Institution Name: Al- Nahdha Hospital

Document Title: Otolaryngology, Head and Neck Surgery and Communication Disorders Departmental Policy

Approval Process

	Name	Title	Institution	Date	Signature
Written by	Department Management Board	Department Management Board	Al- Nahdha Hospital	June 2022	
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Acronyms:

ORL	Otorhinolarygology
OMSB	Oman Medical Specialty Board
SQU	Sultan Qaboos University
GFP	General Foundation Program
TQM	Total Quality Management
OAE	Otoacoustic emission
SSL	Surgical Skill Lab
FESS	Endoscopic Sinus surgery
RFIT	Radiofrequency of inferior turbinates
FOL	Fiberoptic Laryngoscopy
GERD	Gastroesophegeal Reflux Disease
CSOM	Chronic Suppurative Otitis Media
OME	Otitis Media with Effusion

1. Introduction

The department of Otorhinolarygology (ORL), Head and Neck Surgery and Communication Disorders is one of the main and old departments at An Nahdha Hosiptal. It was established since 1974 and significantly advanced over the years to provide high quality tertiary care for complex problems in the Head and Neck, Otology, Rhinology, Rhinoplasty, Airway, Voice and Obstructive sleep apnea for the whole country. It is equipped with state of art facilities in the clinics, wards, and operating rooms. In addition, it has an audiology unit, vestibular unit, speech and language therapist and equipped surgical skill lab. All consultants are well trained in their respective fields and they can perform most surgeries in their subspecialty areas.

The department is fully dedicated in teaching and training Omani doctors. It is involved in teaching undergraduate students from Sultan Qaboos University (SQU) since 1994. In addition, training is extensively provided for residents from Oman Medical Specialty Board (OMSB) in the following specialty: ORL, Family medicine, Emergency, General Surgery and OMFS. Training has further extended to post graduate doctors from the General Foundation Program (GFP) and from regional hospitals in advanced subspecialty areas. Recently, a newly accredited Otology fellowship program has been launched as the first fellowship program in the hospital.

2. Scope

This policy is applicable to ENT surgeons, audiologists, and residents. The scope of Otolaryngology, Head and Neck Surgery and Communications Disorders is to provide services that includes:

2.1 Outpatient and inpatient management of ENT cases.

2.2 Surgical management of ENT cases.

2.3 Investigations and management of cases with hearing disorders.

2.4 Investigations and management of cases with vestibular disorders.

2.5 Assessment and management of cases with speech, voice and language disorders.

3. Purpose

The aim of this policy is to highlight the rules and regulations of the department of Otolaryngology, Head and Neck Surgery and Communications Disorders to maintain the following goals:

3.1 Provide the optimal service to patients while keeping international standards as bench mark.

3.2 Maintain and improve the quality of health care by Total Quality Management strategies (TQM).

3.3 Provide patients with the optimal management for medical and surgical conditions.

3.4 Impart quality training to undergraduate and postgraduate Omani doctors.

3.5 Focus on Continuous Professional Development.

3.6 Play a pivotal role in National Ear Care, Cochlear Implant, Head and Neck Cancer Awareness and other National programs.

4. Procedure:

4.1 Organizational Structure of the Department:

The department has 36 staff besides OMSB ENT residents at various level of their training.

No	**Doctors**	Number
1	Senior Consultant	6
2	Consultant	3
3	Senior Specialists	4
4	Specialists	8
5	Sr. Medical Officer	1
6	Medical officers	9
	Total Doctors	31
7	Speech therapists	2
8	Sr.Audiometricians	0
9	Audiometricians	3
10	Ear Mould Technician	0
	Total	5
Total Staff		36

4.2 Functioning of the Department:

The department functions on a consultant based practice. All consultants are team leaders and look after their patients independently in cooperation with other staff.

The department working time is from 7.30 am to 2.30 pm. The Surgical Teams rotate in the Clinics, Wards, and Operation Theaters. Minor procedures (Nasal Endoscopy, Fiberoptic Laryngoscopy/Stroboscopy, Fine Needle Aspiration Cytology, Ear Microscopy, Ear Syringing, Chemical cauterization of bleeding Nose and Removal of Ear and Nose foreign bodies) are performed in the outpatient clinics.

