DHA Standards for Bariatric Surgery Services
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Acknowledgment

Dubai Health Authority (DHA) is pleased to present “DHA Standards for Bariatric Surgery Services” which represents a milestone towards fulfilling the DHA strategic objective to “Ensure continuous development of health and medical professionals and attract the highly qualified”.

This standard will assist the medical directors of the health facilities in assessing the competences and credibility of physicians to perform bariatric procedures to ensure safe and competent delivery of services.

The Health Regulation Department (HRD) in collaboration with subject matter experts whose contributions have been invaluable has developed DHA Standards for Bariatric Surgery Services. The Health Regulation Department would like to acknowledge these professionals and to thank them for their dedication to quality in surgical care and their commitment in undertaking such a complex task.

The Health Regulation Department
Dubai Health Authority
Scope

DHA Standards for Bariatric Surgery Services applies to all licensed physicians who meet the eligibility criteria to attain privileges to practice bariatric procedures in Dubai private sector health facilities and free zone, excluding Dubai Healthcare City (DHCC). This standard does not attempt to provide information related to the clinical steps necessary in performing bariatric procedures.

This standard may be amended from time to time at the discretion of Dubai Health Authority (DHA), and will be referred to as “DHA Standards for Bariatric Surgery Services”. The latest edition of the document shall be accessed through the DHA website www.dha.gov.ae.

Purpose

DHA is the sole responsible entity for ensuring that all health facilities and healthcare professionals in the Emirate of Dubai provide the highest level of safety and quality patient care at all times, through the development, establishment, and enforcement of minimum required criteria for the different healthcare services.

DHA Standards for Bariatric Surgery Services outlines the minimum requirements that must be fulfilled by the physicians opting to attain the privilege to practice bariatric procedures in the Emirate of Dubai. It also ensures that only appropriately qualified, trained and skilled physicians perform bariatric procedures, and that patients undergoing bariatric procedures are assured of quality and safe procedures.

In addition to the privilege criteria, this standard outlines the requirements that must be fulfilled and maintained by the health facilities that are already involved in or wishing to provide bariatric services.

Definitions

- **Advanced laparoscopic procedure**: consists of, but not limited to, the below procedures:
  - Laparoscopic gastrostomy and feeding jejunostomy placement
  - Laparoscopic inguinal and incisional herniorrhaphy
  - Laparoscopic bariatric procedures
  - Laparoscopic anti-reflux/esophageal procedures
  - Laparoscopic enterolysis
- Laparoscopic small and large bowel procedures
- Laparoscopic renal and adrenal surgery
- Laparoscopic donor nephrectomy
- Laparoscopic splenectomy

- **Bariatric surgery**: is a surgical procedure in the stomach and/or intestines to help an obese (bariatric) person to lose weight.

- **Basic laparoscopic procedure**: is comprised of: diagnostic laparoscopy, laparoscopic cholecystectomy, and laparoscopic appendectomy.

- **Biliopancreatic diversion**: is a surgical procedure that involves removing the lower two-thirds portion of the stomach. The remaining part of the stomach is connected to the distal segment of the small intestine (the ilium).

- **Duodenal switch**: is a laparoscopic procedure that combines the creation of a moderately sized stomach pouch with bypassing part of the small intestine.

- **EndoBarrier Gastrointestinal Liner**: is an endoscopically placed as a removable malabsorptive barrier that blocks both nutrient absorption and prevents mixing of food with biliopancreatic secretions in the duodenum. The plastic liner is 60 cm long and extends into the proximal jejunum. It is attached to a self-expanding implant that seats in the duodenum. Recent published studies of the EndoBarrier have focused on its potential as both a stand-alone primary therapy for obesity as well as a bridge to bariatric surgery. It has also demonstrated considerable glycemic improvements in diabetic patients. The EndoBarrier is currently considered investigational in the United States and is undergoing clinical trials and investigational studies. However, the EndoBarrier is approved and available in multiple countries outside the US, including Australia.

