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Bariatric Surgery Services Inspection Checklist- Random

Name of the Facility: _________

Date of Inspection:____ _/_____/_______

Ref.	Description	Yes	No	N/A	Remarks
5	**STANDARD ONE: REGISTRATION AND LICENSURE PROCEDURES**				
5.5.	The health facility shall provide documented evidence of the following:				
5.5.1.	Transfer of critical/complicated cases when required				
5.5.2.	Patient discharge				
5.5.3.	Clinical laboratory services				
5.5.4.	Equipment maintenance services				
5.5.5.	Laundry services				
5.5.6.	Medical waste management as per Dubai Municipality (DM) requirements				
5.5.7.	Housekeeping services.				
5.6.	The health facility shall maintain charter of patients' rights and responsibilities posted at the entrance of the premise in two languages (Arabic and English).				
5.7.	The health facility shall have in place a written plan for monitoring equipment for electrical and mechanical safety, with monthly visual inspections for apparent defects.				
5.8.	The health facility shall ensure it has in place adequate lighting and utilities, including temperature controls, water taps, medical gases,				

	sinks and drains, lighting, electrical outlets and communications.				
6	**STANDARD TWO: HEALTH FACILITY REQUIREMENTS**				
6.1.	Bariatric surgeries shall be performed only in a general hospital settings or specialized surgical hospitals where a fully equipped intensive care unit (ICU) is available and postoperative care requirements can be adequately met.				
6.2.1.	Hospitals shall maintain a minimum of 60 bariatric surgeries per annum of which 20 will include gastric bypass.				
6.2.2.	Hospitals performing bariatric surgery shall seek recognised accreditation within a period of 2 years, from the time they are licensed by DHA. Refer to DHA Hospital Accreditation policy				
6.3.	All health facilities providing bariatric services shall adhere to DHA policy of Patient Referral and Interfacility Transfer.				
7	**STANDARD THREE: HEALTHCARE PROFESSIONALS REQUIREMENTS**				
7.1.	All bariatric surgery services shall be led by consultant general surgeon.				
7.1.1.	Selected specialist general surgeons are permitted to perform bariatric surgeries in facilities with existing consultant coverage.				
7.2.	For each admitted patient, the health facility should designate a Most Responsible Physician (MRP), who should be the ultimate responsible for admitting, managing and discharging the bariatric patients.				
7.3.	For Bariatric surgery procedures performed by visiting surgeons, the health facility shall ensure the following:				

7.3.1.	Visiting surgeons shall be available up to 5 days after the procedure.				
7.3.2.	Visiting surgeons must always ensure their patients are handed over to a competent bariatric surgeon to oversee patient follow up and patient care during their absence.				
7.4.	Any health facility providing bariatric services should have a dedicated multidisciplinary (MDT) healthcare professional team with experience in bariatric patient management				
7.4.1.	The team should consist of but not limited to the following:				
a.	Bariatric surgeon				
b.	Clinical/Health Psychologist				
c.	Clinical dietitian				
d.	Physician trained in obesity care, this includes either specialist or consultant:				
i.	Endocrinologist				
ii.	Internal medicine				
iii.	Family medicine				
iv.	Gastroenterologist				
v.	Pulmonologist				
7.5.	Physicians performing bariatric surgeries shall be:				
7.5.2.	Suitably trained and assessed as competent and privileged by the Medical Director of the facility to perform bariatric surgeries and must be competent to recognize and treat related complications.				
7.6.	Health facilities providing bariatric surgery services shall have a clear and documented process to record patient details in their health records, which are as follows:				
7.6.1.	Patient selection criteria				

7.6.2.	Pre-operative assessment and counselling				
7.6.3.	Early/acute postoperative care (immediate care at 1-4 days) and upon discharge				
7.6.4.	Postoperative management follow up at 3 months, 6 months, 12 months and then as per the patient's condition. This includes, but not limited to:				
a.	Assessment of weight loss				
b.	Physical activity advice and support				
c.	Management of dietary and nutritional deficiencies				
d.	Bone density measurement at 1 year and 5 years				
e.	Assessment of lipid and glucose level and medication review				
f.	Management of post-operative complications				
7.7.	Eligibility Criteria for Privileging				
7.7.1.	For consultant general Surgeons to perform bariatric surgeries, should meet the following requirements:				
a.	Valid DHA license				
b.	Evidence of successful completion of formal training in bariatric surgery, which includes completion of the following:				
i.	Bariatric surgery fellowship or equivalent OR				
ii.	Updated logbook, showing evidence of 80 surgeries in the UAE in the previous 2 years with a minimum 15 gastric bypass surgeries.				
7.7.2.	For specialist general Surgeons to perform bariatric surgeries, should meet the following requirements:				
a.	Valid DHA license with minimum of 5 years' experience in bariatric surgery in UAE.				
b.	Evidence of successful completion of formal training in bariatric surgery which includes but not limited to:				