4.3 Available Facilities:

The Department has facilities of running Outpatient clinics, Inpatient services (wards), Routine, Emergency Surgeries, Day care surgeries and 24 hours Emergency cover.

4.3.1 Outpatient Consultant based subspecialty clinics:

Since April, 2011 the department is running consultant based sub-specialty clinics with the objectives of focused patient care and resident teaching. The distributions of the clinics are as under**16 Sub specialty clinics per week:**

1 ENT Triage clinic	Daily
2 Speech and language clinics	Daily
2 Vestibular clinics	Daily
5 Neonatal hearing screening and Deafness clinics	Daily
4 Pre-operative clinics	Per Week
1 Cochlear implant clinic	Per Week
6 Airway clinics	Per Week
1 Combined Allergy Clinic	Per Week
4 Voice Clinics	Per Week
4 OSA clinics	Per Week

4.3.2 In addition, Department also runs:

4.3.2.1 Three General ENT clinics daily at Bowsher Polyclinic.

4.3.2.2 Two General ENT clinics daily at As Seeb Polyclinic.

4.3.2.3 Two swallowing clinics at Royal Hospital Monthly.

4.3.2.4 Two Consultant Clinics per week at Bowsher Polyclinic.

4.3.2.5 Two Consultant Clinics per week at As Seeb Polyclinic.

4.3.3 Audiology services offered includes:

4.3.3.1 Pure Tone Audiometry tests.

4.3.3.2 Acoustic impedance.

4.3.3.4 Speech Audiometry.

4.3.3.5 Tinnitus Matching.

4.3.3.6 Brain stem evoked potential response tests (Screening and Diagnostic).

4.3.3.7 Electrocochleography.

4.3.3.8 Otoacoustic emission (OAE).

4.3.3.9 Hearing Aid clinic/Lab.

4.3.3.10 Cochlear implant pre insertion service.

4.3.3.11 Cochlear implant mapping.

4.3.3.12 Vestibular disorders assessment and management.

4.3.3.13 Vestibular Evoked Myogenic Potential.

4.3.4 Bed Compliments:

There are assigned beds for ENT patients in Male Surgical ward (8 beds), Female Surgical ward (8 beds) and Pediatric Surgical ward (2 beds). In addition, patients for Day Care ENT surgery are admitted in the Day Care ward. The department also has access to the Private, VIP, High Dependency and Isolation wards.

4.3.5 Surgical facilities:

There are 2 theater rooms dedicated to Otolaryngology and a 3rd operating room is shared with Ophthalmology on alternate weeks in addition to 24-hour emergency surgery service.

4.4 Day Care Surgery criteria for selection:

4.4.1 Surgeries with no expected significant blood loss.

4.4.2 Patient should not be suffering from any systemic illness which increases the risk of anesthesia to more than average (ASA-I).

4.4.3 The procedure should not need prolonged post op vigilance during recovery phase.

4.4.4 Patient should not need post-op parenteral medication.

4.4.5 Patient should not be coming from areas which are far off (e.g. not more than 1-hour drive to the hospital).

4.4.6 Patient should not be sent home with nasal packs.

4.5 List of Procedures Suitable for Day Care Surgery (If preferred by the Surgeon):

Keeping in mind the above criteria the surgical procedures which can be considered as suitable for day care are following (provided they fulfill the other criteria as well).

4.5.1 Tonsillectomy.

4.5.2 Adeno-tonsillectomy.

4.5.3 Adenoidectomy.

4.5.4 Myringotomy.

4.5.5 Myringoplasty / Tympanoplasty.

4.5.6 Ossiculoplasty.

4.5.7 Excision of Pre-auricular Sinus.

4.5.8 Excision of small cyst.

4.5.9 Lymph Node Biopsy/Directed Head and Neck Biopsy.

4.5.10 Microlaryngeal Surgery (MLS).

4.5.11 Reduction of Nasal Bone Fracture.

4.5.12 Removal of Nasal / Ear foreign bodies.

4.5.13 Radiofrequency of inferior turbinates (RFIT)/ Turbinoplasty procedures.

4.5.14 Sleep endoscopy.

4.5.15 Airway assessment.

4.5.16 Septoplasty.

4.5.17 Septorhinoplasty.

4.5.18 Limited Functional Endoscopic Sinus Surgery (FESS).

4.5.19 Mastoidectomy.

4.5.20 Cochlear Implant.

4.5.21 Stapedectomy.

4.5.22 Diagnostic Sialoendoscopy.

4.6 Department Committee Structure:

The department's functions are monitored by the following committees:

4.6.1 Department Management Board.

4.6.2 Other temporary committees are formed as and when the need arises.

Officially Declared Disasters should follow the chain of command from head of department down wards according to Hospital, Ministry and National policy. There should not be Individual decisions unless no senior is immediately available.

