Help us to help you

Please let us know if any of the following happens:

1. You are to ill to attend you appointment
2. You change your address or contact phone number
3. If you no long require this appointment.

Call 09- 276-1660

Smokefree Policy

Counties Manukau Health is a smokefree environment. This means all buildings and grounds must be smokefree at all times.

We encourage and support patients who want to stop or reduce their smoking. Please ask your doctor or nurse for guidance.

Support is also available at Quitline Ph: 0800 778 778, website *www.quitline.org.nz* or Aukati Kai Paipa-Raukura Hauora O Tainui Ph: 09 270 3499.

The Code of Rights

This means that you should have

1. Respect and privacy
2. Fair treatment
3. Dignity and independence
4. Proper standards
5. Effective communication
6. Information
7. Your choice and decisions
8. Support
9. Right during teaching & research
10. Your complaints taken seriously

Counties Manukau Health Values

CARE & RESPECT - Treating people with respect and dignity: valuing individual and cultural differences and diversity.

TEAMWORK - Achieving success by working together and valuing each other's skills and contributions.

PROFESSIONALISM - Acting with integrity and embracing the highest ethical standards.

INNOVATION - Constantly seeking and striving for new ideas.

RESPONSIBILITY - Using and developing our capabilities to achieve outstanding results and taking accountability for our individual and collective actions.

PARTNERSHIP - Working alongside and encouraging others in health and related sectors to ensure a common focus on, and strategies for achieving health gain and independence for our population.

COUNTIES MANUKAU HEALTH

Contact Details:
General Surgery Department
Manukau SuperClinic™
PO Box 98743, Manukau City, Auckland 2241
Phone: 09 277 1660. Fax: 09 277 1634

www.countiesmanukau.health.nz

Reorder #??????? General Surgery Dept. Review February 2016

COUNTIES MANUKAU HEALTH

Gallbladder Surgery

(Cholecystectomy)

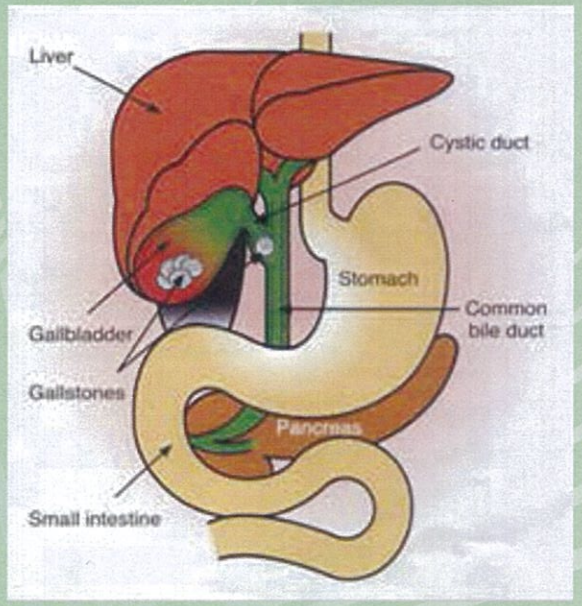
Manukau Super*Clinic*™

General Surgery Department

Patient Information

What is a gallbladder?

- The gallbladder is a pear shaped organ that rests beneath the right side of the liver.
- Its main purpose is to collect and concentrate the digestive liquid (Bile) produced by the liver. Bile is released by the gallbladder after eating, aiding digestion. Bile travels through narrow tubular channels (Bile ducts) into the small intestine.
- Removal of the gallbladder (Cholecystectomy) is not associated with any impairment of digestion in most people.



What causes gallbladder problems?

- Gallbladder problems are usually caused by the presence of gall stones. Small hard masses consisting primarily of cholesterol and bile salts that forms in the gallbladder or in the bile duct.
- There is no known means to prevent gall stones.
- These stones may block the flow of bile out of the gallbladder then, causing it to swell and resulting in sharp abdominal pain, vomiting, and indigestion and, occasionally fever.
- If the gallstone blocks the common bile duct, Jaundice (a yellowing of the skin) can occur.

