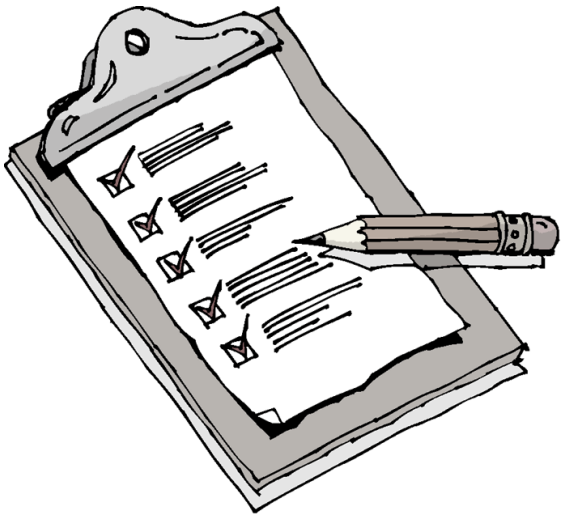
Pre-ops and OR Conduct Code for fellows

(Prepared by Milind Naik, Jan 2021)

OR Check-List

The following points need to be noted for each patient on the OR list. It helps to keep a printout of the list with you, a day prior along with the sequence of surgeries. MN usually plans the OR list sequence by 4pm.



Name/MR No: Correctness against Aadhar card so as to avoid problems with insurance claims. Get into the habit of doing this in OPD itself, if you find obvious spelling errors.

Surgery: Does the posted surgery code cover all components of surgery? Have we missed out on something?

Consent: Signed? Are all possible side-effects mentioned? Double consent for destructive surgeries done?

Investigations: Bleeding/clotting parameters, HTN/DM, aspirin has been stopped?

Viral screening: Has it been confirmed (actual report, not just verbal)

Physician fitness: All moderate/high risk cases: Remind MN to speak to the relative once more in OR about the risk.

Photos: Are recent most photos done and uploaded? Do the photos represent all angles so as to depict the pathology? Are all relevant imaging photos clicked? Did we miss out on uploading scan photos, or any other recent photos?

Imaging: Has the patient been informed to bring along the scan plates? Is the scan relevant and recent? Is B-scan done prior to an evis?
Special preparation: Is any other specialty/medication (Botox/sclerosant, Klein's soln etc)/instrument (lipo cannulas, Navigation,Sonopet etc) required? If yes, keep the OR staff informed 1 day prior.

Intra-op Photos/Video: Any interesting case on the list worth documenting/recording? Inform Video department with an email 1 day prior with CC to MN. Mention MR Number, OR number, and approximate time of shoot as per sequence.

OR Sequence of cases: Go over the sequence with MN once (while in OPD). Counselor would usually have a print copy where MN has jotted down the tentative sequence. Is any adjoining OR going to be free? Is OR-3 faculty on leave? This would allow us more ORs, and timings can change accordingly

OR Day

Arrive early, and prepare: Ensure that one responsible fellow comes inside OR, and ensures all is in place. Download all relevant patient photos to desktop, under a folder MN OR with a dated sub-folder. This will allow quick display of pictures that can be relayed to the big screen.

OR Team: List out the names of fellows/observers with us that day in OR, so assisting line up can be planned equitably.

First case: Ensure the first case is ready, fit, and arrives on time to the OR. This might involve messaging the counselor while you are in the morning class. Ensuring that case 1 begins on time is important, and should commence before 8.30AM on EMR.

Case Display: Prior to each case, write important measurements on the white board, display relevant photo on screen, and relevant CT scan on X-ray viewer. Write your plan or queries you may have, on the white board.

Prilox: For patients under LA, remember to apply Prilox cream at the relevant site of first injection. For supporters and sight savers, apply Prilox at IV line site in consultation with the Anaesthesiologist/OR technician. Prilox works best when applied 45 mins prior, so plan ahead.

Just before Shifting to OR

Manage relatives: Speak to the accompanying person and reassure them once again. Ask them to step out of OR, and have breakfast/lunch. Reassure them that we will call when the surgery is done. Hand them a printout of Post-op instructions, so that they are prepared.

OR Prep: Ensure that the OR is cleaned, sheets have been changed, and nasal O_2 tube is changed (*best to cut and dispose the previous one off so that OR technician is forced to use a new one*)

Inside OR: *Before surgery*

Position on table: Always physically help the patient align on the table correctly. OR tables are very narrow, and risky.

Comfort: Instill paracaine, keep OR lights off until they get adjusted, keep conversation on. Ask if OR temperature is comfortable. Explain anything before doing it.

Timeout: To be done in the accurate manner as described, name confirmed, and facial recognition confirmed from photos.

