Surrey and Sussex Healthcare
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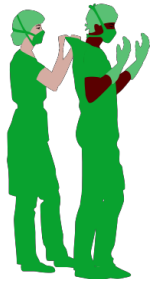

GENERAL SURGERY HANDBOOK

Updated: July 2020

Contents

Teams

LGI – Grabham/Day/Shihab

2 FY1s, 1 CST, 1 SpR

LGI – Smith/Campbell-Smith/Al-Khusheh

1 FY1, physician associate, 1 CST, 1 SpR, 1 Trust Reg

UGI – James/Maheswaran/Belgaumkar

2 FY1s, 1 CST, physician associate, 2 SpRs, 1 Trust Reg

UGI – Jethwa/Monkhouse/Carswell

1 FY1, 1 CST, doctor's assistant, 1 SpR, 1 Trust Reg

Breast – Pogson/Waheed/De Silva/Suleiman

1 FY2, 1 GPST, 1 SpR

Vascular – Loosemore/Rodway

1 Trust Reg

General Surgery On Call

Shifts:

Day on call: 08:00-20:30
Night on call: 20:00-08:30
Twilight: 16:00-23:00
Weekend General Surgery: 0800-2030/ 2000-0830
Weekend urology WR: 08:00-16:00

On call duties

You need to take the bleep (SHO-838, SpR – 839) and attend handover at 8am. Morning handover during the week is in the PGME Medical Student Room. For Saturday & Sunday morning handover, check with your consultant on call. It may be in SAU (Tandridge ward) , the surgical office or Med Student room. Evening handover occurs in SAU at 8pm.

Please take referrals and record this on the take list (kept on the SAU computer). These referrals are from ED, GP, new referrals from other departments in hospital and from other hospitals as well. Some patients may need to be transferred to other hospitals after being seen and/or treated. Please refer to guideline on the board next to computer in SAU for updates. It is the On Call SHO's responsibility to keep the take list/handover sheet up to date and ensure all patients on the take list are handed over. See the patients, clerk and complete drug charts & VTE for those requiring admission, order and chase necessary investigations and make a management plan. Print copies of the list for handover.

Attend trauma calls in ED resus – make sure you sign in, and then await direction from rest of team. You may be asked to do the primary survey / get access / request imaging / leave if surgical input is not indicated.

On call shifts cover SAU and CEPOD. CEPOD is in theatre 8 – Put on scrubs, hat, clogs and go to theatre 8. Introduce yourself to theatre team and brief about the cases you are planning to do. Ensure that the consultant on call is aware of any case being done on CEPOD.

All investigations are requested and followed up on Powerchart. The blood results may be available earlier on `apex`. Shortcut is available on desktop. Enter username and password to login followed by patient details to display blood results. Radiology investigations including US and CT/MRI need to be discussed with radiologists first. For out of hours requests for CT scans, it has to be approved by Everlight. Speak to switch board to put you through to Everlight, obtain a reference number and discuss with radiologist. After approval, bleep radiographer on 567 and let them know.

There is a hospital at night meeting at 2200 in the Ops centre. It is a good opportunity to highlight any problems, discuss serious patients and obtaining input from intensivists/ medical Spr.

In the morning after night shift, ensure list is comprehensive and print at least 10 copies (comes through to printer in SAU reception). Be in handover room by 8am, and get onto the laptop at the front of the room to get up any scans to show consultants.

There should be a `Golden patient` booked, consented and ready to go to CEPOD at 0815 to minimise time lost in the morning.

UGI handovers from colorectal are taken by

Monday – Monkhouse team

Tuesday – Maheswaran Team

Wednesday- Jethwa/Monkhouse team

Thursday- Jethwa/Monkhouse Team

Friday – Maheswaran Team

Unless they are already known to a particular UGI consultant in which case they are handed back to them.

Patients who are known to a specific team are handed back.

UGI handovers e.g cholecystitis, pancreatitis, & UGI cancer proven on imaging e.g US, CT.

LGI handovers e.g diverticulitis, PR bleed, Colorectal ca proven on imaging or known problem with recurrent symptoms.

Consultants are on call from 8am-8am, but actually see patients admitted overnight from 8pm the night before on PTWR then next day.

Handover Sheet (updated daily from 8am -8am next morning)

- **Take section** – includes all new patients referred/admitted and waiting to be seen. The details includes patient name, MRN, DOB, age and

gender, there updated location in hospital, brief history, examination, PMH, important investigation results and management plan. It is worth documenting about the doctor who has actually seen patient. There is separate section for day take and night take on handover sheet.

- **Ward patients** – admitted patients under other surgical teams, sick patients who the take team should be aware of, or who deteriorated overnight and need to be handed over to the teams looking after them
- **SAU Reviews/TCI** - Please put patients returning to SAU/CEPOD for review at the top of this section, with the time of their review and any imaging/bloods requested. There are 3 US and 1 CT imaging 'hotslots' for surgical review patients on weekdays. Children, testicles, and hernias cannot be scanned on the US hotslot unless agreed by radiology.
- **Home** – patients that have seen/treated and discharged home. Please put patients returning to SAU/CEPOD for review at the top of this section, with the time of their review and any imaging requested
- **Urology patients** – these should be recorded separately

Support

There is a SAU registrar (bleep 401) available to support the on call SHO 10:30-17:30 on weekdays.

The On Call registrar (bleep 839) will usually be operating on CEPOD or reviewing patients, but will also be available for help 24/7.

If you struggle to get hold of help please look for the On Call Reg in CEPOD (Theatre 8), and look for help on the ward/elective theatres. If you still cannot get help you should get hold of the On Call consultant via switchboard.

The twilight SHO is there to help clerk patients in the busiest part of the day. Please make sure to hand over the patients you have seen. SHO twilight shifts work Monday to Friday 1600-2300.

All patients should be seen by a SpR within 12 hours and a Consultant within 24 hours. Patients can be handed over to other teams after discussion at handover or after being seen on the PTWR.

On call SHO covers general surgery and urology. However, there are separate registrars for general surgery and urology. Urology registrar can be reached via switchboard for advice on management of urology patients.

Urology Weekend Ward Round

The instructions for the weekend SHO are in the Buckland doctor's office, where the weekend ward round commences. The weekend SHO is on bleep 680, and they should get a copy of the urology take list from SAU, and update the Urology list (on the Buckland office computer) with take and elective admissions before ward round starts (usually 08:30-09:00).

Any jobs or clinic appointments to be handed over to the urology juniors should be added to the bottom of the urology take list.

Training

Normal duties

Please work within your own teams to ensure there is adequate F1 and senior cover. It is essential to co-ordinate leave to avoid leaving the

team short, or seek help from other teams to cover if this is unavoidable.

