



OPERATION THEATRE

AND

ANAESTHETIC POLICY

KOD	101
ALOK	(Dr. An. Ismail) 6/6/2023
NO	101 ROSMA BT LAM (Sul)
NO	81 (Sia Su Inn)
NO	81 (HIP) 6/6/23
NO	
NO	
NO	Richard
NO	
NO	

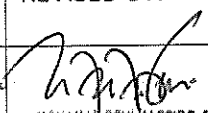

JABATAN KESIHATAN NEGERI SARAWAK

HOSPITAL KANOWIT

DOCUMENT : DEPARTMENTAL OPERATIONAL POLICIES AND PROCEDURES - OPERATION THEATRE	
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DOCUMENT: Departmental Operational Policies & Procedures - Operation Theatre Services

OBJECTIVE: To Provide safe surgery and anaesthetic service with zero complication

	REVISED BY:	APPROVED BY:	
SIGNATURE & CHOP	 MOHAMAD DZULKARZIE B. TAIP PENolong PECAWAI PERUBATAN U321 HOSPITAL KANOWIT NO LPP: 5066	 DR. BERNADETTE SYONNIA BT. JARU SAWAY PENGBARAI HOSPITAL, HOSPITAL KANOWIT, (MMC NO. 6159)	14.11.2025
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ISI KANDUNGAN

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OPERATION THEATRE KANOWIT HOSPITAL/

MISSION

With full support from the hospital administration and use of modern technology, we are committed to provide optimal, patient-oriented, caring and friendly services to all patients with enthusiasm and professionalism

OBJECTIVES.

1. To provide optimal anaesthetic service and perioperative care effectively and efficiently to patient undergoing both elective and emergency surgery.
2. to provide continuous training for paramedical personnel within the unit on safe and efficient preoperative

STRUCTURE OF ORGANIZATION.

1. The operating suite shall be headed by the Anaesthetic Senior Assistant Medical Officer. He shall be responsible for the administrative management of the cooperation suite. He shall be assisted by the Anaesthetic Assistant Medical Officer and the nurses in his administrative work.
2. The administration of anaesthesia to the patients is the responsibility of the anaesthetic Assistant Medical Officer.
3. The day to day running of nursing duties in the operating suite is the responsibility of the operating theatre nursing sister. She shall be assisted by her nurse.
4. figure 1 depicts the organization of the operating suite.

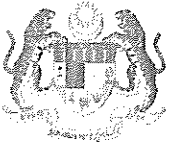
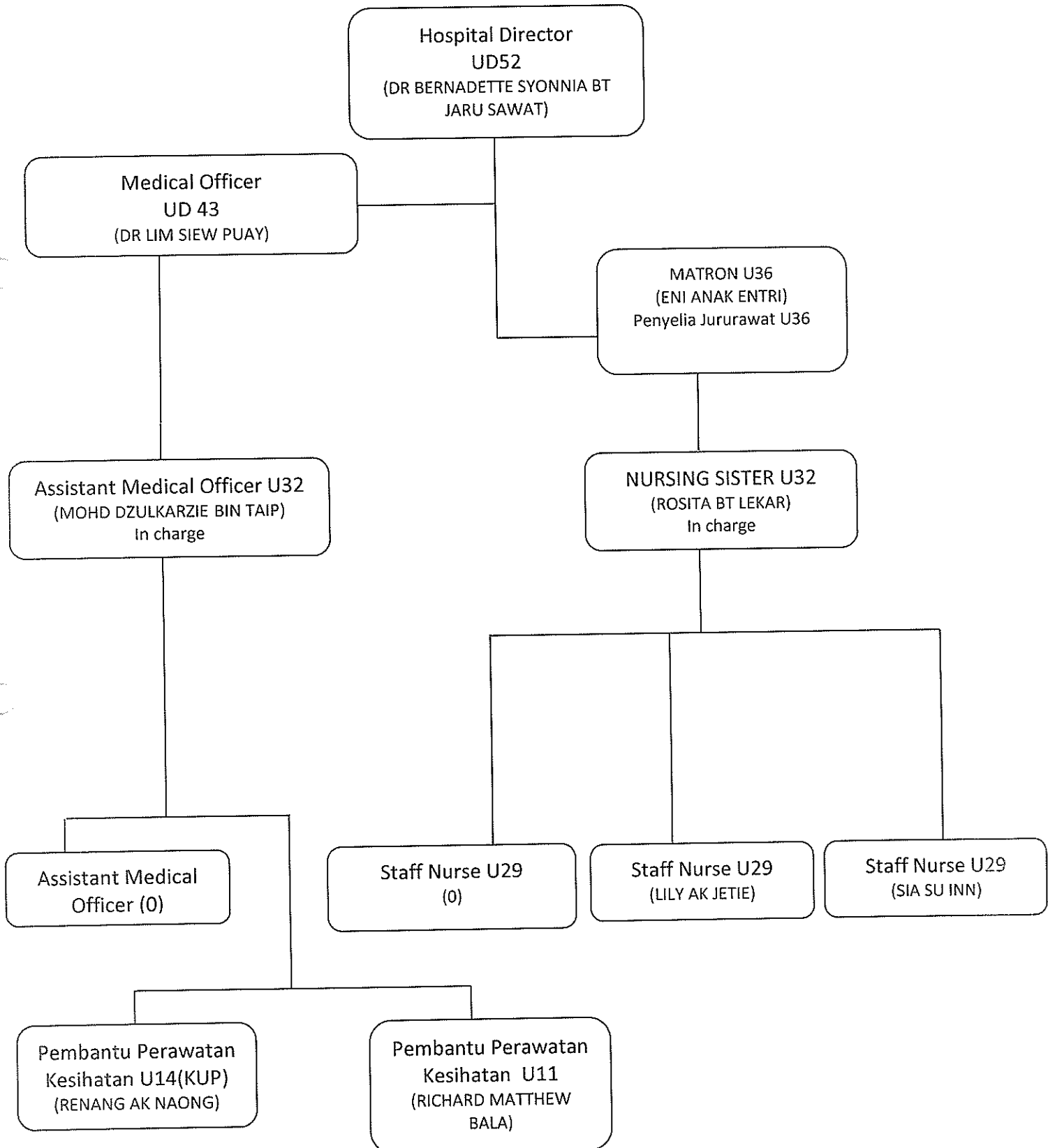


