DIVISION OF GENERAL SURGERY
ST. MICHAEL’S HOSPITAL

ORIENTATION &
EDUCATIONAL OBJECTIVES

ST. MICHAEL’S HOSPITAL
Leading with Innovation
Serving with Compassion
A teaching hospital affiliated with the University of Toronto

Revised March 2007
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WELCOME to the Division of General Surgery at St. Michael’s. This document provides some important information about the Division and about the educational objectives of the rotation.

The members of the Division are committed to providing you with an excellent rotation. We encourage you to avail yourself of all opportunities, to ask questions, and to let us know during the rotation if you have any concerns regarding your experience with us.

HOUSESTAFF ORIENTATION

Anne Sorvari is the division administrative assistant. She will help organize your orientation, pagers, and passwords or will direct you as necessary. Her contact information is as follows:

   Office: 3 Queen, 076
   Telephone: Tel: 416-864-5750
   email: sorvaria@smh.toronto.on.ca

For resident issues contact:

   Michelle Dominey
   Education Coordinator, Department of Surgery
   Room 1-060 Bond Wing
   St. Michael's Hospital
   Phone: 416-864-6060 ext.6397
   Fax: 416-864-5322
   E-mail: dominateym@smh.toronto.on.ca
FACULTY
The following is a list of the Division members, their assistants, contact information and their clinical focus:

<table>
<thead>
<tr>
<th>Physician</th>
<th>Clinical interest</th>
<th>Contact information (E-email, O-office, P-pager)</th>
<th>Assistant contact information</th>
</tr>
</thead>
</table>
| Avery Nathens,       | Trauma, sepsis        | E: nathensa@smh.toronto.on.ca  
                 | Division Head          | O: Queen 3-076  
                 |                          | P: 416-692-7654                      | Anne Sorvari (Admin)  
                                  |                          | sorvaria@smh.toronto.on.ca                | Tammy Kowalyk (Patient Care)  
                                  |                          | kowalykt@smh.toronto.on.ca                | 416-864-5750                     |
| Jameel Ali           | Trauma, breast        | E: alij@smh.toronto.on.ca  
                 |                        | O: 55 Queen Street, Suite 402  
                 |                          | P: 416-685-9475                      | Rachel Gonzales  
                                  |                          |                                            | 416-864-6019                     |
| Najma Ahmed          | Trauma, critical care, thyroid | E: ahmedn@smh.toronto.on.ca  
                 |                        | O: Queen 3-073  
                 |                          | P: 416-685-9797                      | Linde Weedman  
                                  |                          |                                            | 416-864-5481                     |
| John Bohnen          | Surgical infection, hernia | E: bohnenj@smh.toronto.on.ca  
                 |                        | O: 38 Shuter, Room 5027  
                 |                          | P: 416-753-8405                      | Lorna Mirambel  
                                  |                          |                                            | 416-864-3047                     |
| Nancy Baxter         | Colorectal oncology   | E: baxtern@smh.toronto.on.ca  
                 |                        | O: CC 16-066A  
                 |                          | P: 416-685-5308                      | Alecia Fagan  
                                  |                          |                                            | 416-864-5168                     |
| Marcus Burnstein     | Colorectal, IBD       | E: burnsteinm@smh.toronto.on.ca  
                 |                        | O: CC 16-046  
                 |                          | P: 416-685-9422                      | Wendy Bell  
                                  |                          |                                            | 416-864-6050                     |
| Teodor Grantcharov   | MIS, foregut disease, simulation | E: grantcharovt@smh.toronto.on.ca  
                 |                        | O: CC 16-056  
                 |                          | P: 416-685-5465                      | Lorna Mirambel  
                                  |                          |                                            | 416-864-5748                     |
| Jarley Koo           | Breast, general surgery | E: kooj@smh.toronto.on.ca  
                 |                        | O: 55 Queen Street, Suite 402  
                 |                          | P: 416-685-9488                      | Kathy Nguyen  
                                  |                          |                                            | 416-864-5955                     |
| John Marshall        | Sepsis, complex general surgical problems | E: marshallj@smh.toronto.on.ca  
                 |                        | O: 4-Bond, 007  
                 |                          | P: 416-685-5082                      | Elaine Caon  
                                  |                          |                                            | 416-864-5225                     |
| Robert Mustard       | Sepsis, complex general surgical problems | E: mustardr@smh.toronto.on.ca  
                 |                        | O: 38 Shuter, 3-043  
                 |                          | P: 416-563-5251                      | Jo Geary  
                                  |                          |                                            | 416-846-3046                     |
| Ori Rotstein         | Sepsis, complex general surgical problems | E: rotsteino@smh.toronto.on.ca  
                 |                        | O: CC 16-044  
                 |                          | P: 416-685-9524                      | Suzanne Meade (admin)  
                                  |                          |                                            | 416-864-5410                     |
| Bernard Lawless      | Trauma                | E: lawlessb@smh.toronto.on.ca  
                 |                        | P: 416-685-5107                      | See Dr. Ahmed’s assistant for questions                             |
| Talat Chughtai       | Trauma                | E: talatchughtai@hotmail.com  
                 |                        | P: 416-235-8715                      | See Dr. Ahmed’s assistant for questions                             |
Division Members and housestaff are divided into 3 Teams:

<table>
<thead>
<tr>
<th></th>
<th>Oncology</th>
<th>Trauma</th>
<th>PINK</th>
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</thead>
<tbody>
<tr>
<td>STAFF</td>
<td>BAXTER</td>
<td>NATHENS</td>
<td>MUSTARD</td>
</tr>
<tr>
<td></td>
<td>KOO</td>
<td>AHMED</td>
<td>ROTSTEIN</td>
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<tr>
<td></td>
<td>BURNSTEIN</td>
<td>LAWLESS*</td>
<td>Bohnen</td>
</tr>
<tr>
<td></td>
<td>ALI</td>
<td>CHUGHTAI*</td>
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</tr>
<tr>
<td></td>
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<td>MARSHALL</td>
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</tr>
<tr>
<td></td>
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<td>GRANTCHAROV</td>
<td></td>
</tr>
<tr>
<td>RESIDENT</td>
<td>Senior</td>
<td>R3 Senior</td>
<td>Senior</td>
</tr>
<tr>
<td>SENIOR</td>
<td>R1</td>
<td>R1</td>
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<tr>
<td>JUNIOR</td>
<td>R1</td>
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</table>

*Clinical associates

**Trauma service**

The trauma service is closely related to the trauma team above. All trauma patients admitted to General Surgery will be under the direction of the trauma service attending surgeon. This attending rotates from week to week and includes the staff on the Trauma team as well as Dr. Mustard. The residents on the Trauma team are responsible for coverage of all elective cases on that team, all trauma team responses and operative cases during the regular workday (8 am-5 pm) as well trauma clinic. The residents on call are responsible for trauma team responses after hours/weekends or when the resident on the Trauma team cannot respond due to operative or other responsibilities.

The trauma service is responsible for the care of the patient with multisystem injuries and includes coordination and prioritization of care across the different services (e.g. neurosurgery and orthopedics). The service is large and there is both a trauma fellow and a nurse practitioner to assist in the work. The trauma fellow is responsible for rounding in the TNICU each morning to help offload the residents.
<table>
<thead>
<tr>
<th><strong>Oncology</strong></th>
<th>Mon</th>
<th>Tues</th>
<th>Wed</th>
<th>Thurs</th>
<th>Fri</th>
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<tr>
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<tr>
<td>Koo</td>
<td>Clinic</td>
<td>Clinic</td>
<td>Breast clinic</td>
<td>OR</td>
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</tr>
<tr>
<td>Burnstein</td>
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<td>Clinic</td>
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<tr>
<td>Ali</td>
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<td>OR</td>
<td>Clinic</td>
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<table>
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<tr>
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<tr>
<td>Nathens</td>
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<td>Trauma clinic*</td>
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<tr>
<td>Ahmed</td>
<td>OR</td>
<td>Office clinic</td>
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<td>Office clinic</td>
<td>Trauma*/GS clinic</td>
</tr>
<tr>
<td>Grantcharov</td>
<td>OR</td>
<td>Clinic</td>
<td></td>
<td></td>
<td>OR</td>
</tr>
<tr>
<td>Marshall</td>
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<td>OR</td>
<td></td>
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<td>Clinic</td>
<td>Endoscopy (variable)</td>
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<tr>
<td>Mustard</td>
<td>Clinic</td>
<td>Principles of Surgery Lecture Series 7:30 - 9:00 (Mt. Sinai)</td>
<td>Breast clinic</td>
<td>OR</td>
<td></td>
</tr>
<tr>
<td>Bohnen</td>
<td>Clinic</td>
<td>OR</td>
<td></td>
<td></td>
<td>Clinic</td>
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OR days represent usual and most frequent days for each attending. This might vary from week to week.