During ward rounds, one person do curtain / obs charts, drains including NG tube, drug charts and review medication lists antibiotics and VTE prophylaxis. Other person writes legibly in patient`s medical notes with name of the consultant, date and time and detailed plan in legible writing. Include reasons for starting, stopping or changing medicines. Bleep number should also be included and should be legible

SHOs and SpRs can usually attend elective lists in ESH and Crawley, participate in CEPOD activities, and attend clinics, but please make sure the juniors on the team have sufficient support to complete ward jobs and manage sick patients on the ward.

Theatre assistants are frequently required for weekend and other lists, and these will usually be emailed to you.

DSU lists in Crawley are available for training and core trainees will be allocated to these. Please try and swap if you can't make it, or let a consultant know so alternative assistants can be found.

Checking Theatre/Clinic lists

You can use Appointment Book and Surginet on Cerner in order to see upcoming operating and clinic lists, and you should check these as there is sometimes deviation from the Theatre & clinic lists included in this handbook.

If you are attending an elective list you should see and consent patients beforehand in the Surgical Admissions Unit next to endoscopy department.

Friday Journal Club

Every Friday morning one of the juniors is expected to present a paper for discussion. This is a consultant-led meeting and excellent preparation. The rota for this can be found in the surgical office on board next to registrar desk. If you are away for your slot it is essential that you swap this with a colleague. You are recommended to avoid selecting a meta-analysis, but all other papers are fair game. A simple method of evaluating clinical literature is to follow "PP-ICON" approach- Problem, Patient or Population, Intervention, Comparison, Outcome, Number of Subjects, Statistics. Talk to your registrar if you need guidance.

Cancer MDT

LGI MDT is on Tuesday mornings at 8am, and UGI MDT is immediately after. This is held in the MDT room at the back of the Postgraduate Education Centre. (the room is small so only essential MDT members are allowed at the meeting at the moment)

SHOs and Registrars are expected to present the MDT patients during usual times, please sign up to the rota in the surgical office and request access to the somerset cancer registry. During the pandemic consultants are presenting cases. The list of MDT patients will be available in the surgical offices in a trolley on a Friday afternoon. Email lisa.newman2@nhs.net from your trust email to get a login for `somerset` (database where cancer MDTs are kept) and then click on the link in the email to download the application onto your desktop. Login and then find the patient by hospital number. You will need to summarise the patient details and question to be discussed in the "presentation" section. Include age/gender, consultant`s name, BG,

PC, Examination findings, related investigations and questions for MDT.

Benign MDT/ X-ray Meeting (Currently cancelled due to Covid)

Occurs every Tuesday at 12:30 in the radiology department seminar room. There is a free lunch sometimes. Any discussion should be documented in the patients notes if an inpatient or a letter done for the system if an outpatient.

Morbidity and Mortality meeting (M&M)

The M&M meetings occur every month. The rota can be found in the surgical office, again please sign up for this. Presentations are usually prepared by the F1s and physicians associates, but the SHOs are expected to present a relevant national guideline monthly. The patients who need to be discussed should be identified from the discharge list. Generally readmissions/ delayed discharges / all returns to theatres and all deaths are discussed. Major morbidities including anastomotic leaks, bile leaks, VTE events, MIs, CVAs and SSIs are also discussed. Discuss completed months preceding ie if meeting is on 19/06/19, discuss all patients discharged in May. If they are still inpatient then they are discussed in month they are discharged. All the consultants should also be asked if there are any cases they would like to be discussed.

Ask secretaries to get you patient notes. Then prepare 1-2 slides per patient and show them to SHO/Reg. Adding pertinent imaging pictures can be helpful. There is a template available for M&M presentation with the colorectal secretaries. All the presentations are to be

forwarded to Mr Day on Andrew.day1@nhs.net and a copy to be uploaded to the PGEC presentation folder for presentation on day of M&M meeting.

Clinics

If you are expecting to assist in clinics you will need to request access to dictate IT. Please organise this through the surgical secretaries. All core trainees should sit in clinics weekly with a consultant. They can attend any clinic, not just their own team's.

Working on Dictate IT: Log in, "Speech" to dictate letter once pt info has been inputted (ensure on correct pt encounter), Push button up to record and down to rewind and record over mistakes, "Complete" once done. Once letter has been transcribed, you need to log back in to e-approve them (on the tab at the bottom of the page) and correct any amendments.

Teaching

Most teaching in surgery is on the wards, in clinics and theatres. Regular core teaching can be reinstated if a suitable time is identified by the core trainees, which they can and will come to. This will be discussed at induction. It will be aimed at MRCS and CST's are the priority.

There is a laparoscopic trainer in the PGME centre set up in the resus training room. Please obtain keys from pgec reception. A new surgical skills lab is in the process of being built.

You will also have the opportunity of monthly 1-1 sessions with the Surgical Tutor to review your progress and facilitate training goals, but this is not a substitute for your AES meetings.

Every Wednesday at 1300-1400, there is Surgery F1s teaching conducted by SAU registrar. Usually topics of common interest are discussed in the form of presentations and a feedback is given for evidence of teaching for portfolio. Topics and rota are usually emailed ahead of time.

Audit

There is an opportunity to carry out audit and QIPs in surgical department. Proposals are to be discussed and agreed by the consultant/supervisor and formally submitted to audit department. This could be done on intranet datix web audit tool by completing the online form and obtaining a reference number. Completed audits are presented in departmental meetings/presentations.

Hepatobiliary referrals

Transfer over images to Royal Surrey by calling IEP on ext 6714. Call HPB reg at Royal Surrey via switch board and speak to them – if very urgent speak to on call reg who can speak to on call consultant for HPB or will direct you to who to call (sometimes HPB consultant directly via switchboard).

For EUS, write a letter to Mr Tim Worthington, HPB consultant surgeon at RSCH . Secretaries can send it across to his secretary for you.

Theatre Lists 2019

Week 1	
Monday AM	PM
Mr Campbell-Smith Endo (CRW)	Mr Campbell Smith (CRW)
Mr James (CRW)	
Mr Belgaumkar (ESH)	Miss Carswell (ESH - 19:00 finish)
Mr Grabham/Mr Day/ Shihab (ESH - 19:00 finish)	
Tuesday AM	PM
?Shihab	Mr Monkhouse (CRW)
	Mr Day Endoscopy
Miss Waheed (ESH) PA 9	Mr Smith Endoscopy Miss Pogson ESH
Mr Maheswaran (ESH – 19:00 finish)	
Wednesday AM	PM
Mr Alkusheh/Day (ESH)	Mr Suleiman (Crawley)
	Mr Smith Endoscopy
Mr James (ESH 19:00)	
Thursday AM	PM
	Mr Day (Crawley)
	Mr Maheswaran Endoscopy
Mr Campbell-Smith (ESH – 19:00 finish) Ms De Silva Crawley 1400-1900	
Friday AM	PM
	Mr Jethwa (ESH – 19:00 finish)