Figure 1 : Organization chart of operating suite.





5. The position available in the Operating Theatre is shown in the table below.

Portfolio	No. of post	No. of post filled	No. of post vacant
Anaesthetic Assistant Medical Officer U32	0	1	0
Anaesthetic Assistant Medical Officer U29	2	0	1
Nursing Sister U32	0	1	0
Staff Nurse U29	3	2	1
Pembantu Perawatan Kesihatan U14(KUP) and U11	2	2	0

- Please refer to the desk file of individual portfolio for detailed work descriptions and responsibilities.



OPERATIONAL POLICIES

1. Usage of Operation Theatre.

- 1.1. There are two (2) operating theatres in the hospital. These two O.Ts are opened daily for emergency surgery.
- 1.2. The O.T service is available for 24 hours a day. Elective surgery shall be performed between 8.00 am to 1200 noon and from 2.00 pm to 4.00 pm during weekdays. No elective surgery shall be performed after office hours, weekends (Saturday & Sunday) and Public holidays.
- 1.3. There shall be no fix day for any discipline/department to perform elective surgery.

2. Elective cases. (minor cases – BTL, excision of simple cyst, circumcision & breast fibroadenoma)

- 2.1. The elective surgery list (OT list) shall be prepared by the respective doctor. It should be submitted to the OT a day earlier, so that it is screened by the Anaesthetic Assistant Medical Officer before the surgery.
- 2.2. The paediatric and diabetic patients shall be given the priority while the clean cases be done before the infected (dirty) cases.
- 2.3. The Anaesthetic Assistant Medical Officer shall be privileged only to provide anaesthesia for patient with ASA I and II, or dire emergency cases who are ASA III, in the absence of an Anaesthetic Doctor.
- 2.4. The Anaesthetic Assistant Medical Officer shall be privileged to administer both general and regional anaesthesia – spinal only.
- 2.5. The Nurses without Peri operative Course shall be privileged to performed the procedure in OT.

3. Emergency cases.

- 3.1. All the emergency cases shall be notified to OT staff by filling in the appropriate form. The form shall be completed fully and be submitted to the OT. However, in dire, the ward doctor may notify the Anaesthetic Assistant Medical Officer on call by phone so that the OT could be prepared for the emergency promptly.
- 3.2. The patient planned for emergency surgery shall be assessed by the Anaesthetic Assistant Medical Officer either in the ward or in the OT.



3.3. The patient planned for emergency surgery shall be called to OT as soon as a OT is available, during the intervals of elective cases or at any time subjected to the urgency to the surgery and the OT staff capacity.

4. Receiving and discharging patient.

The OT nurse shall call the ward staff for the patient by telephone. The patient is transported to the OT by the ward nurse and attendant. He/she will be handed over to the nurse at the transfer bay of the OT. The nurse shall receive the patient according to the standard procedures. Please refer to the Pre-operative Checklist for details.

The circulating nurse in OR shall check the patient according to the standard procedure using SAFE SURGERY SAVE LIVE form. Please refer to the Pre-operative checklist for details.

All immediate post-operative patients shall be monitored and nursed at the recovery bay. Before being discharged to the general ward, all the post-operatives patients must be assessed by the Anaesthetic personnel. The patients should be discharged only after they have recovered adequately and are in stable condition.

Before handing over the post-operative patient to the ward nurse, the patient shall be assessed again according to the standard procedures. Please refer to The Peri-operative Checklist for details.