- **Endomina (TM)**: is an innovative, newly introduced device in Brussels, Belgium that adds degrees of freedom and a number of therapeutic channels to existing endoscopes. Endomina provides gastroenterologists and surgeons with the capability to perform complex movements and use multiple instruments when operating. These devices offer new possibilities for advances in flexible endoscopy and for the treatment of serious conditions such as obesity, type II diabetes and tumors of the digestive system.
- **Gastric banding or laparoscopic adjustable gastric banding (LABG):** is a procedure usually performed laparoscopically. It involves placement of a “band” high on the stomach creating a small pouch of 15-mL capacity without cutting the stomach. Adjustments are made up to six times per year to limit gastric capacity.

- **Gastric botox injection:** is an investigational procedure that involves injecting the Botulinum toxin A (botox) into the stomach area (gastric antral muscularis propria) guided by endoscopic ultrasound. Botox is thought to delay emptying of the stomach, create fullness feelings, thus prompting patients to consume less food. There are some risks with this procedure and some have found that there was no benefit in terms of body weight loss. Unless further studies show different results, patients/surgeons are advised to seek other means of achieving weight loss.

- **Gastric bypass:** is a surgical procedure involving the stapling of the upper stomach into a vertical or horizontal 15 to 25 mL pouch and creating an outlet to the small intestine. Surgery is reversible and can be performed laparoscopically or with the open approach.

- **Intragastric balloon:** is a non-surgical procedure designed to provide short-term weight loss therapy for obese people. A soft, expandable, silicone balloon is placed inside the stomach endoscopically. Once inserted into the stomach, the empty balloon is filled with sterile saline, occupying a large part of the stomach, creating a feeling of fullness. This balloon is only temporary and is usually removed after six months. It is effective in temporarily reducing hunger, controlling food intake, initiating behavioural change, and achieving target weight loss of 10 to 30kg.

- **Laparoscopic gastric plication:** is a new minimally invasive restrictive laparoscopic procedure that involves shrinking the size of the stomach by making large folds in the stomach’s lining. During laparoscopic gastric plication, the stomach volume is reduced by about 70% making the stomach smaller and thereby limiting food intake. Laparoscopic gastric plication procedure is a reversible procedure as it does not involve cutting, stapling, or removal of the stomach or intestines.

- **Laparoscopy:** is a type of surgery in which small incisions are made in the abdominal wall through which a laparoscope and other instruments can be placed to permit structures
within the abdomen and pelvis to be seen. A variety of probes or other instruments can also be pushed through these small incisions in the skin. In this way, a number of surgical procedures can be performed without the need for a large surgical incision.

- **Mini-gastric bypass**: is modification of gastric bypass with longer lesser curvature tube.

- **Obalon balloon**: is a nonsurgical, fully-reversible device for weight loss that does not involve permanent changes to the anatomy. Up to three lightweight balloons are placed in the stomach (over a 12 weeks treatment period), by simply swallowing a capsule and then inflating it with gas. The balloons are intended to occupy space in the stomach and the majority of patients have reported that these balloons helped feel fuller, eat smaller portions and hence lose weight. The Obalon balloons reside in the stomach for a 6-month period and then are removed in a short, outpatient endoscopic procedure. The Obalon balloon is currently under investigational status in the U.S and is available for investigational use only. The Obalon balloon is approved for sale in the European Union, Mexico and the Middle East.

- **Primary obesity surgery endoluminal (POSE)**: is a new type of weight loss procedures that is performed by endoscopy. During the procedure, the endoscope is inserted through the mouth and into the stomach, therefore no cuts in the abdomen are required. The flexible endoscope has been designed to deploy staples or clips to the floppy part of the stomach. The aim of the procedure is to reduce the size of the stomach by folding the stomach up using these staples that are fired from the endoscope. This procedure is an experimental treatment and is proved to be safe, effective, and well-tolerated for patients with obesity.

- **Revisional surgery**: is a surgical procedure that is performed on patients who have already undergone a form of bariatric surgery, and have either had complications from their primary procedure or have not successfully achieved significant weight loss results from the primary surgery. Procedures are usually performed laparoscopically, though open surgery may be required if prior bariatric surgery has resulted in extensive scarring.

- **Roux-en-Y gastric bypass surgery**: is a one type of gastric bypass surgery, which involves cutting the stomach in two to create a pouch out of the smaller proximal (near) portion of
the stomach, attaching it to the small intestine, bypassing a large part of the stomach and all of the duodenum.