4.7 Admission Policy:

Admissions to the wards are under the names of the Consultants heading each Team and are arranged under following categories:

4.7.1 Emergency admissions during routine working hours are under the care of the consultant in the wards. After 2:30 PM, Emergency admissions are under the 4th unit Consultant On-call. If the team in OPD wishes to admit a patient for treatment, then the patient will be admitted under that clinic consultant.

4.7.2 Elective surgical admissions are under the operating Team.

4.8 Attendant Policy:

The following categories of patients are allowed to have attendants while they are admitted. No attendant under normal situations is allowed while patient is in high dependency ward. The department tries to follow national and hospital policies.

4.8.1 Pediatric patients should have a female attendant when admitted in Pediatric or Female Surgical ward. When only male attendant is available, patient will be admitted to Male Surgical ward.

4.8.2 Handicapped patients who need help for even routine personal care.

4.7 Antibiotic Policy:

4.7.1 Surgical prophylactic antibiotics are given according to the national policy or according to the department protocols made by Department consultants and Infection control committee approval.

4.7.2 Therapeutic antibiotics are given according to the patient condition and Culture Investigating.

4.8 Discharge Policy:

4.8.1 Emergency Admissions are discharged when they are fit for discharge.

4.8.2 Routine Surgical Admissions are discharged according to a fixed protocol.

4.8.3 All diabetic/ immune-compromised patients who have undergone surgery are discharged on appropriate antibiotics.

4.8.4 Patients with associated systemic disease should have the condition mentioned in their discharge summary and ensure that appropriate treatment / prescription and advice has been given to the patient.

4.8.5 ICD CODES must be completed in appropriate column at the time of admission and discharge.

4.8.6 Ensure that the discharge advice including medication and various other precautions have been explained to the patient.

The discharge protocol is only a guideline. The discharging doctor has the responsibility to evaluate whether patient is fit enough to be discharged even if indicated in post op notes.

4.9 Referral Policy:

4.9.1 Emergency Referrals:

4.9.1.1 All Urgent referrals will be referred for urgent appointment to Medical Record Department after discussion with ward team if referral is before 2.30 pm and with on call team after 2.30 pm. All immediate/emergency cases will be sent to the Emergency ENT, after discussion with the concerned doctor.

4.9.1.2 Admissions from the Emergency triage during working hours will be under the ward consultant of the day. Admissions from the outpatient will be under the consultant in the clinic. Admission during emergency hours will be under the 4th on call consultant.

4.9.1.3 Minor cases can be seen and treated by the emergency doctor. These patients should be given follow-up in the local health centers.

4.9.2 Inpatient Referrals:

All the internal referrals during working hours should be seen by the team posted in the ward. Beyond the working hours, the 1st on-call will see these referrals and discuss their management plan with the on-call team on that day.

4.9.3 Outpatient Referrals:

4.9.3.1 ENT Department accepts the following patient as outpatients:

a. Referrals from ENT clinic at Bowsher Polyclinic and As Seeb Polyclinic.
b. Referrals from ENT Department of regional referral hospitals for the cases which require sub specialty management. General cases should be managed at regional hospitals and should not be referred to Al Nahdha Hospital.
c. Referrals from Other Departments at Al Nahdha Hospital.

d. Referrals from ENT Specialists from ROP Hospital, Armed Forces Hospital and Diwan clinic only if patients are from Muscat region otherwise, they should be referred to the Regional Hospital of their catchment area.