5. Discipline and behavior in Operation Suite.

5.1. Discipline.

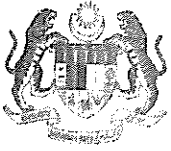
5.1.1. All staff, patient and visitors shall abide by the rules and regulations of the operating theatres.

5.1.2. Talking and noises are to be minimized in the OT proper during the preceding of an operation/procedures.

5.2. Attire

5.2.1. All staff and OT users are to change into the standard OT attire and slippers or boots before entering the operating suite. They are to remove their street shoes at the staff entrance. Shoe rack is provided at the entrance. They are responsible to keep their own valuable items and wallets.

5.2.2. No OT attire are to be worn outside the OT. However, having done so, the personnel concerned has to change into fresh OT attires before re-entering the OT suite.



5.2.3. Mask and caps.

- Masks are to be worn when entering OT. It should covers the nose and the mouth properly & change after every case.
- Masks are to be tied securely to prevent venting at the side and to change when it is soiled.
- All hairs are to be tucked neatly under the theatre caps.

5.2.4. Street sock are not permitted in the operating suite. The staff may bring a clean pair of socks for their own use in OT.

5.2.5. All staff to use designated slippers for toilet when they enter toilet.

5.2.6. All used OT attire and caps are to be placed in the respective laundry bags provided in the staff changing rooms.

5.3. The mother or guardian of the paediatric patient is encouraged to accompany the child up to the process of induction in the operating theatre.

5.4 All staff and OT users are not allowed to bring foods or drink into the OT proper.

6. Infection control and cleanliness.

6.1. Existing regulations on cleanliness, sterilization and disinfection as stated in the Guidelines on control of Hospital Acquired Infection and Disinfection and Sterilization Practice, Ministry of Health shall be observed.

6.2. Strict adherence to the guideline on the universal precaution is mandatory

6.3. The standard protocol shall be made available for referral at all times.

6.4. Environmental cultures are taken from every OT when needed. The appropriate infection control method shall be instituted when needed.

7. Specific standards for Operating Theatre.

7.1. Design.

7.1.1. The OT suite is a highly specialized field. The basic zoning concept is clearly defined to identify and to exclude cross contamination with sensible traffic pattern within the OT. The clean and the contaminated areas shall be clearly defined.



7.2. Environmental Requirements.

7.2.1. Apart from safe water, stable temperature and humidity, the other requirements are,

- A controlled filtered air to provide fresh air and to prevent accumulation of anaesthetic gases in the operating room.
- The environment air monitoring – it is carried out when needed by using settling Agar plate method.
- The environmental surveillance – it is carried when needed by swabbing of operation light, walls and floors.

8. Safety in Operating Suite.

8.1. Usage of Dangerous Drugs.

8.1.1. All drugs listed under Dangerous Acts are kept and locked in the Dangerous Drugs Cupboard. The stock shall be checked by the Staff nurse Daily & weekly (DDA Book). The usage of these drugs is recorded immediately after its use with the patient's details, name, identity card number or hospital registration number.

8.2. Electrical and Mechanical devices

8.2.1. All the devices used must passed SIRIM /International standards and are used according to the manufacturer's or other appropriate guidelines.

8.2.2. Safe use of diathermy. Please refer to The Operation Theatre Work Procedure File for details.

9. Fire Safety.

9.1. Fire safety of the hospital is strictly adhered to.

9.2. All emergency exits are kept clear of objects

9.3. All staff must be familiar with fire evacuation plan.

10. Other key aspect of whole hospital policy.

10.1. Housekeeping.

10.1.1. Cleaning and housekeeping of premises including supply of clean linen shall be the responsibility of the concession holders. The housekeeping shall be carried out according to schedules drawn up and agreed upon between the hospital and the concession holder.



10.1.2. The OT staff shall supervise the cleaning personnel in the general cleaning and the housekeeping of the operation theatre.

10.1.3. Cleaning of OT trolleys, emergency trolley and outside Sterile cupboard done by OT staff daily.

10.1.4. Cleaning of inside sterile cupboard done by OT staff weekly.

10.2. Movement of supplies.

10.2.1. Medical supplies are to be indented by OT staff from the pharmacy. They are collected by OT staff.

10.3. Waste management

10.3.1. Clinical and domestic wastes are to be bagged in separate color-coded bags.

10.3.2. Operating theatre Attendants are to place all bagged clinical waste in the respective OT sluice room. They shall be collected by the concession holder through the dirty corridor daily or whenever by the concession holder through the dirty corridor daily or whenever requested.

10.4. Laundry Services

10.4.1. Soiled linens used in OT are kept in the red lined bags and are placed inside the respective OT sluice room. They are collected by the concession holder daily through the dirty corridor.

10.4.2. Used OT attires are placed inside linen holder at the changing rooms. They shall be collected by the Linen and Laundry services daily.