Week 2	
Monday AM	PM
Mr Jethwa (CRW)	Mr Belgaumkar (CRW)
Mr Campbell-Smith Endo (CRW)	Mr Maheswaran (ESH – 19:00 finish)
Mr Grabham/Mr Day/ Shihab (ESH – 19:00 finish)	
Tuesday AM	PM
?Shihab (ESH)	Mr Jethwa (ESH) ?Shihab (ESH)
	Mr Suleiman (CRW)
	Mr Day (ESH)
	Mr Smith Endoscopy
Miss Waheed (ESH PA09)	
Wednesday AM	PM
Mr Rodway (ESH 06)	Mr Smith Endoscopy
	Mr Belgaumkar Endoscopy
Mr Alkusheh (ESH 04 19:00 finish)	
Thursday AM	PM
Mr Rodway (CRW 13)	Miss Carswell
Mr Day Endoscopy	Mr Maheswaran Endoscopy
Mr Monkhouse (ESH PA09)	
Mr Smith (ESH 04)	
Mr Shihab (CRW wk2pm, wk 4 all day)	
Friday AM	PM
	Mr Jethwa (ESH – 19:00 finish) Miss de Silva (ESH)

Clinics

Week 1	
Monday AM	PM
Miss Waheed (ESH)	
Tuesday AM	PM
Miss de Silva (CRW)	Mr Khemani (ENT) Mr Campbell-Smith (Horsham Clinic)
Wednesday AM	PM
Mr Smith	
Mr Belgaumkar	
Thursday AM	PM
Miss Pogson	
Friday AM	
Mr Jethwa /Mr Maheswaran /Mr Day / Mr Monkhouse/ Miss Carswell CRW pm	

Week 2	
Monday AM	PM
Miss Waheed (ESH)	Mr Campbell Smith (ESH)
Mr Belgaumkar (CRW)	Mr Smith (Crawley)
Miss Carswell (ESH)	
Tuesday AM	PM
	Mr Khemani (ENT)
	Mr Belgaumkar,
Wednesday AM	PM
Mr Smith	Mr Monkhouse
Thursday AM	PM
Friday AM	
Mr Jethwa /Mr Maheswaran /Mr Day / Mr Monkhouse	

General Guidelines:

1) There should always be senior help available to you on the ward. Escalate to your team SHO -> team Registrar -> On Call SHO -> On call registrar -> On call Consultant. Look for help in CEPOD Theatre 8 or SAU if you are unable to get through via bleep / mobile
2) The FY1 is encouraged to attend theatre lists and clinics in addition to their SAU clerking afternoon.
3) Check pre-admission medication with the patient or carer and the summary care record. If in doubt, consult a pharmacist. Do not document at the back of the drug chart as this is for pharmacy use only.
4) Antibiotics MUST have indication and duration/review date written on each prescription. If not sure, ask the person who wants antibiotics prescribed
5) Please review the drug charts daily basis so IV drugs can be stopped or converted to oral substitutes, and antibiotics can be changed/stopped appropriately
6) Ensure all patients who need them have enough IV fluids to last overnight, plus any Warfarin prescription is done to prevent the night SHO being asked to complete this.
7) Please keep up to date patient lists for your firm, and prepare Weekend plans for each patient on a Friday
8) Whenever possible TTOs should be prepared the day before discharge
9) Make sure all TTOs are prepared on Friday for any patients due to go home over the weekend
10) Contact the GP by phone if there is a strong possibility the GP will need to see the patient before a discharge summary is issued.
11) Post-op haemoglobin is measured at 48 hours. It is unnecessary after minor ops, for example appendicectomy or hernia

repair, and in other cases should be done after discussion with the Registrar. Daily full blood count and U&E's are not helpful.

12) Any difficulty obtaining radiological investigations out of hours should be discussed with the on-call Consultant Surgeon.
13) Remember that good communication with the nursing staff is vital. Make sure they are aware of any changes to the patient's plan. Nurse led discharge occurs on some wards for certain patients.
14) Whenever in doubt, seek help from colleagues around/ refer to trust guidelines on intranet.
15) It is always a good idea to run through list in the afternoon, usually around 1500 with the team to follow up with results, patient reviews and outstanding jobs to be done.

Discharge summaries:

All discharge summaries/EDS are done on Cerner. Use your computer login to log in. Generally they should include advice on:

- Wound closure – usually dissolvable stitches so advise to avoid soaking in a bath for a week but can shower and splash wash.
- Clips – usually taken out at 7-10days by GP practice nurse.
- Generally no heavy lifting over 7-10kg for 2weeks following laparoscopic procedure and 4-6 weeks following open surgery.
- Patient can drive once able to emergency stop without hesitation; need to tell insurance company/DVLA about operation. It`s not advisable to drive after elective procedure done under general anaesthetic as a day case procedure.
- As per NICE guidelines, all laparotomies over 90min or cancer resections need VTE prophylaxis for 28 days.
- Dietary advice- e.g after anti-reflux surgery, diverticulitis etc

- Follow up plans – if any. Whether to be seen in clinic or SAU review for drain etc
- Changes to medication and duration of new medicines

Weekend handovers:

There are 2 consultants (1 Upper GI and 1 Lower GI) and 2 F1s on Saturdays to do the ward rounds. The Friday consultant stay on Saturday to do their specialty rounds until 1100 after which the weekend consultant covers the remainder of Sat & Sun with 2 F1s on Sundays along with on call SHO and Registrar to see all inpatients over the weekend. So weekend handover from your patients should be precise.

- Make sure problem list is up to date
- Remove jobs that don`t need doing
- Only request bloods as necessary –mostly on Saturdays.
- Start all patients discharge summaries on PTS.
- Handover only the most important things only
- Complete as much tasks as possible before weekend.

Writing in medical notes

1) All entries should be in black ink.
2) Every page must carry the patient's name and number/ d.o.b
3) All entries should carry a date and time.
4) All entries must be signed and carry identification and bleep number and GMC number.
5) Details of source of admission should be recorded.
6) Details of source of history should be recorded.

7) Social circumstances should be documented
8) A list of drugs and doses should be recorded.
9) A flow-chart of investigations should be recorded and ticked with comments on significant results.
10) Management plans should be recorded.
11) The operation sheet must be completed.
12) The time of operation should be recorded in the notes.
13) An entry should be made every day even to note no change
14) DNAR and ceilings of care should be recorded after discussion with relatives and signed by the consultant
15) Drug charts should be completed legibly in capitals and in black ink, and each prescription should be signed and dated
16) Allergies should be recorded in the notes and on drug chart
17) When a patient is medically fit for discharge, this must be clearly stated in the notes. Expected date for discharge in the daily record is also helpful for planning
18) The discharge letter must be completed
19) Details of a death certificate should be recorded in the notes.
20) Death certificate/ crem form is usually completed in Bereavement office (East entrance) and death summary is recorded on pts for discussion in M&M meeting.
21) Discuss and agree with consultant about causes of death as 1a, 1b, 1c and 2 before putting it in the death certificate.