4.9.3.2 The inter-departmental outpatient referrals will be according to the common An Nahdha referral guidelines.

4.9.3.3 The patient will get an appointment on the earliest available slot.

4.9.3.4 The following are the Sub-specialty clinics which receive inflow of patient only through appointments according to the guidelines of each subspecialty team:

a. Subspecialty Clinics: (With prior appointment through MRD)

i. Otology
ii. Cochlear implant
iii. Rhinology
iv. Rhinoplasty/Facial Plastics
v. Combined Allergy
vi. Head & Neck
vii. OSA
viii. Voice
ix. Airway
x. Deafness screening
xi. Deafness BERA
xii. Speech Therapy
xiii. Vertigo clinic.

4.10 Morbidity and Mortality:

4.10.1 Definition: any Event/Incident that alters the patient's expected stay period or the routine care of the patient.

4.10.2 If there is any Morbidity then the patients name, complication and reason should be entered in the Morbidity Register.

4.10.3 Items for discussion for Audit meeting should include any lack of due Procedure, Materials, and Facilities which impacts on patient care.

4.10.4 All cases of possible Morbidity and Audit should be filed in the appropriate forms in the Hospital Computer System.

4.10.5 These cases are discussed in the subsequent morbidity/audit meeting.

Some of the examples of morbidity are listed below:

Pre-Operative	Peri-Operative	Post-Operative
	Excessive Hemorrhage	Bleeding
	Respiratory problems	Fever
Drug Reaction	Accidents while transferring	Pain Killer Dosage Increase
Postponed/Cancelled		Change antibiotics

4.11 Education and Training:

4.11.1 Residency Training Program:

The Department is involved in teaching and training of OMSB ENT Residents. In addition to the continuous clinical teaching in clinics, wards and operation theatre, following hours were devoted to formal didactic teaching:

Day	Activity	Time	Remarks
Sunday	**Handover of the weekend cases**	**7.15- 7.30am**	**Between Residents**
	Presentation: journal club, radiology, topic, case discussion, morbidity/mortality	**7.30- 8.00am**	**Attended by the whole department including doctors in polyclinics.**
	Discussion	**8.00- 8.15am**	
Monday	**Case discussion (selected by the residents and consultant)**	**During morning round**	**Attended by the consultant and residents posted in the ward**
Tuesday	**CME**	**7.30 – 8:30**	**CME Room**
Wednesday	**Resident teaching**	**2.30-4.00pm**	**OMSB**
Thursday	**CME**	**7.30 – 8:30**	**CME Room**

4.11.2 The undergraduate Teaching Program:

The department is conducting undergraduate teaching since 1994. Medical students are posted for two weeks' rotation in ENT department. The teaching includes case presentation in ward and clinic, rotation through operation theatres and problem based teaching sessions, topic and case presentations.

4.11.3 Family Medicine, General Surgery, A & E and GFPs Training program:

Department is supporting FAMCO General Surgery, A & E and GFPs Training programs. FAMCO residents have rotation of 2 months in the ENT. A&E residents rotate for 2 weeks, General Surgery residents rotate for 1 month in the department, and are trained for ENT emergencies.

4.11.4 National and International conferences:

4.20.4.1 Department runs National Scientific meeting of Otolaryngologist, Head and Neck Surgery and Communication Disorder Society, annually.

4.20.4.2 Grand round seminar/presentation and discussions.

4.20.4.3Besides many of doctors from department attend international conferences/workshops as delegates and invited faculty and presented scientific papers.

4.11.5 CPD activities and Hands on surgical workshops:

A state of the art new surgical skill lab (SSL), first ever of its kind in any of the hospitals in the country & GCC has been created by the department for surgical training of residents and young doctors. The surgical skill lab has fully equipped 10 stations for hands on cadaver dissections. It was deemed by the department to share the facility with other departments who are interested in running the educational course for the benefit of medical community at large. In this regard, surgical skill lab committee (SSL) and Surgical skill lab supervisory committee has been formed to run and oversee the efficient running and maximum usage of surgical skill lab. In a year,7 international hands-on cadaver surgical dissection courses in addition to 3 more local cadaveric dissection courses are conducted by the department, which are as under:

4.11.5.1 Functional and Aesthetic Rhinoplasty Course.

4.11.5.2 Endoscopic sinus surgery (FESS) Course.

4.11.5.3 Head & Neck Surgery Course.

4.11.5.4 Otology Courses (Advanced Implantology Course).

4.11.5.5 Otology Course (Combined British Universities Course).

4.11.5.6 Airway Course.

4.11.5.7 Obstructive Sleep Apnea Course.

4.11.5.8 Septoplasty Course.

4.11.5.9 Basic Temporal Bone Dissection Course.

4.11.5.10 Tracheostomy care workshop (for nurses).

4.12 Triage Policy

4.12.1 ENT triage clinic starts every day from 7.30am to 2.30pm except weekends and holidays.

4.12.2 An ENT Doctor is allocated in this clinic will see all emergency cases referred from:

4.12.2.1 Local health centers in Muscat region.

4.12.2.2 Bowsher and As Seeb polyclinics.

4.12.2.3 Other clinics in ANH.

4.12.2.4 Royal Hospital A&E after discussion with the consultant in the ward.

4.12.3 Sometimes, a ENT resident, FAMCO, A&E or GFP doctor will be attached to the specialist in this clinic.

4.12.4 List of common ENT emergency cases that should be seen and managed in triage:

4.12.4.1 Acute Tonsillitis not responding to oral Medications.

4.12.4.2 Peritonsillar Abscess.

4.12.4.3 Foreign Body in the nose, oral cavity, oropharynx, hypopharynx, larynx, trachea and bronchus.

4.12.4.4 Stridor, Airway obstruction.

4.12.4.5 Post-op ENT surgery complications.

4.12.4.6 Post-op Tonsillectomy not tolerating oral intake.

4.12.4.7 Neck Abscess.

4.12.4.8 Otitis Externa/Media not responding to oral medications.

4.12.4.9 Malignant otitis externa.

4.12.4.10 Foreign body ear (Not urgent) except for batteries and other erosive/corrosives items.

4.12.4.11 Perichondritis.

4.12.4.12 Auricular Hematoma.

4.12.4.13 Pre/Post auricular abscess.

4.12.4.14 Facial Nerve Palsy.

4.12.4.15 Sudden Sensorineural Hearing Loss.

4.12.4.16 Acute Mastoiditis/Subperiosteal Abscess

4.12.4.17 Epistaxis.

4.12.4.18 Foreign Body Nose.

4.12.4.19 Barotrauma.

4.12.4.20 Temporal Bone Trauma, EAC, TM, Middle ear, inner ear.

4.12.4.21 Nasal Trauma/septal Hematoma.

4.12.4.22 Acute Sinusitis with complications or not responding to oral medications.

4.12.4.23 Neck Trauma.

All these cases should be evaluated, investigated and managed by the doctor posted in the triage with consultation with the consultant in-charged in the ward.

4.12.5 Patients, who need medical treatment and further follow up, should be referred to Bowsher and As Seeb polyclinics if from Muscat Region or to regional Hospital if otherwise.

4.12.6 Patients who require admission, it should be done in triage and inform the concern team in the ward with clear written plan of management after discussion with the consultant in the ward.

4.12.7 Patients who are stable and require further subspecialty evaluation in the OPD, a routine appointment should be given in the concern clinic.

4.12.8 Sometimes, patients come for medications, they should be given and follow up with their original team in the clinic.

4.12.9 Tracheostomy tube change will be done in triage if patients are from Muscat region (if done at Al- Nahdha Hospital) and those who come through OPD and need attention or to be done in theater/ theater recovery, it will be under ward consultant responsibility.

Note: patients who do not need any urgent intervention should not be seen at ENT triage and should be directed to either Bowsher or As Seeb polyclinics or to be given routine appointments at Al- Nahdha Hospital clinic only if it required.

4.13 Discharge Policy as Per Attached List

4.13.1Criteria and Plan for discharging patient from Outpatient Department

4.13.1.1 Non-Surgical Conditions:

Condition	Workup/Investigation (If indicated)	ENT Intervention	Total Number of Follow up/Interval	Discharge Criteria	Referral/ Advise on Discharge	Reason to continue Follow Up
Headache	CT P.N.S.	R/O Sinonasal/Ear Pathology	Once	No ENT Cause	Ophthalmology /Neurology	Evidence/Suspicion of ENT Cause
Allergic Rhinitis	CT P.N.S.	Medical Treatment	Twice/ 3 Months apart	No Surgical Intervention Required	Follow up Local Health Centre/Regional Hospital -Immunology Clinic	Possible surgery like (RFIT)
Tinnitus	-Audiological Tests -Imaging (MRI)	-Medical -Tinnitus Masking	Three (with Audiologist) / 3 Months apart	-No CPA Mass -Recovered -Improved with tinnitus masking	-Neurosurgery if Central Lesion	Treatable ear pathology