10.5. Maintenance

10.5.1. The OT staff shall phone the concession holder's help desk for all the services request. The concession holder shall response to all the services requested within the following norms;

The response time norms for;

Type of request	Urgent	Normal
BEMS	15 minutes	1 hour
FEMS	30 minutes	3 hours



ANAESTHETIC UNIT KANOWIT HOSPITAL.

1. LOCATION.

The Operation Theatre is located in the same block with x-ray and the Laboratory department.

2. OBJECTIVES.

To provide good quality and effective anaesthetic services to patient undergoing surgical procedures.

3. SCOPE OF SERVICE

The anaesthetic unit shall provide a good quality and effective anaesthetic services to patient undergoing surgical procedures. There are two operating suite with two anaesthetic machine. These two OTs are equipped with the very basic monitoring equipment like pulse oximeter, ECG monitor BP machine and the major theatre with a capnography.

4. ORGANISATION.

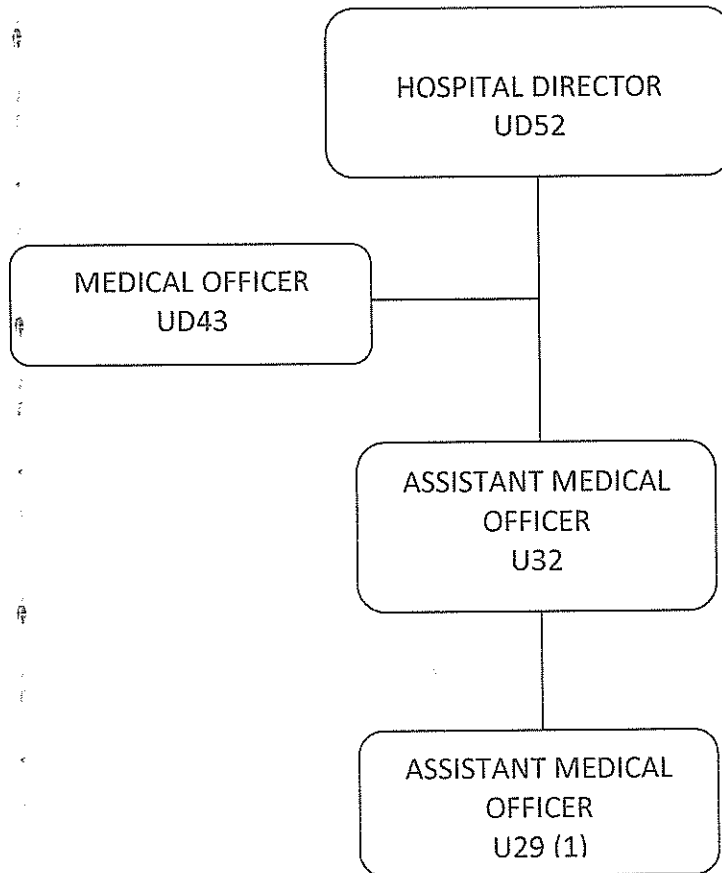
The anaesthetic unit shall be headed by a Senior Anaesthetic Assistant Medical Officer (SAMO). The SAMO is responsible for the proper administrative management of the unit. The SAMO shall be assisted by the Anaesthetic Assistant Medical Officer (AMO) to some extent staff nurse and Jururawat Masyarakat.(JM).

The SAMO shall plan various activities in the unit like,

- a. Review the duty lists of all the members of the unit
- b. Ensuring that the anaesthetic unit is run smoothly and effectively.
- c. Proper duty allocation is done for all members of the unit.
- d. Ensuring that all the anaesthetic equipment are maintained in good order.



4.1 THE ORGANISATION CHART FOR ANAESTHETIC UNIT





5.3. Anaesthetic techniques

Commonly used techniques are;

1. spontaneous respiration with face mask (SR)
2. intermittent positive pressure ventilation (IPPV)
3. regional anaesthesia – only spinal (sub-arachnoid block)
4. local anaesthesia with sedation.

5.3.1. nature of operation will decide the technique of anaesthesia used

5.3.2. attached vital sign monitors before start of each anaesthesia and operation.

5.3.3. ensure that the induction and maintenance agents are appropriate to produce excellent anaesthesia.

5.4. Intra-operatively monitoring of patient.

5.4.1. Mandatory vigilant monitoring of vital signs, b/p, pulse, spo2 and ECG

5.4.2. Communicate with the operating doctor every now and then regarding patient's Condition

5.4.3. Inform the doctor of any abnormal vital signs. To stop operation temporarily and help in the resuscitation. To proceed once the conditions permit or transfer to Sibu hospital to be taken care by specialist.

5.5. Reversal of anaesthesia.

5.5.1. Reverse with atropine 1.0mg and neostigmine 2.5mg (standard agent) patient paralyzed with non-depolarizing neuro-blocking agent.