Outpatient follow up

Uncomplicated patients following hernia repair, appendicectomy, varicose vein operations, laparoscopic cholecystectomy do not generally need routine follow-ups made. They will be seen by their GP.

Otherwise, please discuss with your team whether or not a follow up is required, and at which OPD it should be.

Follow up for SAU patients should be booked with the ward clerk

SAU reviews:

Patients can come in for a review in SAU once discharged if we are worried about them. Generally it is a good idea to get them in after the ward round – from about 10am. Put it on their discharge summaries and go to SAU and add them to review folder – you will need patient details and details of who to contact. If they need bloods before then give them a blood form and ask them to go to phlebotomy then go for a coffee (as blood results take at least an hour to get back) then come to SAU for set time. Leave patient on bottom of list and on day they are for review remind Reg/SHO they are coming in.

Vascular follow up:

Intermittent claudication	No op.	1st visit/ Vas. Lab	6/12	Discharge	SOS
AAA	Post-op	6/12	12/12	Discharge	SOS
Occlusive disease above inguinal lig. No distal disease	Post-op	6/12	12/12	24/12	Discharge
With distal disease	Post-op	6/12	12/12	24/12	Discharge if no symptoms See 6/12 if claudicating

Fem./pop synthetic graft	Post-op	3/12	6/12	12/12	24/12 Discharge See 6/12 if claudicating
Fem./pop vein graft	Post-op	3/12 vasc lab	6/12 lab	12/12 lab	As above
Diabetes Renal grafts Carotid grafts	Long term 12/12				

Booking Endoscopy/Colonoscopy/ERCP

Outpatient colonoscopy booking

All request forms filled in completely with hospital number and telephone details and either discussed and booked on the endoscopy unit or given to secretary if non-urgent these need to be validated by your consultant.

High Yield Indications:

Iron deficiency anaemia; inflammatory bowel disease, CIBH with increased bowel frequency and loose stools; or colorectal cancer diagnosis or surveillance -Investigation of choice is colonoscopy

Low Yield Indications

Altered bowel habit with constipation; or abdominal pain

if < 55 years with fresh PR bleeding for flexible sigmoidoscopy

if > 55 years d/w consultant as total colonoscopy may be more useful (it should discover the polyps found incidentally in 20-30% of this age group).

There is a long wait for endoscopy so please indicate this to the patient. All urgent cases should be discussed.

NB. Stop iron one week before procedure. Discuss diabetics and patients on warfarin.

Inpatient Endoscopy Referrals

Complete inpatient request form, and give in to endoscopy. Patients are added to the next appropriate list. The endoscopy unit will telephone the ward concerned or instruct the referring doctor as to when the procedure may be carried out.

It should not be assumed that the procedure will be carried out immediately a request form has been completed, also these procedures may be deferred at short notice if there is no available time left in a session.

It is critical to the safe running and management of the endoscopy unit that they are notified, in advance, of any infection risk posed by an inpatient. The unit may refuse to carry out a procedure if this practice is not rigorously adhered to. Any suspicion of MRSA, Clostridium Difficile, HIV, Hepatitis, T.B., CJD or any other communicable disease has implications for the reprocessing or endoscopes and potential cross infection of patients. It also protects your colleagues.

In the event of an Emergency procedure being required, i.e. variceal bleeding, bolus obstruction, any list may be interrupted but the Consultant must liaise with the Nurse in Charge of the Unit or the clinician undertaking the endoscopy list at that time.

Following an inpatient endoscopy a report will be filed in the patient's notes, with a summary of the findings and recommendations for future management.

ERCP

Lists are on Tuesdays and Thursdays and patients need to be approved by Dr Stenner / Mr James.

Ask to book ERCP and be ready to provide the following information:

- Patient details
- Indication for ERCP
- USS or CT results
- Comorbidities, PMHx & PSurgicalHx (particularly gastric)
- Blood results (FBC, U & E, clotting & LFT's)
- Urgency

Patients will need: Venflon in right hand; no food from midnight, clear fluids till 2 hours before procedure. Ciprofloxacin 750mg po on morning of procedure; INR<1.4 (give Vit K 10mg IV for 3/7 if INR raised or jaundiced). Consent will be done in the department. Check amylase and FBC the day after

Booking patient for Surgery

Inpatient – Emergency booking for CEPOD see below.

Outpatient- All elective surgery is now booked through CERNER eTCI. Discuss with senior team members if unsure. Yellow TCI cards are no longer used.

Working in Breast Surgery

General guidelines:

- Know your consultants and familiarise yourself with Breast Secretaries, Breast Care nurses, MDT and theatre list coordinators. Go through your consultant's timetable and look up for clinics and theatre lists.
- Make sure that if you are going to be absent for clinic (for on call/zero day/annual leave) that the secretaries know so they can cancel the clinic. Also check through which days they have theatre (e.g. Miss Waheed is on Tuesday) and again if you are absent you must email Jay Frost (rota coordinators) and ensure that they cover theatre with a theatre assistant if SHO and SpR are absent.
- Pick up your bleep (SHO 267, 207 and SPR 683). You have to answer them for inpatient referrals.
- Find out when your first clinic is and try to sit in with someone's clinic prior to this
- New clinic- See new referrals from GPs under TWW, take full history, examine patient. Discuss patient with consultant. Come up with plan, request imaging/investigations as appropriate and dictate letter
- Follow up clinic- Review previous notes/referral letter, check MMG/US results on computer, see patient and examine, make plan, request imaging if needed, dictate letter.
- Final draft of MDM is usually emailed on Friday morning. Attend MDM every Monday at 1300 in PGEC lec theatre, which you have prepared +/- rep lunch. Once MDM finished,

complete outstanding ward jobs. If you are not around to do MDM prep you need to liaise with the other SHO / SpR and if no one is available to do it, you must inform in advance.

- Admin – complete MDM additions, ensure clinic letters are e-approved, review ward referrals, endorse results, chase outstanding jobs from inpatient list etc.
- Ask all consultants whether they have morbidity and mortality patients and present these at monthly M&M. Ms Waheed has a power point proforma that can be used to prepare.
- Check when breast SHO is due to do Friday morning journal club (see print out timetable on wall of surgical office next to the computer on the right hand side) and prepare accordingly
- Ward referrals come in either via bleep/1:1 handover from on call team/via Mandy. Find out reason for referral, see patient and examine. If need imaging, then <40 y/o need USS only, if >40 y/o request bilateral MMG and US of 1 breast – only the breast team can request breast imaging, so if the ward team have already done it you will need to contact breast radiographer and put in a new referral. Add patient to inpatient list and distribute to other breast team members.
- Discuss with consultant (if patient lives in Crawley area, discuss with Mr Suleiman/Miss De Silva, if patient lives in East Surrey area, discuss with Miss Waheed /Miss Pogson) and review with them if necessary. If known to breast care nurses then consider letting them know that the patient has been admitted or had a complication post op. Review patient daily if required. If they need an outpatient apt booking, then contact either Mandy or Gill to arrange this

- If there are overnight stays from theatre, review them daily until discharge and keep consultant aware of progress. You're in charge of doing their EDS
- Keep up-to-date inpatient list and ensure that any imaging requests remain on list until done, once done review results and act on this as required.