Risks of the operation

Some patients may require a Preadmission Appointment to be assessed by a Doctor to ensure they are ready for surgery. Thus includes blood work, medical evaluation, chest x-ray and an ECG (Heart tracing) depending on your age and pre existing medical conditions. Some patients may require to be seen by an Anaesthetist to ensure the anaesthetic is as safe as possible.

What will happen during my operation?

The doctors will decide which the best way to remove your gallbladder. The routine way to remove the gallbladder is with a telescope, a camera, fine instruments and a video monitor. This is called a "laparoscopic cholecystectomy".

In a small number of patients the laparoscopic method cannot be performed. Factors that may increase the possibility of choosing or converting to the open procedure may include, a history of prior abdominal surgery causing dense scar tissue, inability to visualise organs obleeding problems during the operation.

The decision to convert to and open procedure is strictly based on patient safety.

In the operating theatre the anaesthetist will put you to sleep by using a small drip. The surgeon will then pass the telescope through the tummy button and make three more incisions the size of your little finger. All these incisions will have local anaesthetic in them. The gallbladder and stones are then removed through one of the small holes.

The whole operation takes about one hour.

What should I expect after gall bladder surgery?

- A certain amount of pain or discomfort occurs. Nausea and vomiting are not uncommon.
- Once liquids or a diet are tolerated patients are able to leave hospital. This is generally the following day.
- Activity is dependant on how the patient feels. Walking is encouraged. The dressing will be changed after 24 hours.
- Patients will probably be bale to return to normal activities within a week's time, including driving, walking up stairs, light lifting and working.
- The onset of fever, yellow skin or eyes, worsening abdominal pain, distention, persistent nausea or vomiting, or drainage from the incision are indications that a complication may have occurred. Please contact your GP.
- Your sutures will be removed by your GP.
- Most patients can return to work within 7 days following the procedure.

COUNTIES MANUKAU HEALTH

Affix patients identification label here

REQUEST FOR TREATMENT

IF YOU NEED A TRAINED INTERPRETER, PLEASE ASK THE STAFF

Maaori	Mehemea kaare koe e matatau ana ki te reo Paakehaa, whakamoohiotia ki te taakuta
Mandarin/Cantonese	如果您不懂英文，请告诉您的医生。
Samoan	Faamolemole tau i le fomai pe afai e te le malamalama i le Faaperetania
Korean	영어 소통이 안되시면 의사에게 알려주십시오.
Tongan	Kapau'oku'ikai mahino kiate koe'a e lea faka-Pilitānia, kataki'o tala ki he toketā
Cook Island	Me kare koe I marama I te reo papaa akakite ki te taote
Niuean	Kaeke ke nakai maama e koe e vagahau palagi fakaamolemole huhu ke he ekekafo

(Translation - If you do not understand English, please tell the doctor)

Interpreter Required ☐ Yes ☐ No Name _____ Language _____

SURGERY/OTHER PROCEDURE(S)

I _____

of _____

As Parent/Legal Representative of:

Request that the following procedure(s) be performed: _____

_____

_____

_____ Specify side _____

I have discussed this with the Doctor whose signature appears below.
He/she has explained to me why my medical team advise that I have this procedure(s), what is involved, what the side effects may be and what the possible risks to me are, with my clinical history and condition. I have had the opportunity to ask questions and I have received all the information that I want. I agree to any other measures that may be found to be necessary during the procedure(s). The specific risks discussed (I understand these are not all the possible risks) with me include:

_____

_____

_____

I understand that I may withdraw my consent in the future (provided that it is before having this procedure(s)) and that I have the right to refuse to have the procedure(s).
I acknowledge that no assurance has been given that the operation(s)/procedure(s) will be performed by any particular doctor.