5.5.2. Reverse only when patient shows the return of spontaneous breathing like reservoir bag movement (filling and emptying)

5.5.3. Perform the pharyngeal suction gently to avoid trauma.

5.5.4. Extubate only when patient can fully breath spontaneously

5.5.5. Monitor patient in the recovery bay before discharging to ward

5.5.6. Proper instructions regarding patient's conditions on handing over to ward staff.

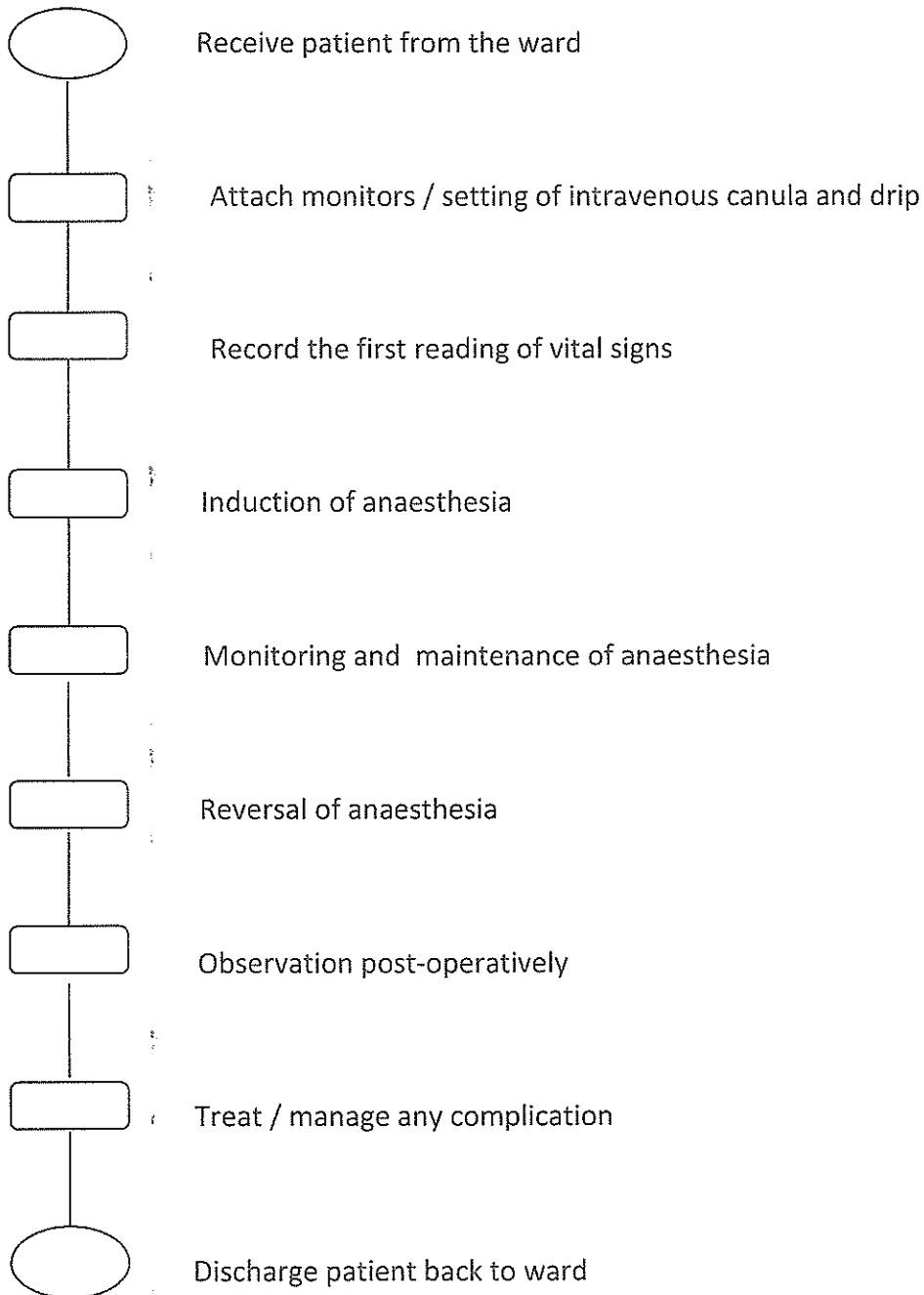
NOTE:

Scavenging of Anaesthetic Waste Gas

1. Anaesthetic waste gas shall be scavenged using approved disposable waste gas canister. It shall be discarded upon reaching 1.4 kilogram in weight and replace with new one.