Reg work-Pre op checklist:

Pre-op:

You need to see the patients and do the following:

- **Consent form** is usually done in Clinic (White form – standard form for various procedures for breast) check that it is in the notes take it out and put it in the theatre pack.
- **Mark** the side of the surgery with an arrow on the shoulder. If they are having WIDE local excision and have a palpable lump you must ask them where they can feel the lump a put a circle around the palpable lump. Some patients may have wire placed before procedure and radioisotope injection for nuclear medicine studies prior to coming for operation.
- **Binder** –(not all consultants use binder)Remind the patients that they will have a binder on which they will remove in 48hrs and to leave the dressings on and shower around them until Clinic OPD and not to get the dressings wet. Tell them that some patients like to keep the binders on for longer for support that is fine. After the binder is off to go into a good supportive bra/sports bra but no underwire.
- **Drain**- If they have a drain age >65y SASH at home with see and review drain and remove when drainage, 50mls in 24 hrs. If <65yr put that Breast Care Nurses will be in touch and explain how to manage the drain.
- **Sentinel node**. If they are having a sentinel node biopsy then to remind them that their wee/bowels will be green/blue for a few days and the skin of the breast will stain blue and the skin

stain can last for a few months. Tell them that the armpit will be sore and patients get numbness/tingling across the shoulder and down to the elbow because of nerves near the nodes which will settle in time.

- **Sick Note**. Make sure you have asked them if they need a sick note and give them one sign them off for 2 weeks (May be useful to get hold of a few before you see patients pre-op)
- **Driving**. If they ask about driving after surgery DVLA say they can drive as long as they are comfortable doing an emergency stop which can be approx. 7-10 days after surgery.
- **Phone call**. Tell patients that they will be seen in recovery but not all patients remember coming so if they want to phone a relative after surgery we can. After surgery if you do the call you just need to say-the operation has gone well and she will be going to surgery centre when they will be contacted to come and pick up.

Post op discharge summaries for Breast Surgery patients-put the following in the text

- Put operation that has been done etc from theatre list
- All patients to go home with 3 days of Cocodamol 30/500 2 tabs QDS if they are ok with that otherwise tell them Paracetamol/ Brufen is fine and to take that regularly for 1 day and then see how they feel
- Remove binder in 48hrs remainder dressings stay until Clinic OPD **UNLESS** have a mastectomy/Axillary Clearance in which case if age >65yr put SASH at home with see and review drain. If <65yr put that Breast Care Nurses have given drain information regarding management
- Clinic OPD with is usually arranged via secretaries, seen in a post op clinic on following week

Clinical Guidelines

1 Emergency Surgery Guideline

Booking patients on CEPOD: booking on cepod can be done on computers in SAU or computer outside CEPOD theatre. CEPOD application can be accessed on intra-net, in applications. It will open in Google Chrome – follow instructions and login as guest once prompted. Enter patient details and procedure, fill in POSSUM score for laparotomy and check for entry into NELA, Add a note if needed. Bleep on call anaesthetist (930) and CEPOD coordinator (808) Th8 ext 1369 .

The anaesthetist will want to know about PMH, DH and fasting. Inform on call reg/Consultant about the booking and consenting with operative plan.

In emergency cases such as severe shock with major trauma, or respiratory obstruction (for example after thyroidectomy), the cepod anaesthetist (bleep 930) and surgical registrar (839) should be contacted immediately.

1) As a general rule, any seriously ill patient must be discussed promptly with the consultant.
2) Theatre guidelines dictate that only life-threatening surgery is performed out of hours (after 22:00 on weekdays and out of hours on weekends). Such cases must be discussed with the consultants in surgery and anaesthetics as per theatre guidelines.
3) All patients >65 undergoing major emergency abdominal surgery are to have a CVP line + urinary catheter preoperatively. Seriously ill patients require a triple lumen line.

4) No anuric/uraemic (urea >18) patient is to proceed to theatre without discussion with the Consultant first.
5) The standard investigations for suspected peritonitis are: FBC, U&E, clotting, G&S, amylase. A contrast enhanced CT should be requested (& discussed with radiology) as 'Code Laparotomy' and should then be performed within a hour. If delay is unavoidable due to workload or very low EGFR, then erect CXR and supine AXR should be requested.
6) Physical rather than chronological age will determine which patients receive an operation and patients may well be transferred if stable and no on-site Specialist Vascular Surgeon is on-call.
7) The regional vascular centre is at St George's Hospital and all acute emergencies should be discussed with them. The vascular team at ESH can be contacted for advice during daytime hours.
8) No inpatient should be transferred to another hospital without discussion with the Consultant and preferably only once the Consultant has seen the patient.

Splenic rupture:

1) Splenic rupture should be suspected in trauma patients with left upper quadrant tenderness, and shoulder tip pain, especially if there are fractured lower ribs.
2) Hypotension may be delayed and a tachycardia should be treated with suspicion. Patients should be kept on ½ hourly observations, nil by mouth until a scan has been done.
3) 90% of children can be successful managed conservatively avoiding the risk of lifetime sepsis.
4) Criteria for conservative management are:

a. blunt trauma
b. isolated splenic trauma (grade1-3 on CT)
c. no haemodynamic instability

d. alert (no head injury/intoxication)

5) Patients treated conservatively should be kept on a high dependency unit, nil by mouth for 24 hours after transfusion stops. CT is undertaken at discharge and at 3 months.

2 Pre-Operative guidelines

1) Check list is correct
2) Consent obtained (see Consent Guideline).
3) Operation site marked (or stoma site on both sides)
4) Blood available if necessary (see Blood Guideline).
5) Intra-op tests booked (eg X-ray, cholangiogram, frozen section)
6) Heparin prophylaxis written up (see Guideline)
7) Antibiotic prophylaxis written up (see Guideline)
8) Implants available in Theatre
9) Bowel preparation complete (see Guideline)
10) Anticoagulation such as warfarin, DOACs, and clopidogrel usually need to be stopped before surgery, aspirin can often continue, but check with your consultant and discuss this with them **early.**

Pre-operative assessment

Objectives:

- To establish that the patient is fully informed and wishes to undergo the procedure.
- To establish that the patient is fit as possible for the surgery and anaesthetic

Questions to be asked:

- Does the patient still want surgery?