**Breast clinic:** 3-Queen (CIBC Breast Centre)

**Clinic:** 4-CC unless otherwise specified

*The trauma service attending on that week covers Trauma clinic*
<table>
<thead>
<tr>
<th>AM</th>
<th>Tumour Board</th>
<th>Discharge planning rounds</th>
<th>M&amp;M Rounds</th>
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<tbody>
<tr>
<td></td>
<td>Time: 4:00 – 4:30</td>
<td>Time: 11:00 - 12:00</td>
<td>Time: 7:30 to 8:45</td>
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<tr>
<td></td>
<td>GI/General Surgery Rounds</td>
<td>Location: 16 CC 101 Bruce Lecture Theatre</td>
<td>Location: 16CC-101 Bruce Lecture Theatre</td>
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<tr>
<td></td>
<td>Time: 4:30-5:30</td>
<td>Mandatory that at least one junior resident on each service attend for discussion of their service</td>
<td>** May be pre-empted by University Rounds OR Periop Service Rounds</td>
</tr>
<tr>
<td></td>
<td>Location: 16CC-101 Bruce Lecture Theatre</td>
<td>** These rounds will be pre-empted by M&amp;M rounds when the following Fridays rounds are cancelled</td>
<td></td>
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<table>
<thead>
<tr>
<th>PM</th>
<th>Risk Management Rounds</th>
<th>Trauma Rounds</th>
<th>Complication Management Rounds</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Time: 5:00</td>
<td>Time: 4:30-5:30</td>
<td>Time: 4:30-5:30</td>
</tr>
<tr>
<td></td>
<td>Location: 16CC-101 Bruce Lecture Theatre</td>
<td>Location: 16CC-101 Bruce Lecture Theatre</td>
<td>Location: 14CC-084 (Dr. Mustard)</td>
</tr>
<tr>
<td></td>
<td>(Dr. Bohnen)</td>
<td></td>
<td>Residents will advise Dr. Mustard about cases for discussion.</td>
</tr>
<tr>
<td></td>
<td>3rd Tuesday of the month General Surgery Journal Club instead of Risk Management Rounds</td>
<td></td>
<td>** These rounds will be pre-empted by M&amp;M rounds when the following Fridays rounds are cancelled</td>
</tr>
</tbody>
</table>

*Responsibility for these rounds is shared between GI Medicine and General Surgery*
RESIDENT RESPONSIBILITIES

Patient Care

The residents share with the staff the responsibilities for patient care and are encouraged to ask questions about all aspects of the investigation and management of clinical problems. The residents are expected to see the patients daily. The staff will round with the housestaff on a regular, usually daily, basis. Notes should be written on a daily basis. Operative notes should be dictated immediately following procedures, either by the resident or the staff surgeon. Operative notes should include a description of indications for operation and the operative findings and a succinct description of the procedure. A brief discharge note should be dictated at the time of discharge from the ward. In general, all patients discharged from the service are to be given a follow-up appointment in the Surgery Clinic (4 Cardinal Carter). Residents should contact the staff in the case of an unexpected death or critical care transfer, or any serious/unexpected clinical event.

On Call

The call will comply with PAIRO guidelines. Residents are expected to leave the hospital by 12:00 after a night of in house call. The chief resident makes up the call schedule and will coordinate housestaff vacations in consultation with the Division Chief. When on call, the in-house resident should consult freely with the senior resident, and the senior resident should feel free to consult with the staff. Should there ever be a situation in which a resident has difficulty contacting a particular staff person, one of the other staff general surgeons should be called upon to help out. If there are issues of a political, administrative, or bed availability nature, the staff surgeon should be notified.

It is NOT the duty of the resident to find a bed if bed availability is an issue. The staff surgeon should be involved early on in this process.

In general, consultation will be directed to the General Surgeon on-call. Consultations may be directed to a specific staff surgeon on the basis of specific clinical interest.