Gastroesophegeal Reflux Disease (GERD)	Fiberoptic Laryngoscopy (FOL)	Antireflux Measures (Diet, PPI)	Twice, 3 Months apart	-Improved -Not improving with treatment	Gastroenterologist	-Associated Laryngeal Lesion -Airway Pathology
Laryngomalacia	Airway Assessment	-Observation -Surgical Intervention depending on the severity	Six: 4 months apart till age of 2 years Or Improved	Improved		-Presence of Tracheostomy -Need for surgical intervention
Nasal Deformity	Rule out Functional Problem/Rigid Nasal Endoscopy	ENT Examination	Once	Pure Cosmetic Deformity	Plastic Surgery	Functional Problem
Otitis Media with Effusion (OME)	-Rule out associated OSA symptoms/Adenoid Hypertrophy -Audiological Tests	Medical Treatment	Twice/ 3 Months apart (2nd follow up onwards can be done at local hospital/Polyclinic) -If improved, one Follow up after 3 months	Improved		-Decision of Myringotomy + Ventilation Tubes

4.13.1.2Surgical Conditions:

Condition	**Workup/Investigation (If indicated)**	**ENT Intervention**	**Total Number of Follow up/Interval**	**Discharge Criteria**	**Referral/ Advise on Discharge**	**Reason to continue Follow Up**
Nasal Deformity	Rigid Nasal Endoscopy	ENT Examination	-Five: One week 2weeks 1 month 2 months 6 months	Maximum Achievable Correction/ Good function		Need of Revision
Otitis Media with Effusion (OME)	-Rule out associated OSA/Adenoid hypertrophy -Audiological Tests	Medical Treatment if Failed then Surgery	Three time after grommet 2-4 weeks6 months 12 months	Improved		-Persistent Grommet -Need Revision (Grommet/ T Tube)
Deviated Nasal Septum	Rigid Nasal Endoscopy	Surgery	Two: 2 weeks – 3-6 months	Improved		Complications

Chronic Suppurative Otitis Media(CSOM), Tubotympanic Disease		Audiological Tests	Tympanoplasty	3 Times: 2 weeks, 3 months, 6 months	Healed Perforation No Active disease		Unhealed Perforation
Sialoadenitis	**Sialolithiases**	ENT Examination	Sialoendoscopy	3Times: 2Weeks 2 Months 6 Months	Improved		
	-Stenosis -Autoimmune	ENT Examination	Sialoendoscopy	4Times: 2Weeks 2 Months, twice every 6 Months	Improved		Need Revision Siloendoscopy, Botox Injection
Benign Head and Neck Mass		CT Neck	Excision	Twice: 2weeks, 2 months	Improved	According to Histopathology	-Recurrence like VC lesions. -Presenceof Risk Factors of malignancy
Chronic Rhinosinusitis	**With Polyposis**	ENT Examination	Medical vs FESS	Twice: 2 weeks, 6 months	Improved	Follow up Local Hospital	Need Revision Complications
	Without Polyposis	ENT Examination	Medical vs FESS	Twice: 2 weeks 6 months	Improved		Need Revision Complications
Otoscelerosis		Audiological Tests	Stapedectomy	3 Times: 1week 1Month 3 months	Improved		NEED REVISION / BILATERAL EAR SURGERY
Mastoidectomy		Audiological Tests	Mastoidectomy	4 Times: 1week, 1Month, 3 months 6 months	Improved		Cavity Care Need Revision

5. Responsibilities

5.1 Distribution and Duties:

5.5.1 Responsibilities of the team in the Wards:

5.5.1.1 Provide comprehensive care to all admitted patients. This includes continuation, adjusting or changing management of these patients, initiating investigations when required, in consultation with the consultant In-charge.

5.5.1.2 Attend and manage all internal referrals within the An Nahdha Hospital. If any patient requires further follow up, it will be done by ward consultant in the following days.