WORK FLOW FOR ADMINISTRATING GENERAL ANAESTHESIA





6. ADMINISTRATING GENERAL ANAESTHESIA (SPINAL/SAB) WORK PROCESS

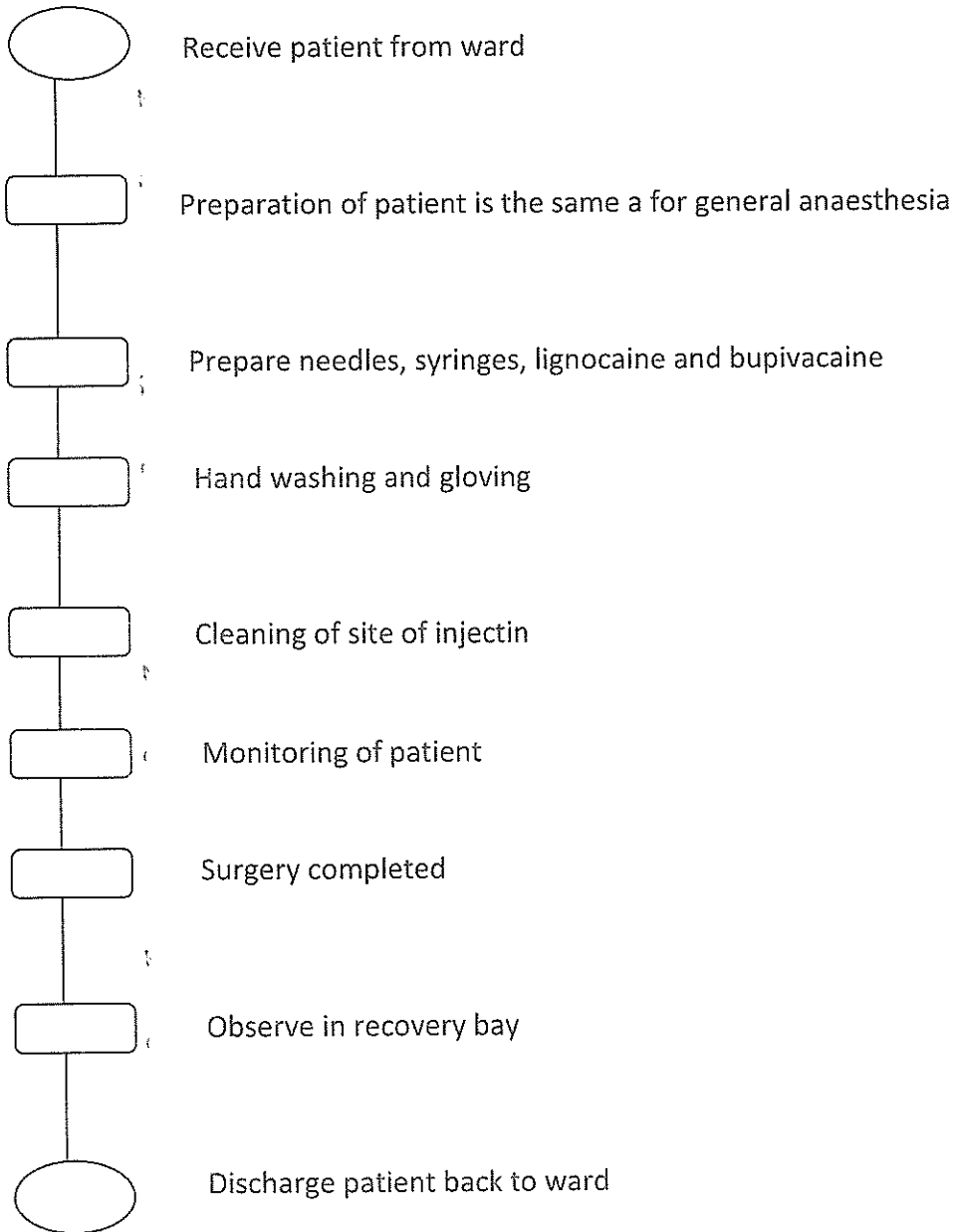
Preparation for regional anaesthesia is the same as for general anaesthesia

In the operating suite.

- 6.1. Explain to patient the nature of anaesthesia to be given.
 - 6.2. attach monitoring equipment once patient is on the operating table
 - 6.3. record all initial vital signs reading for base information
 - 6.4. preload patient with 0.5L NaCl 0.9% or Hartman
 - 6.5. draw injection ephedrine 6ml/ml in 5 ml syringe
 - 6.6. prepare 25G / 27G spinal needle, lignocaine, 2 & 5ml syringe, injection needle and heavy bupivacaine 0.5%
 - 6.7. perform proper hand washing and donning of sterile surgical gloves
 - 6.8. inject lignocaine to anaesthetize the intended spot of lumbar puncture.
 - 6.9. perform lumbar puncture and inject a pre-calculated dose of heavy bupivacaine 0.5% once inside the sub-arachnoid space (evidence of backflow of clear CSF)
 - 6.10. place a dressing cover the puncture site and plaster.
 - 6.11. put back patient to supine position in due care.
-
- 6.1. Intra-operative monitoring
 - 6.1.1. vigilant monitoring of vital signs and record every 5 minutes.
 - 6.1.2. run intravenous fluid fast or give intravenous ephedrine (titrate) should the b/p drops.
 - 6.1.3. keep the patient warm
 - 6.1.4. talk to patient to ensure she/he is fine.
 - 6.1.5. upon completion of surgery, advise patient the Dos and Don'ts post-operatively
 - 6.1.6. continue monitoring of patient before being discharge to the ward.
 - 6.1.7. proper handing over instruction to ward staff.