In the case of referrals from Respiratory Medicine, these should be directed to Yaron Shargall, Thoracic Surgery. Dr. Shargall can be reached at his office, 416-530-6653 or in case of urgent or emergent referrals, on his pager, 416-664-6944. Referrals for open lung biopsy and management of empyema can be directed to Dr. Ahmed or Dr. Nathens. Dr. Shargall has a clinic at SMH on alternate Friday afternoons and referrals can also be directed to the clinic (5408). Residents are encouraged to attend the Clinic.
Our Emergency Department is very busy and a prompt response to requests for consultations is greatly appreciated. If you are unable to respond to a request in a timely fashion, you should ask another resident or the staff surgeon to deal with the request. It is hospital policy that patients are seen and assessed within one hour of a request for consultation. A disposition decision must be made within two hours of consultation.

**Emergency OR bookings**

To book an emergency case, go to the OR desk (5 CC, ext. 5901) and complete the OR booking sheet (attachment F). Designate the case as P1 (within 2 hours), P2 (2 - 6 hours), P3 (6 - 48 hours) & P4 (1 week). The designation should be discussed with the staff surgeon.

**Morbidity and Mortality rounds**

Morbidity and mortality rounds are held on either Thursday afternoon or Friday morning. Assume they are being held on the Friday morning, with the exception of those Fridays when either University rounds or Perioperative services rounds are held. Attendance is required for these rounds unless in the operating room. For tracking purposes, please report in a standard format (see below) all operative cases between the Friday to the following Thursday (inclusive) on the week prior to M+M’s as follows: Fri Sat Sun Mon Tues Wed Thurs Fri Sat Sun Mon Tues Wed Thurs M+M. This gives you ample time to read up on the cases that require discussion. The purpose of listing all operative cases is to identify other cases that might be of interest but did not necessarily have a bad outcome. All adverse outcomes should be reported. All complications including deaths, unplanned returns to the operating room or transfers to the ICU need to be reported. Plan to discuss your complications so that the group can learn from the event. Presenting the facts of the case without any pertinent literature is not conducive to learning.

By no later than the Wednesday afternoon prior to rounds, please email Anne Sorvari (sorvaria@smh.toronto.on.ca) your case list and no more than one additional page consisting of the literature review that you plan to discuss. Anne will put these on transparencies and have these available in the conference room prior to rounds. Powerpoint presentations are neither expected nor desired. There is a means to present imaging studies in the conference room if necessary.

<table>
<thead>
<tr>
<th>Date From:</th>
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<tbody>
<tr>
<td>MRN</td>
<td>Date of procedure</td>
</tr>
<tr>
<td>1</td>
<td>2</td>
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<tr>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>11</td>
<td>12</td>
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</table>

If no procedure, specify date of admission
If no procedure, specify principal diagnosis

Revised March 2007
16-CARDINAL CARTER NORTH

The majority of general surgical patients will reside on 16-CC. This floor will be your home base for many of the clinical and educational activities at SMH.

About 16CCN:

16CCN is a 40-bed Inpatient General Surgery & Gastroenterology unit ext. 5233
- There are 28 General Surgery beds & 12 Gastro beds
- You help to manage the patient flow by beginning discharge planning upon admission
- Our staff include: RNs & Clinical Assistants (Unregulated care providers), and a full allied health team.
- Staffing ratio for nurses is: Days- patient to nurse is 5:1 & on Nights 6 or 7:1
- We have computerized the process for Non-Medication Order Entry (NMOE) so presently RN’s & Clerical Staff will be entering all NMOE’s. This requires specific information and clarity from you in your written orders.

Other resources:
- The CLM (Clinical Leader/Manager) is: Cathy Bouthillier ext. 5552, feel free to discuss any concerns/issues with her.
- The Charge Nurse Maria Araneta manages the day-to-day running of the floor; please touch base with her daily to address pt issues.
- The CNS/NP Jo Hoeflok x 5112 (pager 685-9370) for Stoma expertise manages the ostomies, fistulas & difficult wounds. Consult her for all ostomy patients both pre & post-operatively for teaching, marking, etc.
- The Case Manager Joan Park x 2764 will go on Rounds & will help to coordinate the use of clinical resources to achieve favourable outcomes & timely discharge for our patients.