INFECTIOUS RISKS

I agree that if in the course of my treatment, a healthcare worker is placed at risk by accidental exposure to my blood or body fluids, a sample of my blood can be taken to test for infectious diseases such as Hepatitis B and C and HIV (the virus that causes AIDS).
I understand that if an infectious disease is detected I will be informed of this by the medical team and I will be given appropriate health information, treatment and counselling.

BODY PARTS

I understand that body tissues maybe required for making a diagnosis and for testing and that small amounts of these are kept by the hospital for future reference/testing and audit purposes. I accept and agree to this.
I would like to have any body parts/tissues removed during the procedure(s) which are not required for diagnosis and testing

☐ to be returned to me OR ☐ to be disposed of by the hospital

I understand that once I have been discharged from hospital following my surgery, that I need to collect my tissue within 4 weeks. If not collected and there has been no contact from myself or my family after three months, Middlemore Hospital will arrange appropriate disposal.

Patient/Legal Representative's Signature	Interpreter's Signature	
Doctor's Signature	Doctor's Name & Designation *(print)*	Date

All clinical pages to be dated, timed and signed

REQUEST FOR TREATMENT

COUNTIES MANUKAU HEALTH

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REQUEST FOR TREATMENT

ANAESTHESIA

I acknowledge that I require an anaesthetic for the above procedure. I understand that having an anaesthetic involves risks which are separate from, and are additional to, the risks of the operation/procedure that I am having.

I have been able to discuss this with the doctor whose signature appears below. He/she has explained to me why this particular anaesthetic is recommended, what it involves, what its effects will be and what the possible risks to me are, with my clinical history and condition. I have had the opportunity to ask questions and have received all the information that I want.
I agree to have this anaesthetic, and to any other measures that may be found to be necessary during the course of the procedure.
I acknowledge that no assurance has been given that the anaesthetic will be administered by any particular anaesthetist.

I acknowledge that anaesthesia/sedation has residual or "hangover" effects that may impair my judgement and performance and that this will be prolonged if I take alcohol, sedatives or recreational drugs. I understand that because of this, I should not drive a motor vehicle, operate potentially dangerous machinery or appliances, drink alcohol or make important decisions on the same day that I receive this anaesthetic/sedative and that I may need to limit my activities for a longer period of time if I take alcohol/sedatives/recreational drugs or if I continue to feel/be impaired.

Medicines that are not registered in New Zealand may sometimes be used in place of registered versions of the same, or similar, medication during anaesthesia, in line with recognised professional practice. If this happens, details about the supply of the medicine and the patient concerned will be sent to the Director General of Health. If you have any questions about these medicines please discuss these with your anaesthetist.

Patient/Legal Representatives Signature	Interpreters Signature

Doctors Signature	Doctors Name & Designation *(print)*	Date

BLOOD OR BLOOD PRODUCT TRANSFUSION

I have been advised that I may require blood, or blood product transfusion. I have been advised of the possible risks, benefits and alternatives to blood transfusion.

I have had the opportunity to ask questions and discuss this with Dr _____
whose signature appears below.
I agree to receive blood or blood products if these are considered necessary by the doctors looking after me.

Patient/Legal Representatives Signature	Interpreters Signature

Doctors Signature	Doctors Name & Designation *(print)*	Date

PROCEDURE TO BE FOLLOWED IN URGENT CASES WHERE THE PATIENT IS UNABLE TO GIVE CONSENT

The legality of operating on a patient who is unable to give informed consent depends on whether or not the treatment is in the best interests of the patient. This process is detailed in the Clinical Board policies and procedures and these should be reviewed when time permits. In summary, before proceeding without consent staff should be able to document:

1. *That proceeding is in the patients best interests*
2. *That the treatment is in accordance with prevailing medical standards, practices, procedures and traditions which command general approval within the medical profession.*
3. *That advance directives (if known) have been taken into account.*
4. *That reasonable attempts have been made to obtain consent, or that delaying the procedure in order to do so was not in the patient's best interests.*
5. *That the consultant having overall responsibility for the patient has sought a second opinion from another specialist who is NOT involved in the patients care.*

Patient/Legal Representatives Signature	Interpreters Signature

Doctors Signature	Doctors Name & Designation *(print)*	Date

COUNTIES MANUKAU HEALTH

Affix patients identification label here

HEALTH QUESTIONNAIRE PATIENT TO FILL IN

All clinical pages to be dated, timed and signed

HEALTH QUESTIONNAIRE

This form is part of your health assessment prior to surgery. It will not influence your priority and will be dealt with in strict confidence. Please answer all questions on the next four pages.