WORK FLOW FOR ADMINISTRATING SPINAL ANAESTHESIA.





7. THE ASSOCIATION OF ANAESTHETIST *Of Great Britain & Ireland*

The following checks should be made prior to each operating session. In addition, check 2, 6 and 9 (monitoring, breathing system and ancillary equipment) should be made prior to each new patient during a session.

1. Check that the anaesthetic machine is connected to the electricity supply (if appropriate) and switch on.

Note: Some anaesthetic work station may enter an integral self-test programme when switch on; those functions tested by such programme need not be tested.

- Take note of any information or labeling on the anaesthetic machine referring to the current status of the machine. Particular attention should be paid to recent servicing. Servicing labels should be fixed in the service logbook.
2. Check that all monitoring devices, in particular the oxygen analyzer, pulse oximeter and capnograph are functioning and have appropriate alarm limits.
 - Check that gas sampling lines are properly attached and free from obstructions.
 - Check that an appropriate frequency of recording non-invasive blood pressure is selected.
(Some monitors need to be in standby mode to avoid unnecessary alarms before being connected to the patient)
 3. Check with a "Tug Test" that each pipeline is correctly inserted into the appropriate gas terminal.
Note: carbon dioxide cylinders should not be present on the anaesthetic machine unless requested by the anaesthetist. A blanking plug should be fitted to any empty cylinder yoke.
 - Check that the anaesthetic machine is connected to a supply of oxygen and that an adequate supply of oxygen is available from a reserve oxygen cylinder
 - Check that adequate supplies of other gases (nitrous oxide, air) are available and connected as appropriate.
 - Check that all pipeline pressure gauges in use on the anaesthetic machine indicates 400 – 500kpa.
 4. Check the operation of flow meters (where fitted)
 - Check that each flow meter valve operates smoothly and that the bobbin moves freely throughout its range.
 - Check the anti-hypoxia device is working correctly.
 - Check the operation of the emergency oxygen bypass control



9. Check that all ancillary equipment which may be needed is present and working.
 - This includes laryngoscopes, intubating aids, intubation forceps, bougies etc, and appropriately sized face masks, airways, tracheal tubes and connectors, which must be checked for patency.
 - Check that the suction apparatus is functioning and that all connectors are secured
 - Checked that the patient trolley, bed or operating table can be tilted head down.
10. Check that alternative means to ventilate the patient is immediately available. (e.g self-inflating bag and oxygen cylinder)
 - Check that the self-inflating bag and cylinder of oxygen are functioning correctly and the cylinder contains an adequate supply of oxygen.
11. Recording.
 - Sign and date the logbook kept with the anaesthetic machine to confirm the machine has been checked.
 - Record on each patient's anaesthetic chart that the anaesthetic machine, breathing system and monitoring has been checked

This checklist is an abbreviation version of the Association of Anaesthetists Publication "Checking Anaesthetic Equipment 2012".

(Endorsed by the Chief Medical Officer and the Royal College of Anaesthetists)



- Antibiotic sensitivity – resistant to several drugs, most are still sensitive to Flucloxacillin or vancomycin.
- Survive on contaminated surfaces for as long as 6 months in room temperature.
- Good sterilization technique for potentially contaminated surfaces and safe handling of high risk items e.g needle is crucial.

9.4. HEPATITIS

- Infection with Hepatitis B is transmitted by the parenteral route but may also occur by contact with saliva, vaginal secretion or faeces.
- High risk group include;
 - . Intravenous drug users
 - . Haemophiliacs
 - . Haemodialysis patient
 - . Health care workers
 - . Homosexual men with multiple partners
- Incubation period 4-24 months
- Presence of HbsAg or HbsCg implies infectivity.
- Antibody to core antigen (anti-Hbc) and antibody to surface antigen(anti-Hbs) implies patient is no longer infectious but has active immunity against active re-infection.
- Presence of HbsAg of more than 6 months in the absence of antibody implies a chronic carrier.

9.5. PREVENTION OF HEPATITIS INFECTION

There is currently no treatment for viral hepatitis, hence, prevention becomes all the more important. Serological markers for type B infection has been found in more than 20% of anaesthetic personnel compared with 5% of general population. Adoption of certain isolation compared as outlined in the section for HIV is the best way to avoid exposure. There is a safe vaccine against type B virus, hence, vaccination is recommended for anaesthetic personnel. If an exposure occurs for e.g needle stick injury from an infectious patient, the treatment with immunoglobulin enriched with anti-Hbs (HBIG) is recommended. The virus survive on contaminated surface for as long as 6 months at room temperature. Good sterilization technique for the potentially contaminated surfaces and safe handling of high risk items such as needle is crucial.