How you can work with us:
- Please become part of the team, communicate your plans/concerns with us so we can facilitate patient care
- Round every morning on all patients, starting no earlier than 0630 hours – this time allows the staff to chart the information that you will need.
- You should be familiar with the Soarian system and how to write your orders to ensure that we can process them correctly.
- Use the scut lists in the am and pm to address routine requests – regular usage of this will prevent unnecessary pages to you.
- If you have additional requests for AM bloodwork in the morning, bring these requests to the desk to prevent having to redraw blood.
- Upon completing rounds, return the charts inside the Nursing Station, & have one member of your team give the Charge Nurse (Maria) a brief report on what you have planned for your patients.
• Before leaving the unit, please ensure that all discharge paperwork is completed – including: filling out the Discharge Summary, prescription, follow-up appointments or instructions.
• CCAC - Homecare Referrals require 24 hours notice. These should be completed & signed at least a day prior to your patient’s expected discharge.
• To reduce the number of pages you receive, please tell the Charge Nurse who on your team will be answering calls daily, should we need to reach one of you for an urgent matter. Remember to use the scut list! If you pay attention to the scut list you will cut down on the number of pages.
• Every Wednesday we have Multidisciplinary Patient Planning Rounds in the Lecture Theatre on 16CCN @ **1100 hours**. One person from each team is expected to attend these rounds to present the patients & discuss the plans. This is a team approach and we need your input. These rounds are mandatory.
• **Please limit the time spent on the computers in the Nursing Station, as these will be crucial to our success with NMOE.**
• Remember to put the **date, time & a resident’s printed name & signature** on all orders, to flag the charts on which you have written orders. With NMOE – you are required to write a diagnosis & reason for all tests, specific information for radiology, medical imaging etc or we cannot process the orders.
• You can check the progress of various orders on your patients using the Soarian system.
• We are fortunate to have a dedicated infection control practitioner. We pay very close attention to infection control practices. Use the alcohol gel dispensers to wash your hands before (and after) touching a patient.
# The General Surgery Multidisciplinary Team on 16-CC

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Telephone</th>
<th>Pager</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Management Team</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cathy Bouthillier</td>
<td>Clinical Leader Manager 16 Cardinal Carter North</td>
<td>864-5552</td>
<td>685-9462</td>
</tr>
<tr>
<td>Mae Burke</td>
<td>Clinical Leader Manager Endoscopy 16 Cardinal Carter South</td>
<td>864-5601</td>
<td>685-9651</td>
</tr>
<tr>
<td>Harriet Georgas</td>
<td>Administrative Secretary</td>
<td>864-6060 x 2534</td>
<td></td>
</tr>
<tr>
<td><strong>Case Manager</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Joan Park</td>
<td>Case Manager</td>
<td>864-6060 x 2764</td>
<td>685-9516</td>
</tr>
<tr>
<td><strong>Unit Leader</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Maria Araneta</td>
<td>Unit Leader</td>
<td>864-5233</td>
<td></td>
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<tr>
<td><strong>Dietitians</strong></td>
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</tr>
<tr>
<td>Abby Langer</td>
<td>Clinical Dietitian</td>
<td>864-6060 x 6229</td>
<td>685-9117</td>
</tr>
<tr>
<td>Fiona Press</td>
<td>Clinical Dietitian (M,T,W)</td>
<td>864-6060 x 2681</td>
<td>685-9479</td>
</tr>
<tr>
<td>Julie Seale</td>
<td>Clinical Dietitian (Th, F)</td>
<td>864-6060 x 6227</td>
<td>685-9789</td>
</tr>
<tr>
<td><strong>Clinical Nurse Specialist/Nurse Practitioner Enterostomal Therapy/Wound Care</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jo Hoeflok</td>
<td>Nurse Practitioner/CNS</td>
<td>864-5112</td>
<td>685-9370</td>
</tr>
<tr>
<td><strong>Pharmacists</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brian Jurewitsch</td>
<td>Pharmacist</td>
<td>864-6060 x 6117</td>
<td>685-9218</td>
</tr>
<tr>
<td>Yee Wah Ng</td>
<td>Pharmacist (W, Th, F)</td>
<td>864-5130</td>
<td>685-9937</td>
</tr>
<tr>
<td>Sanaz Mozayyan</td>
<td>Pharmacist</td>
<td>864-5130</td>
<td>685-9119</td>
</tr>
<tr>
<td><strong>Physiotherapists</strong></td>
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</tr>
<tr>
<td>Menaka Thevathasan</td>
<td>Physiotherapist</td>
<td>864-6060 x 9631</td>
<td>685-9772</td>
</tr>
<tr>
<td><strong>Social Work</strong></td>
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</tr>
<tr>
<td>Ursula Lielbardis</td>
<td>Social Worker</td>
<td>864-6060 x 6225</td>
<td>685-9776</td>
</tr>
<tr>
<td><strong>Speech Pathologist</strong></td>
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</tr>
<tr>
<td>Janet Wu</td>
<td>Speech Pathologist</td>
<td>864-6060 x 6317</td>
<td>685-9792</td>
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<tr>
<td><strong>Spiritual Care</strong></td>
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<tr>
<td>Catherine Walther</td>
<td>Chaplain</td>
<td>864-5324</td>
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</tr>
<tr>
<td><strong>TPN Nurses</strong></td>
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<tr>
<td>Clare Meechan</td>
<td>TPN Nurse</td>
<td>864-6092</td>
<td>685-9227</td>
</tr>
<tr>
<td>Tracey Pignatiello</td>
<td>TPN Nurse</td>
<td>864-6092</td>
<td>685-9227</td>
</tr>
<tr>
<td><strong>Infection Control</strong></td>
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<tr>
<td>Anjum Khan</td>
<td>Infection Control Practitioner</td>
<td>864-6967</td>
<td>685-9396</td>
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CLINICAL NURSE SPECIALIST