i.	Updated logbook, showing evidence of 100 surgeries in the UAE in the previous 3 years with a minimum 15 gastric bypass surgeries				
8	**STANDARD FOUR: PRE-OPERATIVE EVALUATION AND POST-OPERATIVE PROCEDURES**				
8.1.	Recognized bariatric procedures include:				
8.1.1.	Intra-gastric balloon				
8.1.2.	Roux-en-Y Gastric Bypass (RYGB)				
8.1.3.	Biliopancreatic diversion with duodenal switch (BPD/DS)				
8.1.4.	Laparoscopic One-Anastomosis Gastric Bypass (OAGB)				
8.1.5.	Single anastomosis duodeno-ileal bypass with sleeve gastrectomy (SADI-S)				
8.1.6.	Sleeve Gastrectomy (SG)				
8.1.7.	Revisional Bariatric Surgery				
8.2.	A detailed medical history with respect to any previous disease, drug intake and prior surgical procedures shall be taken of any patient indicated for bariatric surgery.				
8.7.	Preoperative investigations shall be based on clinical judgement and shall focus on screening for the following but not limited to:				
8.7.1.	Cardiac arrhythmia				
8.7.2.	Prolonged QT syndrome				
8.7.3.	Cardiomyopathy				
8.7.4.	Uncontrolled endocrinology disease				
8.7.5.	Sleep apnoea				
8.7.6.	Impaired thyroid function, especially in risky patients.				
8.8.	The minimum preoperative assessment for bariatric surgery should include, but not limited to:				

8.8.1.	Upper GI Endoscopy				
8.8.2.	Blood studies including:				
a.	Complete blood count (CBC)				
b.	Blood urea nitrogen (BUN)				
c.	Serum creatinine				
d.	Electrolytes				
e.	Thyroid stimulating hormone (TSH)				
f.	Thyroid function test				
g.	Liver function test (LFT)				
h.	Haemoglobin A1c (HbA1c)				
i.	Serum insulin				
j.	Fasting blood glucose.				
k.	Coagulation profile such as prothrombin time (PT)/ partial thromboplastin time (PTT)				
l.	Vitamin essay for vitamin B12, folate and vitamin D				
m.	Ferritin				
n.	Calcium				
o.	Lipid profile				
8.8.3.	Echocardiogram (ECG)				
8.8.4.	Assess sleep patterns				
8.10.	Patients with comorbidities should be referred to consultant or specialist for evaluation and clearance for the relevant conditions before the bariatric surgery.				
8.11.	As per the Decree of the Federal Law number (4) of 2016 concerning Medical Liability, informed consent shall be obtained by the treating physician from the patient or his designated representative (as applicable) after discussion of the following but not limited to:				

8.11.1.	Complication, risks, benefits, and alternatives of surgery/procedure.				
8.11.2.	The possibility of failure to lose weight				
8.11.3.	The patient's right to refuse treatment				
8.14.	Laparoscopy should be the primary choice for bariatric surgery/procedure				
8.15.	When the laparoscopic approach proves to be difficult, the treating physician shall possess the necessary skills to convert to an open bariatric surgery/procedure.				
8.16.	Patients are considered high-risk candidates for bariatric surgery if he/she have one of the following risk factors:				
8.16.1.	Venous Thromboembolic Event (VTE)				
8.16.2.	BMI 60 or more				
8.16.3.	Severe Obstructive Sleep Apnoea: Apnoea Hypopnea Index > or equal to 30				
8.16.4.	Poor functional status (decided by the MDT team)				
8.16.5.	History of Myocardial Infraction (MI) or Percutaneous Coronary Intervention (PCI)				
8.16.6.	History of end-organ failure or transplant				
8.16.7.	Age 60 year or more				
8.16.8.	Revision/conversion				
8.16.9.	History of multiple open abdominal surgeries				
8.17.	High-risk surgeries may be performed under the following conditions:				
8.17.1.	Must be performed by a consultant surgeon with minimum 125 lifetime bariatric procedures including 50 LRYBG and have a minimum 50 bariatric procedures performed annually.				

8.17.2.	Bariatric surgery shall be performed in a unit with at least two surgeons, ICU, interventional radiology, and endoscopy management options to be handle any complications.				
8.18.	Patients' ability to comply with postoperative care should be determined.				
8.18.1.	To ensure the above a minimum of two (2) visits to the physician performing the bariatric surgery is required preoperatively, where the last visit should be after the completion of the preoperative investigation.				
8.19.	Postoperative assessment and follow up shall be conducted at 3 months, 6 months, 12 months and then as per patient's condition.				
8.20.	Postoperative assessment shall include the following:				
8.20.1.	Two (2) surgeons visits after date of surgery.				
8.20.2.	Two (2) dietician visits (2-3 weeks apart)				
8.20.3.	One (1) psychiatric visit				
8.20.4.	Blood work post-surgery include but not limited to:				
a.	FBC				
b.	Creatinine				
c.	U&E (urea and electrolyte panel)				
d.	HbA1c				
e.	TSH				
f.	LFT				
g.	Lipid profile				
h.	Ferritin				
i.	Iron				
j.	Calcium				
k.	Folate (every 3-6 months in the first 2 years)				

