The HR, Credentialing and Privileging Committee shall do the needful

5.9 Post-operative notes shall be prepared by the surgeon which includes procedure performed, post-operative diagnosis, plan of care and status of the patients and documented prior to transfer out of patient from recovery area

5.10 The post-operative care plan shall be prepared by the operating surgeon I.V. Fluids, Medications, Care of wound, Nursing care, Monitoring of patient vitals and Observation for complications

5.11 The operation theatre layout shall minimize the mix of sterile and unsterile patients. The OTs shall be cleaned and carbolized/sterilized after every case. All OT staff shall adhere to standard precautions, handwashing, PPEs and safe handling of the patients

5.12 The Operation Theatre complex shall have the necessary facilities for conducting the said procedures, changing rooms, equipments, appliances and instrumentation

5.13 All the patients who are to undergo surgery have full details of their medical condition in their case records. Depending on his/her medical condition the patient may need either elective or emergency surgical procedures

5.14 The elective procedure could either be minor in nature or major. Emergency surgical procedures though usually major, could also be minor in nature

5.15 Surgical patients have the preoperative assessment and the provisional diagnosis documented prior to the surgery

5.16 Before the conduct of the daycare surgery the surgeon examines the patients and makes an assessment of his/her condition based on the clinical presentation of the case, signs and symptoms, and results of the investigations

5.17 A provisional diagnosis is made and this is documented in the patient's case notes before he is taken up for surgery. This is done mainly to avoid adverse events like wrong site, wrong patient and wrong surgery etc

5.18 Daycare surgery cases need to have the following tests done: Hb, Random blood sugar, HIV and HbsAg

5.19 Preoperative initial assessment has to be done for all patients undergoing elective major and emergency operations

5.20 If the surgeon comes across any abnormal findings in the pre operative tests, it has to be documented in the patient's records and this has also to be informed to the patient's relatives

5.21 Apart from the general consent which is obtained routinely from all in-patients, patients undergoing surgery should be informed about the procedure, its probable outcome, and its possible outcome and its probable rare complications. Following this informed consent from the patient is taken. The name of the surgical procedure, site of surgery and complications of surgery should be written in capital letters.

5.22 Patients with cardiac or renal problems are provided with informed consent in his/her handwriting and signed with a witness other than a hospital staff. One of the witnesses should be the ward nurse in charge

5.23 Surgical Patient Preparation:

5.23.1 The patient is prepared for surgery as follows:

5.23.2 The patient's dress is changed to a clean one.

5.23.3 Patients ID tag is kept in place.

5.23.4 The patients depending on their physical condition are shifted to the OT by wheel chair or trolleys

5.23.5 A Staff nurse from the ward accompanies the patient with the case sheet to the OT. The OT nurse takes over the patient after checking the case sheet and making identification and documents.

5.23.6 Here after the OT staff is responsible to take care of the patient till he/she leaves the recovery room.

5.23.7 Once the patient has been received at the OT, his/her dress is changed to sterile OT gown/dress supplied by the CSSD

5.24 All type of surgeries performed in this hospital are by well qualified, experienced surgeons who have had extensive training and expertise in their particular fields. Complex surgeries are sometimes performed by a team of doctors, each dealing with his /her specialty

5.25 Prior to surgery the case file shall be reviewed, the condition of the patient shall be checked and surgical safety checklist (annexure) before provision of local anaesthesia, before skin Incision

5.26 After the surgery is completed, before the patient is transferred back to the ward, the surgeon writes down and documents a brief operative note and post operative plan of care.

5.27 All the events during the stages of anaesthesia are recorded and documented.

5.28 As a quality assurance programme, the OT and its surrounding areas like the recovery room, CSSD etc are under the strict supervision by the infection control

nurse and the hospital infection surveillance team who ensures absolute sterility of the operation areas so as to avoid the risk of transmission of infection.

5.29 The plan also includes monitoring of surgical site infection rates. All the post operative patients shall be screened for the same.

5.30 The hospital infection control team conducts regular documented surveillance which includes monitoring of surgical site infection sites. Culture swabs are taken from infected or suspected wound sites to analyse them with the aim to prevent or reduce the risk of hospital associated infections

ANNEXURE A: SURGICAL SAFETY CHECKLIST

BEFORE INDUCTION OF ANAESTHESIA → **BEFORE SKIN INCISION** → **BEFORE PATIENT LEAVES OPERATION THEATRE**

SIGN IN
Patients has confirmed • Identity • Site • Procedure • Consent
Site marked / not applicable
Anaesthesia safety check completed
Pulse oxymeter on patient and functioning
Does patient have a: Known allergy? • No • Yes Difficult airway/aspiration risk • No • Yes, and equipment/assistance available risk of > 500ml blood loss (7ml/kg in children) • No • Yes. And adequate intravenous access and fluids planned.

TIME OUT
Confirm all team members have introduced themselves by name and role
Surgeon, anaesthesia professional and nurse verbally confirm • Patient • Site • Procedure
Anticipated critical events • Surgeon reviews: what are the critical or unexpected steps, operative duration, anticipated blood loss? • Anaesthesia team reviews: are there any patient-specific concerns? • Nursing team reviews: has sterility (including indicator results) been confirmed? are there equipment issues or any concerns?
Has antibiotic prophylaxis been given within the last 60 minutes • Yes • Not applicable
Is essential imaging displayed? • Yes • Not applicable

SIGN OUT
Nurse verbally confirms with the team: The name of the procedure recorded That instrument, sponge and needle counts are correct (or not applicable) How the specimen is labeled (including patient name) Whether there are any equipment problems to be addressed
Surgeon, anaesthesia professional and nurse review the key concerns for recovery and management of this patient.

Signature of Nurse Incharge Signature of Ophthalmologist Date/time

S No	Record	Responsibility	Retention Period
1	Blood & Blood components – transfusion record form	Doctor Incharge	As per MRD policy
2	Blood & Blood components usage form	Doctor Incharge	As per MRD policy
3	Blood Transfusion Consent Form	Doctor Incharge	As per MRD policy
4	Adverse Anesthesia Reactions Register	Nurse Incharge	I Year
5	OT Nominal Register	Nurse Incharge	1 Year
6	OT Surveillance Register	Nurse Incharge	1 Year
7	Surgical Consent Form	Doctor Incharge	As per MRD policy
8	Anesthesia Consent Form	Doctor Incharge	As per MRD policy
9	Surgical Safety Checklist	Doctor Incharge	As per MRD policy