Clinical Nurse Specialist for GI/GS
- Jo Hoeflok, RN
- Referrals via voice mail (5112) or pager (9370)
- Available Monday to Friday
- 8am to 5pm

Patient population
- Follow all patients with new/established stomas, enterocutaneous fistulas, abdominal wounds and abdominal hernias
- Follow patients through the entire spectrum of care (pre-admission, peri-operative, out-patient)

Roles/Responsibilities
- have medical directives that allow for ordering of selected treatments, diagnostics, and pharmaceuticals on the patients that I follow
- ideally like to see all patients for pre-operative stoma site marking ➔ can see elective patients in pre-admission facility or in ambulatory clinic; in-patients at any time on the unit
- will provide education to all new stoma patients prior to discharge
- will provide assessments and treatment suggestions for wounds, fistulas and hernias
- will follow patients in ambulatory setting
- am available on “PRN” basis to assess patients in surgeons’ clinics
- assist with discharge planning, completion of rehabilitation application papers, family meetings, patient care-planning, Homecare referral completion
Cognitive Skills

CORE RESIDENTS (PGY I - II)

The major focus is the development of skills related to peri-operative diagnosis and management. At the end of the rotation, the core resident should:

- Have a good understanding of the pathophysiology, diagnosis and management of patients with:
  - GI malignancy
  - IBD
  - anorectal diseases
  - breast disease
  - hepatobiliary disease
  - multiple trauma

- Be able to do a history and physical examination on patients presenting with these problems

- Be able to manage routine post-operative patients, including complications such as:
  - urinary retention, oliguria
  - DVT/PE
  - fever
  - fluid and electrolyte disturbances
  - wound and stoma problems

- Understand the role and rationale for adjuvant therapies in breast and GI malignancies

SENIOR RESIDENTS (PGY IV - V)

- Are expected to be proficient in the diagnosis and management of surgical patients, including those with complex abdominal surgery, major cancer resections, re-operation, complex multiple trauma, and critically ill surgical patients
Technical Skills

CORE RESIDENTS

- At the end of the rotation, the resident should be able to perform part or all of the following, under supervision
  - Breast biopsy and lumpectomy
  - EUA anus, simple fistulotomy, abscess drainage
  - Rubber band ligation
  - Laparoscopic cholecystectomy
  - Appendectomy (laparoscopic and open)
  - Open and closing the abdomen
  - Bowel mobilization
  - Rigid sigmoidoscopy

SENIOR RESIDENTS

- Should be competent as surgeon in all of the above, plus the following:
  - small bowel resection & anastomosis
  - appendectomy
  - laparoscopic cholecystectomy
  - rigid sigmoidoscopy, flexible sigmoidoscopy
  - anorectal procedures, including fistulotomy, haemorrhoidectomy
  - colectomy
  - gastric resection
  - hernia repairs
  - tracheostomy
  - breast biopsy, lumpectomy, mastectomy, axillary node dissection
  - trauma laparotomy
  - damage control surgery
  - thyroidectomy

- Should be competent under supervision in the following
  - low anterior resection
  - abdominoperineal resection
  - complicated hepatobiliary operations such as bile duct reconstruction and Whipple procedure
**Independent operating by residents**

The following procedures do not require an in-house general surgical attending:

- *Tube thoracostomy (chest tube)*
- *Wound debridement, irrigation, and/or major dressing change*
- *Incision and drainage of perianal abscess, thrombosed hemorrhoid, and other soft tissue abscesses*
- *Central line insertion*
- *Appendectomy*
- *Incarcerated umbilical hernia*
Ambulatory care and attendance at clinics is an educational priority on this rotation. This is the principle opportunity for you to be involved in the primary assessment of elective clinical problems, in formulating management plans, in communicating with patients and families, and in obtaining operative consents. The clinics also provide the opportunity to follow up with the patients you have treated and to recognize and manage complications.