9.6. HIV (HUMAN IMMUNO-DEFICIENCY VIRUS)

Acquired immuno-deficiency syndrome (AIDS) has become a significant health threat throughout the world.

High risk group are;

- Homosexual or bisexual men
- Intravenous drug users
- Transfusion recipient
- Sexual partners of infected individuals
- Newborn of infected mothers.

When exposed report immediately. Worker and patients are tested for serological evidence of infection to be tested periodically for a minimum 6 months for HIV antibodies. During this period, the person should prevent transmission of HIV to family members and patients. Some hospital may give Azathioprine (AZT) as a prophylactic measures. HIV survive dry and storage at 25.C and remain viable in dried material at room temperature for 3 days. Hospital sterilization techniques utilizing disinfectant such as sodium hypochlorite(bleach) will remove the virus from the contaminated surfaces such as anaesthetic machines. Many institutions have adopted the use of disposable equipment for patient with AIDS.

STANDARD PRECAUTION.

Assume all patient are infected because it is presently considered unethical to test all patient for evidence of HIV prior to surgery. Centre for Disease Control (CDC) guidelines for health care workers recommend that all patient regardless of HIV status be treated with proper precaution as follows:

- Wear gloves when performing procedures on patients
- Use appropriate barrier precaution when exposure to aerosol or splashes is likely. This includes endotracheal intubation and tracheal suctioning e.g use gloves, wear mask and protective glasses.
- If contact with body fluids occurs, the affected part should be washed immediately.
- Open or exudates wound should be covered and contact with potentially infective fluids avoided.
- To reduce the risk of needle stick injuries, needles are immediately disposed of in a suitable containers. The needles are not re-sheath or passed from one to another. (Risk of zero conversion following a needle stick injury is 0.3%)
- Use of respiratory isolation precaution for patients with pneumonia.
- Areas in which resuscitation may be requires should have equipment to allow ventilation without resorting to mouth to mouth to nose technique.



9.7. PROTECTION FOR UNINFECTED PATIENT.

- Routine disinfection and sterilization procedures are adequate to prevent transmission of infection.
- Disposable equipment is used for infected patients

10. OT PROTOCOL.

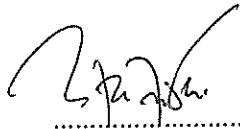
1. All staff wishes to enter OT must remove their street shoes before entering the changing room.
2. Dress code.
 - Change to standard OT attire
 - No street attire to be worn underneath OT attire unless a clean one brought for OT use only.
 - No OT attire to be worn outside OT.
 - Street socks are not to be worn in OT.
 - Hair must be tucked neatly under OT cap.
 - Used OT attire pocket must be emptied before being discarded into laundry bag provided.
 - Used linen cap are to be placed into the laundry bag provided
 - Surgical mask must be properly worn
 - Only clean and washable slippers are to be worn
 - The OT doors are to be kept closed at all time
 - There should be minimum loud talking.
 - All staff should adhere to standard practice of scrubbing and gowning



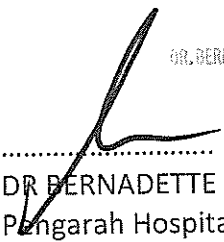
PATIENT AND FAMILY RIGHT

1. All patients shall have access to safe and medically appropriate treatment regardless of race, culture, sex, nationality or source of payment.
2. Information with regard to patient care shall be kept confidential.
3. Inform consent shall be obtained from the patient or relative before surgery and anaesthesia. The operating Doctor shall signed consent for surgery while anaesthesia by the Anaesthetic Assistant Medical Officer. Both procedures shall be witness by the nurses.
4. Any refusal by the patient or relative to consent for surgery and anaesthesia shall be accepted with respect.
5. OT staff shall explain the procedure to be performed and the expected anticipation from patient upon recovery from anaesthesia.
6. Patient valuable upon documentation if any, shall be handed over to the ward staff for safe keeping.
7. Taking of pictures of patient shall not be permitted without prior consent from him/her.
8. Surgery for paediatric and Diabetes Mellitus patients shall be given priority.
9. Patient's family shall be informed from time to time about the progress of surgery if takes more than an hour, including where appropriate the unanticipated outcomes.



Revised by : 
MOHD DZULKARZIE BIN TAIP,
Penolong Pegawai Perubatan U32
Hospital Kanowit.

Date: 14 .11. 2022

Approved by: 
DR BERNADETTE SYONNIA BT JARU SAWAT,
Pangarah Hospital UD ~~48~~ **UD 52**
Hospital Kanowit.

DR. BERNADETTE SYONNIA BT. JARU SAWAT
PENGARAH HOSPITAL,
HOSPITAL KANOWIT.
MMC NO. 61590

Date: 6/12/22