- **Sleeve gastrectomy**: is a restrictive procedure that involves removing part of the stomach (left side) leaving a narrow gastric “tube” or “sleeve”. This surgery is performed laparoscopically and involves stapling of the stomach upon removal of the left side of the stomach. Intestines are not removed or bypassed during sleeve gastrectomy.
Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>ACLS</td>
<td>Advanced Cardiovascular Life Support</td>
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<tr>
<td>BMI</td>
<td>Body Mass Index</td>
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<td>CAD</td>
<td>Coronary Artery Disease</td>
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<tr>
<td>CCU</td>
<td>Critical Care Unit</td>
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<td>CPD</td>
<td>Continuous Professional Development</td>
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<td>DHA</td>
<td>Dubai Health Authority</td>
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<td>DHCC</td>
<td>Dubai Healthcare City</td>
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<td>GIT</td>
<td>Gastrointestinal Tract</td>
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<td>HRD</td>
<td>Health Regulation Department</td>
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<tr>
<td>ICU</td>
<td>Intensive Care Unit</td>
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<td>POSE</td>
<td>Primary Obesity Surgery Endoluminal</td>
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<tr>
<td>T2DM</td>
<td>Type 2 Diabetes Mellitus</td>
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<td>UAE</td>
<td>United Arab Emirates</td>
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1. Introduction

1.1 Physicians performing bariatric procedures shall be responsible for demonstrating defined experience and exposure to the discipline’s unique cognitive, technical, and administrative challenges.

1.2 As with other surgical/interventional procedures, it is essential that the physicians carrying out bariatric procedures received suitable training and are assessed as competent to perform it. This will involve that the physicians have undergone advanced/specialized training in bariatric surgeries/procedures and achieved a certain minimum level of skills to safely perform the surgery/procedure, to recognize and treat complications.

1.3 Physicians performing bariatric procedures shall have clear and documented process and patient record for the following:

1.3.1 Pre-operative assessment and counselling, refer to point 3.4 for more details
1.3.2 Patient selection criteria
1.3.3 Early/Acute post-operative care (immediate care at 1-4 days) and upon discharge
1.3.4 Postoperative management follow up at 3 months, 6 months, 12 months, and then as per the patient’s condition. This shall include:

1.3.4.1 Assessment of weight loss
1.3.4.2 Physical activity advice and support
1.3.4.3 Management of dietary and nutritional deficiencies
1.3.4.4 Bone density measurement at 1 year and 5 years
1.3.4.5 Assessment of lipid and glucose level and medication review
1.3.4.6 Management of post-operative complications

2. Indications for bariatric procedures

2.1 Bariatric procedure is not for cosmetic purposes but for prevention of the pathologic consequences of morbid obesity.

2.2 Bariatric procedure is an option for carefully selected patients with clinical obesity when less invasive methods of weight loss have failed and the patient is at high risk for obesity-associated morbidity or mortality.
2.3 Screening of the patients to ensure appropriate selection is the ultimate responsibility of the physician and the supporting healthcare team.

3. Patient selection criteria

Bariatric procedures shall be considered for individuals who meet the below criteria:

3.1 Age of 18 years and older

3.1.1 Adolescent patients (12-18 years of age), shall be referred to health facilities with multidisciplinary obesity management teams. These teams shall include specialists in pediatrics/adolescent obesity evaluation and management, such as bariatric surgeons, psychologists, nutritionists, and physical activity instructors. The availability of additional pediatric specialists in endocrinology, pulmonology, gastroenterology, cardiology and/or orthopedic may be recommended as well.

3.1.2 The criteria for undergoing bariatric procedures in adolescents has particular risks and benefits that must be accounted for when considering this approach. The unique psychological and emotional needs of adolescent patients make the patient selection criteria and perioperative management substantially different from those of adult patients to better address the needs of this group of patients. A separate standard will be issued by DHA in order to regulate this practice in this age group.