5.5.1.3 and manage all internal referrals within the An Nahdha Hospital. If any patient requires further follow up, it will be done by ward consultant in the following days.

5.5.1.4 Manage all emergency admission from emergency department if askedby the attending A&E doctors.

5.5.1.5 Admit patients who are referred for inpatient care from specialty clinic (A clear plan of management should be outlined by the specialty clinic doctor initiating the request for admission).

5.5.1.6 Arranging the list of Operation Theater is not the duty of ward team, instead it is the duty of the concerned team.

5.5.1.7 Arrangement of operation theater list is not the duty of ward team, instead it is the duty of the concerned team.

5.5.1.8 Teach and train post graduate doctors in the ward.

5.5.1.9 Take part in teaching undergraduate medical students in the ward.

5.5.1.10 Handover of all inpatients to on call doctors by the end of the day and to the ward team of the next day.

5.5.1.11 Check the drug chart post-op for analgesia and other medications and adjust accordingly.

5.5.1.12 Enter all investigation reports in the computer system.

5.5.1.13 Admit, review and check investigations and consent of all booked cases for operation theatre and to decide whether surgery indication is still valid after discussion with the concerned team.

5.5.1.14 Ward team is responsible to reply to all online referrals.

5.5.1.15 Before discharge:

a) Prepare discharge summery and discharge the patients.
b) Check that all bandages and dressings are removed at the time of discharge if instructed by the surgeon.
c) Check that the nasal packs/ drains have been removed before patient is discharged unless stated by the operating surgeon.

5.2 Responsibilities of emergency cases in the ward are as follows:

5.2.1 Post-operative complications occur before 2.30 pm done in the same day is to be taken by the same operating team.

5.2.2 Emergency cases after 2.00 pm is to be taking care by the on-call team.

5.2.3 Any other emergency that requires management including surgical procedure is the duty of ward team.

5.2.4 Consultation from subspecialty teams can be arranged if required.

5.3 Responsibilities of the consultants and specialists working in the Clinics:

5.3.1 Plan and initiate management of all patients (New and Follow up) given an appointment.

5.3.2 Teaching and training postgraduate doctors and undergraduate medical students attending the clinic.

5.3.3 Pre-operative work up of patients who need surgery as part of the management such as routine and special investigations as advised, getting the pre-anesthesia checkup and clearance from physicians/pediatricians if required.

5.3.4 Work up all pre-operative patients:

5.3.4.1 Check all details of the patient mentioned in the work up clinic.

5.3.4.2 Check any recent change in the status of the patient.

5.3.4.3 Check all investigations.

5.3.4.4 Refer the patients to other concerned specialties if required.

5.3.4.5 Take consent for surgery after explaining details of the operation.

5.3.4.6 Execute the plan and prepare patients for surgery.

5.3.5 Always complete the appropriate column for ICD CODES.

5.3.6 The management plan should be clear enough for any other treating doctor to understand on subsequent visits.

5.3.7 The medication should be prescribed with enough justification. Also take note of the medication prescribed on previous visits and by other departments.

5.3.8 Investigation plan should be specific, relevant to management and undesired repetitions should be avoided.

5.3.9 The following code of conduct is appreciated during Doctor-Patient interaction:

5.3.9.1 Initial contact with patient should start with appropriate salutation and introduction to develop a good doctor-patient rapport.

5.3.9.2 The Doctor should explain about the nature of the condition and the management plan wherever necessary, about the chronic nature of the disease and the need for long term treatment.

5.3.10 All planned surgeries should be given appointment only after approval by a consultant.

5.3.11 When surgery is indicated the following should be discussed with the patient/relative:

5.3.11.1 Nature of surgery.

5.3.11.2 Expected outcome.

5.3.11.3 Relevant complications to be explained in the light of benefits (balance to be maintained).

5.3.11.4 What to expect if not operated.

5.3.11.5 Explore the possibility of surgery as Day Care (keeping in mind the criteria for selection).

5.3.12 If the patient is a minor, mentally handicapped or geriatric, discuss the management plan with the parents / guardian (please establish that the person you are talking to is the parents / guardian).