- Has there been any change in the clinical condition of the patient with regard to that particular surgery (e.g. If a patient is listed for inguinal hernia repair please make sure the patient has an inguinal hernia)
- Any comorbid conditions which would increase the risk of anaesthesia and surgery
- Please check list of current medications (Warfarin, Aspirin, COCP, Steroids etc)
  Please make sure all the relevant investigations are available

  There is no substitute for thorough general and systematic examination.

  If in doubt, please ask.

Cancellation

The Junior Anaesthetist is not able to cancel patients unless they have first discussed this with their Senior and the Surgeon whose operating list it is. Children are to be seen on the Ward before they are cancelled.

Patients who are seen in the pre-op clerking and do not seem any longer to need their surgery, should be discussed with:

- The Surgeon if it seems their surgery is no longer indicated
- The anaesthetist if they are medically unfit, or failing this the on-call Registrar in Anaesthetics.

Scheduling lists

1) Children and diabetics first

2) Day cases first on afternoon lists
3) "Dirty" cases last (eg proctology, abscesses)

Preoperative investigations

- FBC Hb only when anaemia is suspected or significant bleeding is expected.
- U&Es Only when indicated e.g. on diuretics, patients with renal failure or electrolyte disturbance or i.v.i. > 24 hours.
- CXR Only if history or examination reveals significant cardio-respiratory symptoms or signs, in which case lung function tests are more appropriate.
- ECG Unnecessary unless over 65 years or significant cardiac symptoms. Previous ECG within one year acceptable if no change in cardiac status during that period.
- Clotting studies for:
    - All patients on anticoagulants (if screen send INR only)
    - Jaundiced patients
    - Patients for ERCP/PTC
    - Patients for percutaneous biopsy
- LFTs Known or suspected malignancy, jaundiced patients, Chronic illness, Gallstone disease

Ordering blood products

If INR is deranged (eg >1.4) and patient needs urgent surgery please discuss with haem. Give 5-10mg Vit K, and consider 2 pools FFP

Group & Save	Group & Save + Cross match if Hb<100
Lap/open Cholecystectomy	Hartmann's
ERCP	Sigmoid colectomy
Closure of loop ileostomy	Hemicolectomy
Haemorrhoidectomy	Reversal of Hartmann's
Liver biopsy	Panproctocolectomy
Laparoscopy	AP resection
Mastectomy & reconstruction with LD flap	Anterior resection
Bilateral Mastectomy	Partial gastrectomy
Thyroidectomy	
Parathyroidectomy	
Parotidectomy	
Below knee amputation	
Above knee amputation	
I&D abscess and Lap appendix do not routinely need G&S or cross match	

Antibiotic prophylaxis

Please refer to the microguide app.

Bowel preparation

Before colonoscopy and some large bowel surgery, clear fluids from 24 hours pre-op, with an IVI running from midnight the night before the operation. Consent and venflon.

For small bowel or right sided resections (ileocaecectomy, right hemicolectomy or extended right hemicolectomy) or reversal of loop ileostomy	No prep required
For left sided colonic resections (sigmoid colectomy, left hemicolectomy, elective Hartmann's, total colectomy, proctocolectomy) and APER, sphincter repairs, rectocoeles, Delormes	Phosphate Enema x1 (0.7.30am for morning or 12.00pm for afternoon list
All anterior resections and colonoscopies All diverticular resections	Full bowel prep with senna x10 at 11am and Citramag x2 (i.e 1 b.d at
For reversal of Hartmann's or closure of loop colostomy	Senna x 10 at 11am, Citramag 1 bd at 2pm & 6 pm (on pre-op day) and Phosphate enema on morning of surgery
Flexible sigmoidoscopy (inpatient)	Phosphate Enema x 2 (7.30 and 8 for AM and 12 and 12.30 for PM list)

Comment [DH1]: Need to check the detail with Endoscopy, I think some has changed.

Pre & Post-op checks for Thyroid/Parathyroid Pts

Pre-Op

Patients should have a vocal cord check in ENT outpatients (this may well have been investigated when the surgery was booked).

Post-Op

Patients should have calcium results on the afternoon of the surgery. Any hypocalcaemia should be treated accordingly with supplements.

Patients should have a blood form for repeat calcium and thyroid function tests at four weeks to bring to their six week follow-up appointment to check on further need for supplementation of either thyroxine or calcium.

3 DVT Prophylaxis

A DVT Nurse Specialist is available at ESH for advice and follow up.

1) All patients must have VTE assessment and prophylaxis completed.
2) All patients should receive TEDS and enoxaparin except those <40 undergoing minor surgery who require early mobilisation
3) Early mobilisation is to be encouraged in all cases.
4) Patients undergoing major surgery should be discussed with the Anaesthetist as those having epidurals should be given their first dose of heparin after the epidural catheter has been placed
5) Only one dose of heparin should be given pre-operatively in planned surgery
6) Patients with peripheral vascular disease should not have TEDS.

7) All patients with any risk-factor (see NICE guideline 46) should have enoxaparin. Those with renal impairment may require Heparin instead of enoxaparin.
8) Patients should receive written and verbal advice about oral contraceptives, travel and signs of DVT.

Post-operative DVT Prophylaxis

To be prescribed for 18:00 or 6 hours post op depending on case

Low Risk Group: Early Ambulation
Moderate Risk Group (2 or more risk factors):
Enoxaparin 20mg s/c o.d (unless contraindicated). First dose at 6pm on day of surgery, ensuring it is at least 2 hrs post-op plus Graduated compression stockings.

High Risk Group (3 or more risk factors):
Enoxaparin 40mg s/c (if creatinine clearance <30ml/min then give 20mg s/c). Usually given at 6pm, however ensuring it is at least 2 hrs post operative plus TEDS

Colorectal cancer patients
All patients (unless contraindicated) who have had a colorectal cancer resection continue with prophylactic enoxaparin for 28 days post operatively. They will be taught on the ward how to self-administer. It must be prescribed on their TTO.

Heparin Protocol (iv)

Load with heparin 5000 units in 5 ml iv. bolus. Then set-up initial infusion: 20,000 units heparin in 20 ml (pre-made, do not dilute), start at 1.5 ml per hr

Check APTT at 6hrs then adjust according to chart below. Recheck 4 hours after any adjustment and always check at least every 24 hours.

APTT(Sec)	Infusion Rate
< 45	Increase rate by 0.4ml / hr
46 - 54	Increase rate by 0.2ml / hr
55 - 90	No change
91 - 102	Reduce rate by 0.2ml / hr
121 - 140	Reduce rate by 0.5ml / hr
> 140	Stop infusion for 1 hr, recommence at 0.8 ml /hr

Warfarin

Patients may need therapeutic enoxaparin cover while titrating warfarin dose. All patients must have a warfarin appointment made prior to discharge.