3.2 BMI:

3.2.1 Have BMI of > 40 kg/m$^2$ with or without comorbidities

3.2.2 Have BMI of 35-39.9 kg/m$^2$ with one or more of the below comorbidities

3.2.3 Have BMI of 30-34.9 kg/m$^2$ with at least two of the below comorbidities

The comorbidities may include:

3.2.3.1 Life threatening cardiopulmonary problems as coronary artery disease (CAD), type 2 diabetes mellitus (T2DM), obstructive sleep apnea, obesity hypoventilation syndrome, Pickwickian syndrome, non-alcoholic fatty acid disease or non-alcoholic steatohepatitis, hypertension, dyslipidemia, pseudotumor cerebri, asthma, venous
stasis disease, severe urinary incontinence, debilitating arthritis or obesity related cardiomyopathy.

3.2.3.2 Other obesity-induced physical problems that are interfering with lifestyle as musculoskeletal or neurologic or body size problems precluding or severely interfering with employment, family function and ambulation, and infertility in females.

3.3 Made significant efforts at weight loss by participating in physician or professionally supervised weight loss programs and failed to achieve sustained weight loss.

3.4 Passed the patient pre-operative assessment

3.4.1 The health facility shall provide a clear protocol/clinical guideline for assessing patients pre-operatively including, preoperative evaluation, pre-operative management, and other pre-operative investigations.

3.4.2 The patient shall be assessed suitable for the procedure via a process involving psychological, surgical, dietetic and medical review.

3.4.3 Pre-operative investigations shall be based on clinical judgement and shall focus on screening for cardiac arrhythmia, prolonged QT syndrome, cardiomyopathy, uncontrolled endocrinological disease, sleep apnea, and impaired thyroid function, especially in risky patients.

3.4.4 The patient shall be physically and psychologically fit to proceed to bariatric procedure.

3.4.5 Expectations shall be managed by giving patients the correct and realistic information on what the procedure can achieve.

3.4.6 For each patient, the benefits of the procedure should outweigh the risks.

3.4.7 Patients’ ability to comply with post-operative care shall be determined.

4. Procedure selection

4.1 The treating physician shall take a pragmatic approach to the choice of procedure, and the decision shall be determined by the individuals’ clinical phenotype, the aims of therapy, and peri-operative risk.

4.2 Physicians shall have enough experience in that particular procedure and can deal with its complications.

4.3 Laparoscopic procedure shall be the primary choice for bariatric surgeries.
4.4 When the laparoscopic approach proves to be difficult, the treating physician shall possess the necessary skills to convert to an open bariatric procedure.

4.5 Contraindications to surgery may include, but not limited to, severe heart failure, unstable coronary artery disease, end-stage lung/renal/hepatic/cardiovascular disease, active cancers, cirrhosis with portal hypertension, uncontrolled drug or alcohol dependency, severely impaired intellectual capacity and patients who are unable to understand the nature of bariatric procedure or the behavioral changes required afterward, including untreated schizophrenia, active substance abuse and noncompliance with previous medical care.

5. Informed consent

5.1 As per the Federal law No. (10) of 2008 concerning Medical Liability, and the Cabinet Decision No. (33) of 2009 promulgating the bylaw of the Medical Liability Law, the informed consent shall be obtained by the treating physician from the patient or his designated representative (as applicable) and after a discussion of the complication, risks, benefits, alternatives of procedures/surgeries, the possibility of failure to lose weight and patient’s right to refuse treatment.

5.2 The informed consent shall meet all DHA criteria mentioned in Appendix 1.

6. Evidence-based bariatric surgeries/procedures

6.1 Bariatric surgeries

6.1.1 Adjustable gastric banding
6.1.2 Biliopancreatic diversion
6.1.3 Duodenal switch
6.1.4 Gastric bypass / mini gastric bypass
6.1.5 Laparoscopic gastric plication
6.1.6 Revisional surgeries
6.1.7 Roux-en-Y gastric bypass
6.1.8 Sleeve gastrectomy

6.2 Endoscopic bariatric procedures

6.2.1 Intragastric balloon
6.2.2 Obalon balloon treatment
7. Restricted bariatric procedures

DHA recommends to restrict the below, but not limited to, listed procedures due to various reason. The facility, which decide to perform any of these procedures, should apply for a special approval from HRD; a separate consent form shall be obtained from the patient with special empathy on the nature, risks and outcomes of the procedure. The physician shall inform the patient that the selected procedure is new/investigational in nature and such information has to be mentioned in the consent form.