5.3.13 If they are willing for the procedure, do baseline investigations:

5.3.13.1 CBC: for all patients. If Hemoglobin is below 10 g/dL, refer the patient to the physician / pediatrician.

5.3.13.2 RBS, U&E, ECG and chest x-ray for patients above 45 years or in the presence of any significant medical illness.

5.3.13.3 If BMI > 30 get Physician's clearance prior to date for surgery.

5.3.13.4 For all major elective cases or those requiring hypotensive anesthesia; ECG should be done and evaluated by the physician.

5.3.13.5 For all OSA patients get pre anesthesia and physician clearance in advance.

5.3.14 The outpatient notes are only a guide to the doctor working up the case. He/she should note down his/her independent findings. In case of any doubt/discrepancy a senior colleague should be contacted.

5.3.15 All patients suffering from malignancy of Head & Neck should have their clinical staging mentioned in the notes. Any periodic updates in the staging system or symptoms of patients should be consulted and changes adopted accordingly.

5.4 Responsibilities of Doctors posted in Bowshar Polyclinic and As Seeb Polyclinic:

5.4.1 Examining all the referred patients from primary health care.

5.4.2 Refer to An Nahdha hospital for further management if needed.

5.4.3 General cases that need a consultant opinion are seen in the consultant clinic for review and if needed, an arrangement for surgery at An Nahdha Hospital will be made by the same consultant

5.5 Responsibilities of the teams in the Operation Theater:

5.5.1 A consultant should be in charge and team leader of the OT list.

5.5.2 The unit is responsible for operating all the patients listed for surgery.

5.5.3 Supervise and assist all the operations performed by the resident doctors.

5.5.4 Plan and write all post op care management and follow up of the operated patients.

5.5.5 Discuss, audit and hand over any special post-op care needed by any operated team by the end of the day.

5.6 On call Doctors Responsibilities and Duties:

5.6.1 First on call:

5.6.1.1 1st on call stays in the hospital for the duration of on call (2.30 PM -7:30 AM).

5.6.1.2 Manages all the emergencies in the hospital.

5.6.1.3 Seeks opinion of 2nd on call doctor if required.

5.6.1.4 Hand over all patients, routine and emergency, to the ward team during working days in the morning rounds and to the next on call team during weekends and public holidays.

5.6.1.5 Discharge Day care cases (unless required admission if stated by the surgeon)

5.6.1.6 Do evening rounds along with the 2nd on call and to document progress notes.

5.6.2 Second on call:

5.6.2.1 Provides cover for 1st on call.

5.6.2.2 In case of multiple emergencies needing more than one doctor or in case the 1st on call is unreachable or is suddenly indisposed the 2nd on call takes over the duty.

5.6.2.3 Consultation and help with 3rd on call should be made for cases requiring urgent attention, surgical management problems.

5.6.2.4 To cover emergency cases attending A/E from 7.00 pm to 9.00 pm (Except weekends and Public Holidays).

5.6.2.5 To review all emergency admissions along with 1st on call.

5.6.3 Third on call:

5.6.3.1 Attends to requests for consultation by 2nd on call or 1st on call if 2nd on call is unreachable.

5.6.3.2 Receive referrals from other hospitals in Oman including surgical emergencies.

5.6.3.3 Communicates with 4th on call for the management of all difficult cases.

5.6.3.4 To be present in the OT for an emergency surgery under general anesthesia if required.

5.6.3.5 To inform the 4th on call about all the admitted patients and if any patients taken to the OT.

5.6.4 Fourth on call:

5.6.4.1 Has overall responsibility for the on call duties of the team.

5.6.4.2 Provides opinion, assistance on cases for 3rd on call.

5.6.4.3 Provide coverage to 3rd on call in case of multiple emergencies or if the 3rd on call is unreachable.

5.6.4.4 Decides if 3rd on call can supervise/conduct an emergency surgery on his/her own, or the presence of 4th on call is required.

5.7 Escort Duty:

As per the Hospital policy and rules.

6. Document History and Version Control

Document History and Version Control			
Version	**Description of Amendment**	**Author**	**Review Date**
01	Initial Release	Department Management Board	2020
02	Revised version	Department Management Board	2025

Written by	**Reviewed by**	**Approved by**
Department Management Board	Department Management Board	Hospital Director