4 Consent

1. This is the responsibility of the Surgeon placing the patient on the waiting list, and consent should be confirmed on day of surgery. Please check the outpatient letter for any special points

2. Consent should include a description of the procedure involved, a brief list of general and specific complications and the chance for the patient to ask questions.
3. This should be aimed at a level which the patient can understand.
4. The age for informed consent is 16, although mature younger teenagers can give consent if the doctor feels they understand the proposed procedure and its problems.
5. Use a paediatric consent form (2) if parental consent is being sought, and a consent form 4 if the patient does not have capacity.
6. There are separate pre-printed consent forms for breast surgery procedures which are signed in clinics at the time of booking of operation.
7. No person may legally consent for any other and in emergency cases consent from relatives is unnecessary. However it is good practice to keep relatives informed (with the patient's consent).
8. For all major operations the need for possible blood transfusion should be explained to the patient. If the patient refuses for blood transfusion, it has to be highlight. Similarly for bowel surgery, the need for a stoma should be indicated and recorded.

Specific operations and associated risks

1) Thyroid surgery: calcium supplementation, thyroxine, hoarse voice

2) Cholecystectomy: Need to convert procedure if started as laparoscopic in 1 in 20 cases, need for cholangiography, bile leak and bile duct injury.

3) Hernia repair: recurrence in 1–2% of cases, ilioinguinal nerve injury, ischaemic orchitis 1 in 300 cases. In recurrent hernia repair there is an

increased risk of recurrence and ischaemic orchitis and in addition the possibility of orchidectomy needs to be written on the consent form

5 Capacity

Incompetent adults and independent mental capacity advocates

NHS bodies must instruct an IMCA whenever they are proposing to take a decision about 'serious medical treatment', if:

- The person concerned does not have the capacity to make a decision about the treatment, and
- There is no-one appropriate to consult about whether the decision is in the person's best interests, other than paid care staff.

Instructions of how to contact an IMCA are available on the wards, (Also see consent policy section on intranet)

The only situation in which the duty to instruct an IMCA need not be followed, is when an urgent decision is needed (e.g. life saving) - in such cases the decision must be clearly recorded with full reasoning.

If the patient is for surgery, a Consent form 4 should be used.

Remember the five statutory principles of the Mental Capacity Act:

1) A person must be assumed to have capacity unless it is established that they lack capacity.
2) A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
3) A person is not to be treated as unable to make a decision merely because he makes an unwise decision.

4) An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be in his best interests.
5) Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

Assessing capacity

Anyone assessing someone's capacity to make a decision for themselves should use the two-stage test of capacity.

- Does the person have an impairment of the mind or brain, or is there some sort of disturbance affecting the way their mind or brain works? (It doesn't matter whether the impairment or disturbance is temporary or permanent.)
- If so, does that impairment or disturbance mean that the person is unable to make the decision in question at the time it needs to be made?

You should assess and document whether a patient is able to:
1) Understand the information relevant to the decision,
2) Retain that information,
3) Weigh that information as part of a decision making process
4) Communicate that decision (by talking, BSL, or any other means)

6 Post-operative pain management

Generally the anaesthetist will have prescribed post-op analgesia. Most anaesthetists give an anti-inflammatory agent during surgery. If pain is a problem post-op follow the analgesia step ladder approach

and combination of analgesics for effective control. Seek advice from acute pain team if required

Current philosophy is to use three different analgesic methods wherever possible.

1) Local anaesthesia.
2) Paracetamol
3) An anti-inflammatory agent.
4) An opioid drug – use morphine unless contraindicated (Add laxative as well)

Major cases often have a local anaesthetic wound catheter/epidural + a small dose of opiate or a patient controlled analgesia device (usually 1mg. morphine as the unit dose, maximum 30mg. in 4 hours).

Beware NSAIDS & patient with poor renal function/elderly patients.

7 Acutely unwell patients – EWS/sepsis

There is considerable evidence that the early identification of acutely ill and physiologically compromised patients, and their appropriate management involving transfer to high dependency, or intensive care units, improves patient outcome.

One method used in this trust to identify early a sick patient is the Early Warning Score. Nurses will typically bleep the surgical team if a patient is EWS ing 5 or more, or has experienced a deterioration in their EWS.

The Critical Care Outreach team (CCOT) is available to review sick patients on the ward, and the ITU anaesthetist is available on bleep 830. Sick patients can also be highlighted at the 22:00 hospital at night meeting where the Medical registrar, Anaesthetic & ITU registrar, and CCOT will be available.

If you are bleeped about a patient with sepsis please ensure you review them promptly **start them on antibiotics within 30 minutes**.

THINK SEPSIS SIX

3 IN	***3 OUT***
Oxygen	Lactate
Fluids	Urine output / fluid balance chart
Antibiotics	Blood cultures

All cases of post-operative oliguria (<0.5mls/kg/hr) are to be referred to the SHO, Registrar or Consultant. Frusemide should only be given if hypovolaemia can be confidently excluded**, only after discussion with registrar or consultant.**

EWS Score	Actions
1-3	Ensure repeat observations. Calculate urine output. Review score in 2 hours.
4-7	Measure U&ES, FBC, glucose. Inform surgical registrar & CCOT Resuscitate: IV fluid, Oxygen, Antibiotics
≥ 8	Inform Anaesthetics and surgical consultant

8 Paediatric Surgery

Paediatric surgical patients:

These children are managed jointly by the Paediatricians and Surgeons.

Children <5yrs are not operated on at ESH and are transferred to St Georges' Hospital/Brighton Hospital, but in cases of extreme urgency, the Surgeons available will assist in any resuscitation required.

Similarly opinions should be provided for the under 5's in A&E if needed ASAP (<30mins), and either the SHO or Reg on call must attend all paediatric trauma calls.

All paediatric patients who are referred to surgery are seen in Paeds ED and admitted in Outwood ward. They may be reviewed in CAU – next to Outwood ward on first floor. All the consultations are documented and EDS done.

9 Infection Control

Dress Code: Medical staff are expected to look professional and smart. You are representing the Trust and your team.

In any clinical area:

1. White coats should not be worn.
2. Nothing should be worn below the elbows apart from wedding bands. Watches should be removed.
3. Ties (apart from bow-ties) should not be worn.
4. Gloves and aprons should be worn in ITU.

Hand hygiene:

Thorough hand hygiene with soap and water or alcohol hand rub using the six-step technique according to Trust policy must be undertaken:

1. Before and after examining any patient
2. Before and after donning disposable gloves
3. On entry and exit from every clinical area

10 Common surgical conditions

Acute Appendicitis

Calculating the Alvarado score has been found to assist decision-making in suspected acute appendicitis and should be recorded in the notes.