7.1 EndoBarrier gastrointestinal liner
7.2 Endomina
7.3 Gastric botox injections
7.4 Primary obesity surgery endoluminal (POSE)

8. Eligibility criteria for privileging

8.1 General surgeons

For general surgeons to perform bariatric surgeries listed in point 6.1, they shall maintain the following requirements:

8.1.1 Valid DHA license as consultant general surgeon. Specialist general surgeon might perform bariatric surgeries only under the supervision of a consultant general surgeon eligible for performing bariatric surgeries.

8.1.2 Evidence of successful completion of formal training in bariatric surgery, which includes completion of one of the below courses:

8.1.2.1 Bariatric surgery fellowship
8.1.2.2 General surgery logbook showing evidence of performing different types of bariatric surgeries including gastric bypass and restrictive operations. The logbook shall:

8.1.2.2.1 Contain at least 50 cases, performed in the previous 2 years, of laparoscopic bariatric surgeries involving stapling or division of the GIT.
8.1.2.2.2 Contain at least 10 cases, performed in the previous 1 year, of laparoscopic bariatric surgeries that do not involve stapling or division of the GIT.
8.1.2.2.3 Be supervised and countersigned by an experienced bariatric surgeon.

8.1.3 Training certificate in advanced laparoscopic procedures (for list of procedures, refer to definition of advanced laparoscopic procedures).

8.1.4 In certain cases in which the surgeon has successfully completed at least 2 day bariatric training course including live demonstration and hands-on training; the surgeon shall provide a logbook showing evidence of at least 25 bariatric surgeries performed in the previous 1 year.

8.2 Gastroenterologist

For gastroenterologists to perform endoscopic bariatric procedures, listed in point 6.2, they shall maintain the following requirements:

8.2.1 Valid DHA license as consultant/specialist gastroenterologist.

8.2.2 Evidence of successful completion of formal training in the endoscopic bariatric procedure that the gastroenterologist is welling to perform.

8.2.3 Logbook showing evidence of at least 25 of the endoscopic bariatric procedures the gastroenterologist is welling to perform in the previous 1 year. The logbook should be supervised and countersigned by an experienced gastroenterologist.

8.2.4 Have the skills and experience required to diagnose and manage the complications after bariatric surgeries/procedures as bleeding, ulcers, foreign bodies, stenosis, leaks, fistulas, bilio-pancreatic diseases, weight regain, and dilated outlets.

9. **Granting bariatric procedure privilege**

9.1 The medical director of the health facility is the ultimate responsible to:

9.1.1 Grant privileges to full-time, part-time and/or visiting physicians to perform bariatric procedures in the health facility. The medical director shall ensure that the physician has the appropriate certification, training, and experience as mentioned in this document.

9.1.2 Ensure that the healthcare professionals involved in providing bariatric services are adequately qualified and well trained to provide such services.
9.1.3 Ensure that the degree of complexity of the procedures shall be within the health facility capabilities (refer to facility requirements).

9.2 To grant the privilege, the physician shall fill a specific privileging form that shall be reviewed and approved by the health facility credentialing and privileging committee and then by the medical director of the health facility.

9.3 This privileging document shall be kept in the physician’s personal file and provided for DHA revision whenever required.

9.4 For newly applying physicians, the process of granting privilege shall be completed before conducting any bariatric procedure in the health facility.

9.5 Existing privileges provided to physicians before issuing this standard shall be reviewed according to this standard within a period of 2 months of this standard date of issue.

9.6 Privileges are subject to being revoked by the credentialing and privileging committee/medical director at any time and the action shall be validated with appropriate documented reasons.

10. Renewal of bariatric procedure privilege

10.1 Privileged surgeons involved in bariatric procedures shall maintain their knowledge and clinical skills on an on-going basis by attending 20 hours annually of CPD courses related to bariatric surgery. These 20 hours shall be considered a part of the total annual CPD hours required for licenses renewal.

10.2 The health facility credentialing and privileging committee shall review the surgeons’ skills, competencies and CPD courses to renew their privilege in bariatric procedures.

11. Facility requirements

11.1. Bariatric surgeries shall be performed only in hospital settings or specialized surgical hospitals where a fully equipped intensive care unit and all of the below mentioned equipment and requirements are available.