The senior residents should organize the housestaff team so that both medical students and residents are able to attend clinics, including Breast Clinic, on a weekly basis.

Family Practice PGY1s will have a schedule of ambulatory clinics which they are expected to attend. This schedule is organized as part of a larger curriculum for family practice residents organized through Dr. Ahmed’s office. If you are a family practice PGY1 and have not yet been contacted by Dr. Ahmed’s office, please email Linde Weedman (weedmanl@smh.toronto.on.ca) to receive the necessary information.

EVALUATION

Formal resident evaluation will occur at the exit interview, and at the mid-way point of the rotation. Both meetings will include review of the Can MEDS competencies. Evaluation will include an overall assessment of performance ITER, as well as a specific evaluation with reference to the educational objectives of the St. Michael’s General Surgery service.

In addition to formal evaluation, the faculty will provide regular informal feedback. We strive to maintain a very open and collegial environment. Don’t hesitate to ask for more feedback!
ADMINISTRATIVE ISSUES

- Each resident is automatically given a smh email account. Your email address will be lastnamefirstinitial@smh.toronto.on.ca. Your default password into the system is the 5 digit number found on the back of your ID badge. (If this does not work, please call the help desk at: x. 5751 and they will give you a temporary password to login to the system). Due to confidentiality and privacy issues, all communication will be sent to your smh email account, please make sure to use this email address while with us.

- There is a divisional folder accessible to all residents on the network to store confidential patient information, presentations, and share information. This can be found by clicking on the “my computer” icon and clicking the down arrow in the address bar. The location is “J” and the drive is named “common1 on sharedrive1”. Please do not save confidential materials on the computers located at the nursing station. Please contact Anne Sorvari if you have difficulties with accessing this drive.

- A senior resident office is located on 3 Queen. Lockers are available but you need to bring your own lock.

- Residents are allowed two weeks of vacation for each six month rotation; for residents spending less than six months, only one week of vacation can be taken; All vacation requests must be made one month in advance, in writing, to the chief resident and to the Divisional Administrative Assistant; only one resident can be away at a time, and vacations will generally not be given during the last week of a rotation, or during the months of December and June.

- Final year residents are funded to attend a conference; Jan McEvoy in the General Surgery Postgraduate Education office at 864-5475 can help with your reimbursement; the travel policy is detailed elsewhere.

ROUTINES

Bowel preparation, antibiotic prophylaxis and perioperative care for Dr. Burnstein

- IV antibiotics are given at induction in the OR:
  - Ancef 1 gm IV (if not penicillin allergic)
  - Flagyl 500 mg IV
  - Gentamicin 80 - 120 mg IV

- Antibiotics maybe repeated once postoperatively

- For loop ileostomy closure:
  - Mechanical prep is clear fluids on the day prior to operation
- The antibiotic is Cefoxitin 1 - 2 gm IV on call to OR (if pen allergic, use Flagyl and Gentamicin)
- Anorectal cases (haemorrhoidectomy, fistulotomy) receive one Fleet enema 2 - 4 hours pre-op; the enema is not ordered if there is a painful anal condition
- For laparoscopic cholecystectomy, no antibiotic is given in routine elective cases

**Post-op steroid coverage**

Patients can be divided into 3 groups:

*Group 1:* those not currently using steroids but have used them for periods of time within one year of surgery

*Group 2:* those using small doses of steroids (< equivalent of Prednisone PO 10 mg OD) or high doses for short periods of time (< 6 months)

*Group 3:* those using large doses of steroids (> equivalent of Prednisone PO 10 mg OD) for long periods of time (> 6 months)

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<tr>
<th>Op Stage</th>
<th>Medication</th>
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<tr>
<td><strong>Group 1 Patients</strong></td>
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<tr>
<td>Pre-op</td>
<td>Hydrocortisone (SoluCortef) IV 100 mg</td>
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<tr>
<td>Post-op</td>
<td>Hydrocortisone (SoluCortef) IV 100 mg x 1 dose</td>
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**Group 2 Patients**

| Pre-op   | Hydrocortisone (SoluCortef) IV 100 mg |
|          | Hydrocortisone (SoluCortef) IV 100 mg daily until tolerating oral diet |
| Post-op  | Prednisone PO 15 mg x 1 week |
|          | Prednisone PO 10 mg OD x 1 week |
|          | Prednisone PO 15 mg OD x 1 week then D/C |