ALVARADO SCORE

0-3	DISCHARGE with advice to return if no improvement, subject to social circumstances
4-6	REVIEW AFTER 12 HRS. If score < 4 then manage as for score 0-3
7-10	Appendicectomy

Symptoms	Signs	Investigations
Migratory RIF pain – 1 Anorexia – 1 Nausea/Vomiting -1	RIF tenderness 2 RIF reboud 1 Pyrexia 1	Leucocytosis 2 Left shift 1

There may be a need of preoperative imaging studies including CTAP and ultrasound scan (TVUS) before planning for operation depending age and gender of patient.

Acute pancreatitis

Acute pancreatitis (AP) is characterised by inflammation of the exocrine pancreas and is associated with acinar cell injury and both a local and systemic inflammatory response. AP may range in severity from self-limiting, characterised by mild pancreatic oedema, to severe systemic inflammation with pancreatic necrosis, organ failure and death.

The UK incidence of acute pancreatitis (AP) is estimated as 15–42 cases per 100 000 per year and is rising by 2.7% each year. Gallstone pancreatitis is more common in women over the age of 60, especially among those with microlithiasis, while alcoholic pancreatitis is more frequent in males. In the UK, gallstones followed by alcohol intake are responsible for 75% of cases of AP.

Diagnosis centres upon a raised serum amylase though the diagnosis can also be made by cross sectional imaging (CT/MRI/USS). A raised serum amylase is also seen in a variety of other conditions (mumps, posterior DU, mesenteric ischaemia etc) so a good history is vital. The most common presenting pattern of pain is severe epigastric pain that radiates to the back, is exacerbated by movement and is alleviated by leaning forwards. Patients may appear agitated, confused and in distress. They may give a history of anorexia, nausea, vomiting and

reduced oral intake. A history of symptoms in keeping with associated cholangitis should be sought.

Patients usually have signs of hypovolaemia and may appear diaphoretic, tachycardic and tachypnoeic. Fever may occur due to either cytokine release as part of the normal inflammatory response or may represent complicated pancreatitis, for example, pancreatic necrosis with or without infection.

Routine blood tests including amylase, CRP, FBC, U&E, BG, calcium liver enzymes, triglycerides and calcium should be obtained. An amylase 3x ULN is highly suggestive. All patients to have CXR and supine AXR on admission.

Patients with organ failure or poor prognostic signs (persistent SIRS, Glasgow score >3, APACHE score >8 and Ranson score >3) should be assessed for admission to a high dependency unit.

An urgent ultrasound should be requested. If this demonstrates a dilated pancreatic duct and there is deranged LFTs then an ERCP should be considered within the first 48 hours.

Patients that become systemically unwell, septic or who do not improve should have a multiphase contrast-enhanced CT scan to rule out peripancreatic collections, necrosis, abscesses and vascular complications of pancreatitis (eg, development of portal venous thrombus, pseudoaneurysms or haemorrhage). While CT is the preferred initial modality for staging AP and detecting vascular complications, it is not advised within the first 48 hours of admission - unless there is diagnostic uncertainly. All patients to have significant

IV fluid resuscitation as they tend to be intravascularly deplete due to third spacing and intra- abdominal oedema

Resuscitation with intravenous fluids, analgesics and anti-emetics should form part of the initial treatment even before the diagnosis of AP is made. The use of antibiotics in non-infected pancreatitis is not currently recommended as there is no clear evidence of benefit. Only patients needing HDU/ITU should be considered for urinary catheter but hourly urine measurements should be routinely performed. All patients to have regular obs. of P, BP & T.

Patients with alcohol-induced pancreatitis may need alcohol-withdrawal prophylaxis. Metabolic needs of AP are high and enteral nutrition should be recommenced as soon as abdominal pain has subsided .In severe pancreatitis an enteral tube feeding should be considered.

All patients presenting with gallstone pancreatitis should be considered for cholecystectomy when they are well enough to undergo surgery.

Please read: https://fg.bmj.com/content/10/3/292

Acute cholangitis

Acute cholangitis (AC) is a surgical emergency which can cause death in hours. There are three feature (Charcot's triad). Rigors, jaundice and RUQ pain. It is due to acute biliary obstruction with ascending infection.

In cases of suspected AC patients need to be aggressively to be treated with iv fluids & antibiotics without delay. Seek advice from the

microbiologist on call if inadequate initial response to those antibiotics in the protocol

Ultrasound should be obtained as emergency on first available list. ERCP and stent to be arranged ASAP. If patient deteriorates consider cholecystostomy drain under US or surgically.

Breast Abscess

Pointing

- Full clerking, Bloods
- Incision and Drainage required – consent and book for CEPOD (Reg on call to do)
- No routine OPD needed-District Nurse or Practice nurse follow up for packing changes Patient to see GP if ongoing problems

Non-pointing

- Full clerking, Bloods
- Commence oral/IV abx as per systemic symptoms and blood biochemistry Flucloxacillin or Clarithromycin if Penicillin allergy
- Book Breast USS +/- drainage-via Radiologist
- If septic consider IP stay and intravenous antibiotics
- If stable, discharge home no routine OPD needed

Mastitis

- Full clerking, Bloods
- Commence oral/IV abx as per systemic symptoms and blood biochemistry

- Patient can continue Breast feeding safe to do on antibiotics-Flucloxacillin or Clarithromycin if Penicillin allergy. If painful to breast feed they can stop or express the other side
- Book Breast USS via Radiologist
- If septic consider IP stay
- If stable, discharge home and no routine OPD needed

Post operative Breast haematoma

- Full clerking, Bloods
- General surgery reg review – if large +/- expanding +/- low Hb +/- haemodynamically unstable - book and consent for evacuation of haematoma on CEPOD (Surgical Reg on call to do/Gen Surg Consultant support if needed
- Can leave drain 10F Exudrain in cavity or leave open and pack
- All post op breast patients will have OPD with Breast Consultant for Follow up but make sure Breast Consultant in charge of patient is aware of return to theatre

Head Injuries

The initial management of head injuries is undertaken by the Emergency Department, unless there are concomitant general surgical problems that require intervention (see: Emergency Care Guidelines under Policies & Procedures on the hospital intranet).

Patients requiring further management/observation as per neurosurgical advice are transferred to the general surgical team on-call.

Patients with positive head CTs following trauma should be discussed with St. George's Hospital Neurosurgery (should be done by A&E) and may require observation on the surgical wards.

Patients may also be transferred back from neurosurgical centres after completing treatment.

MANAGEMENT, REPORTING AND INVESTIGATION OF INCIDENTS (INCLUDING SERIOUS INCIDENTS – SI) POLICY

"We can only make the NHS safer if you speak out when things go wrong" - James Johnson, BMA

The purpose of incident reporting is to make an organisation aware of where its systems and processes may not be supporting patient and staff safety.

Please visit the *Management, Reporting and Investigation of Incidents (Including Serious Incidents – SIs) Incident Policy* on the Surrey and Sussex Healthcare intranet, via the policies workspace:

https://sashnet.sash.nhs.uk/workspaces/policies