11.2. Endoscopic bariatric procedures shall be performed in hospital settings where a fully equipped intensive care unit is available. Otherwise they can be performed in day surgical centers of level II or III where all of the below mentioned equipment and critical support care requirements are available.
11.3. If the health facility opting to perform bariatric procedures does not have the required capabilities, it shall have a signed written transfer agreement that details the transfer plan of bariatric patients to another health facility that fully meets the missing requirements.

11.4. Appropriate equipment and instruments

11.4.1. The health facility shall maintain appropriate equipment and instruments for the care of bariatric surgical patients. This includes, but is not limited to, the following equipment:

11.4.1.1. Surgical and exam tables; 450 kg rated
11.4.1.2. Radiological tables and facilities
11.4.1.3. Medical imaging equipment for diagnostic purposes
11.4.1.4. Surgical instruments (staplers, retractors, long instruments, etc.)
11.4.1.5. Intensive care unit (ICU) equipment
11.4.1.6. Lifting and transfer equipment
11.4.1.7. Crash carts
11.4.1.8. Blood pressure cuffs
11.4.1.9. Sequential compression device sleeves

11.5. Appropriate facilities and space

11.5.1. The health facility shall maintain and manage the following requirements, that are strong enough and wide enough to accommodate the morbidly obese patients:

11.5.1.1. Entrances and Routes
11.5.1.2. Doorways and Corridors
11.5.1.3. Chairs and seats
11.5.1.4. Beds
11.5.1.5. Scales
11.5.1.6. Gowns
11.5.1.7. Floor-mounted or floor-supported toilets
11.5.1.8. Shower rooms
11.5.1.9. Bariatric Wheelchairs
11.5.1.10. Stretchers
11.5.2. The healthcare professionals at the health facility shall be trained to use these equipment and be capable of moving the obese patients without injury to the patient or themselves.

11.5.3. The health facility does not need to change all of the equipment, furniture, and instruments throughout the entire facility. This requirement only applies to those areas where patients undergoing bariatric procedure receive care, including the operating room, emergency department, radiology suite, designated bariatric unit, and waiting areas.

11.5.4. To accommodate obese patients, the health facility requires attention to issues that significantly affect the facility design as determining the percentage of beds per specific unit, operational space and storage space to accommodate the oversized wheelchairs, stretchers and beds, as well as the portable lift equipment.

11.5.5. Weight capacities shall be documented by the manufacturer’s specifications, and this information shall be readily available to relevant staff.

11.5.6. Bariatric procedures shall be restricted according to weight limits of the existing equipment.

11.6. Critical care support

The responsibility is upon the health facility medical director and the bariatric physician to appropriately select patients and develop selection policy for the health facility relative to the available resources and experience. For example, patients who are at risk for specific and predictable complications (renal failure, airway compromise, heart failure, etc.) shall only be managed in a health facility where access to all reasonable medical care is available.

11.6.1. Availability of Advanced Cardiovascular Life Support (ACLS)-qualified healthcare professional

11.6.1.1. An ACLS-qualified physician, ACLS-qualified physician extender, or other licensed healthcare provider that is capable of administering ACLS (defibrillation, drug administration, etc.), as
well as advanced airway management, shall be on-site at all times when bariatric procedure patients are present.

11.6.1.2. Hospitals with an emergency department can fulfill this requirement with a licensed emergency room physician, as long as the hospital’s policies dictate that this physician is available at all times.

11.6.2. Ability to stabilize patients and transfer

11.6.2.1. When necessary, the health facility shall have the ability to stabilize critically ill patients and transfer them to a higher level of care if the health facility is unable to manage this bariatric procedure patient on-site (refer to point 11.6.3 regarding written transfer agreements).

11.6.2.2. The health facility shall have immediately available ventilators and hemodynamic monitoring equipment as well as have the capacity to manage a difficult airway and intubation.

11.6.3. Written transfer agreement

11.6.3.1. If the health facility is unable to manage the full range of bariatric procedure complications, it shall provide a written and signed transfer agreement with other emergency or critical care health facility that have the capability of managing the complications. This transfer agreement shall detail the transfer plan of the bariatric procedure patients.