l.	Magnesium (every 6 months in the first 2 years)				
m.	Zinc (every 6 months in the first 2 years)				
n.	Vitamin B12 (every 3 months in the first 2 years)				
o.	Vitamin D3 (every 6 months in the first 2 years)				
8.21.	Follow-up blood tests should be conducted every 3 months in the first year postoperatively, then every 6 months for 1 year, and then when required.				
9	**STANDARD FIVE: CRITICAL CARE SUPPORT**				
9.2.4.	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.				
9.3.	An intensivist/anaesthesiologist trained and competent in handling obese patients and post-operative complications.				
9.4.	Trained critical care nursing staff available 24/7.				
9.5.	An Advanced Cardiovascular Life Support (ACLS) qualified physician shall be available on-site to provide ACLS when bariatric surgery/procedure patients are present, this include but not limited to; defibrillation, drug administration, advanced airway management, etc.				
9.6.	The health facility shall have in place ventilators and hemodynamic monitoring equipment as well as have the capacity to manage a difficult airway and intubation.				
9.8.	If the health facility is unable to manage the full range of bariatric surgery/procedure complications, it shall have a written and signed				

	transfer agreement with a hospital capable of managing bariatric related complications.				
9.8.1.	The transfer agreement shall detail the transfer plan of the bariatric patients.				
9.9.	The health facility shall maintain diagnostic and interventional radiology services requirements as per the DHA Standards for Diagnostic Services				
9.10.	The health facility shall have, at all times, licensed consultants/specialists experienced in managing the full range of bariatric surgery/procedure complications:				
9.10.1.	Cardiology				
9.10.2.	Emergency and critical care				
9.10.3.	Gastroenterologist				
9.10.4.	Nephrology				
9.10.5.	Pulmonology				
9.10.6.	Psychiatry and rehabilitation.				
9.11.	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 and a plan for provision of these services in the future.				
APPENDIX 1:	**ELIGIBILITY CRITERIA AND CONTRAINDICATIONS FOR BARIATRIC SURGERY**				
A1.1.	BMI (kg/m2): 35 or above, Obesity related diseases: No medical problems				
A1.2.	BMI (kg/m2): 30 – 34.9, Obesity related diseases: Poorly controlled T2DM OR Two (2) obesity related diseases*				
A1.2.1.	Obesity related diseases*:				
A1.2.1.1.	Type 2 Diabetes Mellitus (T2DM)				
A1.2.1.2.	Hypertension				
A1.2.1.3.	Dyslipidemia				

A1.2.1.4.	Asthma				
A1.2.1.5.	Gastroesophageal reflux disease GERD (Proven by endoscopy or manometry/PH study, BA study)				
A1.2.1.6.	Nonalcoholic Fatty Liver Disease (NAFLD)				
A1.2.1.7.	Disabling arthropathy (report from orthopedics)				
A1.2.1.8.	Ischemic heart disease				
A1.2.1.9.	Obstructive Sleep Apnea (OSA)/obesity hypoventilation syndrome				
A1.2.1.10.	Severe urinary incontinence				
A1.2.1.11.	Polycystic Ovary Syndrome (PCOS)				
A1.2.1.12.	Benign intracranial Hypertension				
A1.2.1.13.	Infertility				
A1.2.1.14.	Gout				
A1.2.2.	Contraindications for Bariatric Surgery:				
A1.2.2.1.	Severe uncontrolled eating disorder				
A1.2.2.2.	Active Alcohol or drug abuse/dependence				
A1.2.2.3.	Severe uncontrolled depression				
A1.2.2.4.	Not Fit for GA				
A1.2.2.5.	Active malignancy				
APPENDIX 2:	**CRITERIA FOR INFORMED CONSENT**				
A2.1.	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.				
A2.2.	Patients shall be provided with comprehensive and accessible information concerning and procedure/surgery alternatives.				
A2.3.	The health facility management shall clearly define investigations, treatment and surgical procedures that require patient consent.				
A2.4.	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.				
A2.5.	Informed consent form shall be maintained in the patient's health record. It should be bilingual and contain the following:				
A2.5.1.	Patient full name as per the passport/Emirates ID, age, gender, and patient identification number				
A2.5.2.	The diagnosis				
A2.5.3.	The name of proposed surgery				
A2.5.4.	The risks and benefits of proposed procedures or treatment e.g. re-operation, excess skin, gallbladder disease, vitamin deficiency and malabsorption				
A2.5.5.	Alternatives and the risks and benefits of alternatives				
A2.5.6.	Statement that surgery was explained to patient or guardian				
A2.5.7.	Date and time consent are obtained				
A2.5.8.	Name and signature of the treating physician				
A2.5.9.	Signature of a minimum one healthcare professional witnessing the consent (optional)				
A2.6.	Informed consent shall be signed by the patient/guardian, witness, treating health professional, and translator if applicable.				
A2.7.	All contents of the “Informed consent forms” should comply with the Decree of the Federal Law number (4) of 2016 concerning Medical Liability Law.				
A2.8.	Healthcare professionals working in the health facility shall be informed and educated about the consent policy.				

A2.9.	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.				