GA Assist: Always actively assist the Anaesthesiologist in the induction of GA. It will give you an opportunity to learn key steps, or even learn the actual intubation skill. This knowledge will come in handy when you begin your practice and have a solo visiting anaesthesioloigst.

LA assist*:* If injecting local, perform it slow, with overhead lights off. Choose the entry of the first needle poke through Priloxed area.

After induction: Once the patient is induced, the anaesthesia clock begins to tick (medical and financial), so there has to be a sense of urgency. Local infiltration, lip Vaseline, donor site prep, or any other preparation has to be done in a flash, and painting order has to be announced within 120 seconds.

Overhead lamp: Adjust it to the side of surgery, and place it slightly above the patient's intercanthal line. Start with lowest illumination, and gradually increase as the patient gets adapted. Blocking the light with your hand for few seconds can also help adaptation.

Documentation: Mark/Announce the start of surgery.

Inside OR: During *Surgery*

Painting: In relevant cases, paint the entire face (Trichon to Menton, and tragus to tragus). Donor site to be prepped in relevant cases. If approach/incision is transconj, instill Povidone iodine drops in addition to external painting. Avoid ointment if incision is trans-conj.

Conduct during LA surgery: Avoid un-necessary/apprehensive conversations, avoid answering telephone calls, and play music only with the permission of the patient.

Shifting out of OR:

GA case shifting: Use the *safe-slide* sheet to transfer patient from OR table to mobile bed. Actively assist the anaesthesia team in shifting. Send SMS to the RMN (Hello! XXX surgery went off very well! She/he is now in recovery, and shall be shifted out/to the room after a while. Thank you).

LA case shifting: Rub off any eye markings or obvious blood/Betadine streaks. Ensure patient isn't giddy. Walk them out.

Between two cases

Clean: Ask staff to get OR cleaned by housekeeping. Clean ECG leads with alcohol swabs if used.

Dispose: Nasal O_2 tube to be discarded (preferably after cutting into two)

OR Notes: Avoid copy-paste templates. Revise the steps with your surgeon towards the end of surgery, so you know what to write. Write in great details, including deviations if any, with reasoning.

Pathology specimens if any: Ensure packing and transfer (confirm receipt in pathology lab by calling).

Turn off: Overhead lamps and music.

Post-Op Discharge process:

Post-op medications: Confirm all medications with Dr MN. Avoid ointment for trans-conj wounds, and avoid antibiotics/steroids unless required.

Post-op instruction sheet: Ensure they receive a copy.

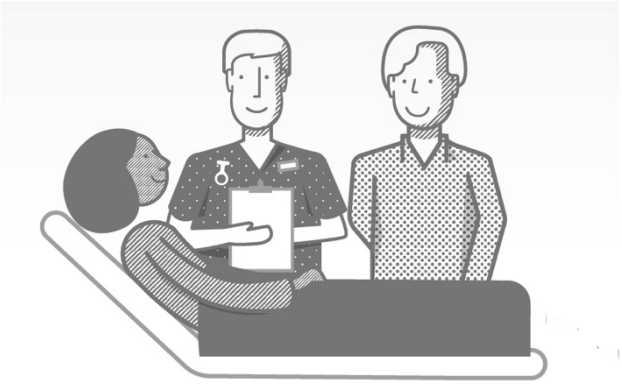
Deluxe/Sightsaver medicine pouch: Always ensure that relevant medications are retained, and irrelevant ones are removed from the pouch before handing over. Always open it and explain the use of each component/medication to the patient's relative.

Discharge summary: Remember, this is a legal document, and any error can invite trouble. Fill it on time, with full attention. Any change of financials/surgery code, check with MN before entering. Take a printout of discharge summary and show it to MN before checking out the patient. Always inform them that Pharmacy is on Level 0.

Belongings: Handover all belongings such as CT scan, prosthesis, etc to the relatives.

Checkout: Always keep a tab on already operated patients in recovery, and step down. Ensure relatives are aware, and ensure each patient is physically sent out of OR without delay. Keep checking on them after each case.

Post Op Rounds:



Visit each inpatient, and call each day-care patient to check they are doing well.

Post-Op Day 1:

OR list printout: Paste a printout of previous day's OR list on the OPD whiteboard to avoid missing out on anyone.

Post-op rounds: Start them early (excuse yourselves from the class 15 min prior if possible).

Post-op photos: Photography room is busy in the morning. After the check-up is done, Inpatients can be sent to room, and asked to return to photography later (before discharge). Day care cases can undergo photography immediately while you wait for the consultant to arrive. Avoid advising irrelevant post-op phptos (evis, DCR, etc).

Wound care: Explain and demonstrate wound care to the relatives. Share wound care video link where external incision has been taken: https://youtu.be/9RU2qf97hOI