11.6.3.2. The health facility shall maintain the following transfer requirements:

11.6.3.2.1. A plan for safe transfer of a bariatric procedure patient to a full-service health facility shall be implemented, from the time of the transfer decision to the initiation of care at the accepting health facility.

11.6.3.2.2. Health facilities shall have adequate staff available to provide emergency support, including the time during transfer, until the receiving health facility assumes the patient’s care.
11.6.3.2.3. An ACLS-certified individual shall accompany the patient during the transfer.

11.6.4. Required available services

11.6.4.1. Anesthesia services

11.6.4.1.1. The health facility shall have a protocol for anesthesia care that adheres to UAE laws and governs their scope of practice.

11.6.4.1.2. All anesthetists shall be trained and competent in handling obese patients. This shall include:
   a) Dosing anesthetic drugs
   b) Choice of anesthetic type
   c) Patient positioning
   d) Special equipment needs to anesthetize severely obese patients safely as: special equipment for positioning, large beds and operating tables, mechanical transfer mechanisms, additional personnel, extra-long needles, ultrasound and blood pressure cuffs

11.6.4.2. Critical care services

11.6.4.2.1. The health facility medical director shall maintain the below required licensed professionals in the facility:
   a) An intensivist/anesthetist trained and competent in handling obese patients and post-operative complications
   b) Trained critical care nursing staff available 24 hours per day, 7 days a week.

11.6.4.2.2. Day surgical centers opting to perform endoscopic bariatric procedures and do not have fully equipped intensive care unit (ICU) capabilities, shall:
   a) Have ventilators and hemodynamic monitoring equipment on-site to perform necessary patient resuscitation.
b) Have signed written transfer agreement that details the transfer plan of bariatric procedure patients to another health facility that fully meets all the above requirements.

11.6.4.3. Endoscopy services
The health facility shall maintain the below endoscopy services requirements:
11.6.4.3.1. Physician who has met DHA licensing criteria to perform diagnostic and therapeutic endoscopy
11.6.4.3.2. Trained nursing staff responsible for assisting the physician in performing upper gastrointestinal endoscopy
11.6.4.3.3. A health facility that does not have a required endoscopy capability shall have a signed written transfer agreement that details the transfer plan of bariatric procedure patients to another health facility that fully meets all the above requirements.

11.6.4.4. Diagnostic and interventional radiology services
The health facility shall maintain the below diagnostic and interventional radiology services requirements:
11.6.4.4.1. Interventional radiologist or a physician who has met DHA licensing criteria to perform imaging, percutaneous drainage, and other radiology procedures
11.6.4.4.2. A radiology department that can perform emergency chest x-rays with portable machinery, abdominal ultrasonography, and upper GI series
11.6.4.4.3. Ensure that blood tests can be performed on a 24-hour basis that blood bank facilities are available, and blood transfusion can be carried out at any time.
11.6.4.4.4. A health facility that does not have a required interventional radiology capability shall have a signed written referral agreement.
11.6.4.5. Access to additional required services

11.6.4.5.1. The health facility shall have, at all times, licensed consultants/specialists experienced in managing the full range of bariatric procedure complications:

a) Pulmonology
b) Cardiology
c) Nephrology
d) Psychiatry and rehabilitation

11.6.4.5.2. A health facility that does not provide any of the consultation service listed above shall provide a copy of the signed written agreement for that service.
12. References


Appendix 1: DHA criteria for the informed consent

- If the patients lack the full capacity (e.g. less than 18 years old) informed consent shall be taken from their relatives up to the fourth degree, before the procedure/surgery is performed.

- Patients shall be provided with comprehensive and accessible information concerning treatment/procedure and alternatives.

- The health facility management shall clearly define investigations, treatment and surgical procedures that require patient consent.

- The health facility management must develop an internal consent policy and procedures that are consistent with the federal legislation including procedures for individuals lacking the capacity of making informed decisions.

- Informed consent formed shall be maintained in the patient's health record. Consent form should be bilingual and should contain the following:
  - The diagnosis, if known
  - The name of proposed procedure or treatment
  - The risks and benefits of proposed procedures or treatment
  - Alternatives and the risks and benefits of alternatives
  - Statement that procedure was explained to patient or guardian
  - Date and time consent is obtained
  - Name and signature of the treating physician
  - Signature of person witnessing the consent

- Informed consent shall be signed by the patient/guardian, witness, treating health professional, and translator if applicable.
• All contents of the “Informed consent forms” should comply with the Cabinet Decision No. (33) of 2009 promulgating the bylaw of the Medical Liability Law, click here to see the law or visit www.dha.gov.ae.