**Group 3 Patients**

| Pre-op   | Hydrocortisone (SoluCortef) IV |
| Post-op  | Hydrocortisone (SoluCortef) IV 100 mg q8q x 48 hrs then |
|          | Hydrocortisone (SoluCortef) IV 100 mg q12q x 48 hrs then |
|          | Hydrocortisone (SoluCortef) IV 50 mg q8q x 48 hrs or |
|          | Prednisone PO 15 mg OD x 14 days then |
|          | Prednisone PO 10 mg OD x 14 days then |

Revised March 2007
Prednisone PO 5 mg OD x 14 days then
Prednisone PO 2.5 mg OD x 14 days then D/C

**NOTES:** Giving full dose once daily in the morning allows for faster recovery of the adrenals. If Group 2 or Group 3 patients are to be continued on steroids post-op they may stop tapering once maintenance dose is reached.

**Post-op Diet, Drains, Catheters**

- Jackson Pratt drains in the pelvis are generally left in place until:
  - POD # 5 - 7
  - volume < 20 - 30 cc’s per day per drain
  - if drainage remains high, patients may go home with drains in situ for later removal at the surgery clinic

- Foley catheters are generally left in situ until POD # 4 - 5 after extensive pelvic dissection; after abdominal surgery, Foley catheters are usually removed on POD # 1 - 2, or when clinically indicated; if the patient has an epidural, the Foley catheter is left until the epidural catheter is removed.

- If TPN is needed, consult the TPN service. Central line placement is usually PICC technique by Radiology.

- Nasogastric tubes are not routinely used in elective bowel surgery

**Blood Products**

- For ileoanal reservoir, abdominoperineal resection, other major pelvic surgery - BGAS minimum

- Major bowel resections - BGAS if necessary but usually not required

- Most other operations will not require group and screen or crossmatch
Central Line Placement by General Surgery Housestaff

1. The recovery room will be available to you for the placement of central venous catheters. Please contact the recovery room nurses to ensure that space is available for your procedure. The nursing staff will facilitate your procedure but will not be available to assist you.

2. Two housestaff must be present during the procedure at all times. An experienced MD must be either doing the procedure or directly supervising the procedure.

3. Please make sure that the appropriate sedation/analgesia/local anaesthetic is drawn up and available before you start the procedure.

4. Difficulties with this policy, as identified by either housestaff, staff, or nursing, should be brought to the attention of Dr. Avery Nathens at 864-5750 or pager 692-7654.

5. Arrangements for transportation of the patient to and from the recovery room will be the responsibility of the housestaff involved.

6. It is the responsibility of the housestaff involved to ensure that the area is completely tidied up after use. If blood or body fluids have been left on the floor or furniture, housekeeping should be notified.

7. The patient should remain in the recovery room until the chest X-ray is done and read.

8. Please ensure that appropriate documentation of the procedure is recorded in the chart, including medications used and patient condition.
RECOMMENDED READING

Colorectal Surgery

Some recommended reading in colorectal surgery accompanies this document. The following texts are in the SMH library and are also recommended. The library is located on the first floor of the Queen Wing. The hours are: Monday to Friday 8:00 a.m. - 8:00 p.m., and Saturday and Sunday 11:00 a.m. - 5:00 p.m.

Gordon, Nivatvongs. Principles and Practice of Surgery for the Colon, Rectum, and Anus.

Corman. Colon and Rectal Surgery

Nicholls, Dozois. Surgery of the Colon and Rectum.

These three references are comprehensive text books and all are excellent. There are not many questions which will not be satisfactorily answered by these texts. The journal Diseases of the Colon and Rectum is available in the SMH library. This is the journal of the American Society of Colon and Rectal Surgeons. In addition to publishing original research, there are also regular review articles and practice parameters.

Trauma

Mattox, Feliciano, Moore. Trauma, 5th edition 2004

Journal of Trauma, Injury and Critical Care

General Surgery

Roses. Breast Cancer, 1999


Selected Readings in General Surgery
Surgical Clinics of North America

Current Surgical Therapy. Cameron.