• Healthcare professionals working in the health facility shall be informed and educated about the consent policy.

• Where consent is obtained by the visiting community physician, the health facility management shall ensure that the signed consent is received and filed in the patient health record.
Appendix 2: Facilities and space requirements

- Health facilities opting to provide care for bariatric patients must provide adequate spaces and a safe built environment for these patients.

- The hospital shall determine the proportion of bariatric patients to the whole patient population to best determine the quantity of rooms that, through either addition or alteration, can accommodate this group.

- New health facilities wishing to opt bariatric procedures, shall maintain the followings to accommodate the morbidly obese patients:

  1. Entrances and routes
     Provide easy access with ramps and handrails, and wide enough to accommodate bariatric wheelchairs, walkers and other specialized conveyances to facilitate access to the health facility building.

  2. Bariatric wheelchairs
     Establish an accessible path from the health facility entrance to all major departments by accommodating for a 39 inches by 49 inches wide wheelchair (317 kg capacity) with a 6 feet turning radius.

  3. Elevators
     Consider elevator weight capacity to make common areas more easily accessible for a patient, equipment and caregivers.

  4. Bariatric patient room
     - More space is needed for the bariatric inpatient rooms to accommodate the larger equipment needed for bariatric patients.
     - The design shall provide a minimum of 7.43m² for each patient bed, and for clearance of at 1.52 meters between patient beds and 1.22 meters at the foot of the bed.
• One additional design consideration is the placement of cubicle track in relation to ceiling-mounted lift tracks. This is especially important for privacy curtain placements as the lift track runs from bed to bathroom.

5. Bathrooms
• Shall be sized to allow for staff assistance on two sides of the patient at the toilet and shower.
• Dispensers shall be flush mounted to aid in clearance and safety.
• Opt for open showers with a floor drain.
• Bigger shower stalls with sufficient opening and space to feature heavy-duty wall-mounted grab bars.
• Additional options to consider for showers are:
  o Multiple handrails, larger seats, and handheld showerheads
  o Space for adaptive equipment such as wheelchairs and lifts
  o Tracking for ceiling lifts, accommodating ready access to shower, toilet and sink

6. Toilet rooms
• Oversized toilet seats.
• Toilet fixtures and sinks shall be mounted to the floor versus the wall, although care should be taken that floor-mounted sinks do not interfere with wheelchairs.
• Floor-mounted toilets with a drop weight rating of 317.5 kg and a clearance of 1.52 meters shall be used.

7. Lifting equipment
• Accommodations for patient lift and transport shall be provided either by an overhead lifting system or by a portable lifting assist. These devices shall be designed to accommodate a weight of not less than 362.87 kg.
• In those instances where mounted lifts rather than portable ones are being used, ceilings require additional steel reinforcement to be designed into the structure to support these devices.

8. Wider corridor
In order to accommodate a patient with a bariatric walker and allow passage for other foot traffic, a minimum of 1.52 meters is required for the width of a corridor.

9. Doorway widths
   - Wider door standards in the diagnostic and treatment rooms, inpatient rooms, and surgical suites and other areas where a bariatric patient is treated.
   - To accommodate bariatric wheelchairs, 1.14 meters doorway openings are required.
   - Where the passage of bariatric stretchers is needed, doorways should be a minimum 1.32 meters.

10. Lobbies and waiting areas
    - Up to 15 to 20% of reception and family waiting room seating should accommodate obese individuals, which may require purchasing steel reinforced furniture.
    - Considering the obese people shape is important when considering seating, as pear-shaped people cannot abide chairs with arms, whereas apple-shaped bodies will do well in seating with or without arms. Offering both types of seating would service the general population as well as the severely obese.
    - Avoid too low seats as the patient may have trouble standing without assistance.
    - The seat arms must have a grasp point on the front of the arm, providing a stable platform or push point.
    - A larger seat width accommodates the greatest number of patients.