Date questionnaire is filled in _____

Name of person completing questionnaire _____

What is your relationship to the patient? *(eg self, wife, husband, partner; mother; daughter; caregiver; friend)* _____

Communication Impairment _____ Other _____

Planned operation _____

Yes No

☐ ☐ Do you want this operation?

☐ ☐ Have you had any previous operations or admissions to hospital? If so, when, where and what for?

Reason	*Date*	*Hospital*

☐ ☐ Do you take any regular medications (including the pill, pain killers, puffers, herbal, eyedrops, sprays), anticoagulants, pain relieving medications/non steroidal medications?

Medication (please list)	*Dose*	*Frequency*

☐ ☐ Have you taken steroid tablets in the last 6 months? If so why?

☐ ☐ Do you have any **allergies** (eg. medicines, food, sticking plaster, latex)? Please describe reaction.

☐ ☐ Do you have a medic alert bracelet? Condition or reason? _____

☐ ☐ Have you or a blood relative ever had any problems with a general anaesthetic? If so what happened?

☐ ☐ Do you have problems with your neck or opening your mouth? Please give details

☐ ☐ Please tick if you have any of the following

☐ Any loose teeth ☐ Full denture

☐ Caps, crowns or bridge ☐ Partial denture

Please have any problems with your teeth fixed before your operation. Some operations cannot be done if there are dental problems.

COUNTIES MANUKAU HEALTH

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HEALTH QUESTIONNAIRE

PATIENT TO FILL IN

Have you ever had...

Yes	No	
☐	☐	High blood pressure?
☐	☐	If Yes, is your blood pressure being monitored/treated by your GP?
☐	☐	Heart problems? (angina, irregular pulse, fluid on the lungs, pacemaker). If Yes, please list
☐	☐	A heart attack?
☐	☐	Rheumatic fever?
☐	☐	A heart murmur?
☐	☐	Asthma? Give details if you stayed in hospital because of your asthma
☐	☐	Lung problems? (eg. bronchitis, emphysema, TB)
☐	☐	Have you been told you snore loudly?
☐	☐	Obstructive sleep apnoea? (told you snore loudly then stop breathing)
☐	☐	A stroke?
☐	☐	Regular fainting or blackouts?
☐	☐	Epilepsy? If Yes, when was your last seizure?
☐	☐	Kidney disease?
		Hepatitis or yellow jaundice?
☐	☐	Diabetes? If Yes, what treatment are you on?
		☐ A diet ☐ Tablets ☐ Insulin
☐	☐	Blood clots to the legs or lungs?
☐	☐	Blood disorders?
☐	☐	Anaemia?
☐	☐	Blood transfusion?
☐	☐	Is there any reason why you should not receive a blood transfusion? (ie. Jehovah Witness)
☐	☐	Rheumatoid arthritis?
☐	☐	Hiatus hernia, heartburn or acid reflux?
☐	☐	Are you, or could you, be pregnant?
☐	☐	Have you ever received treatment for cancer?

IF YOU HAVE ANSWERED YES TO ANY OF THE PREVIOUS QUESTIONS PLEASE GIVE ANY FURTHER DETAILS HERE INCLUDING WHERE YOU WERE TREATED

All clinical pages to be dated, timed and signed

HEALTH QUESTIONNAIRE

COUNTIES MANUKAU HEALTH

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HEALTH QUESTIONNAIRE

PATIENT TO FILL IN

Yes No

☐ ☐ Do you have any restrictions on your physical ability?

_____

☐ ☐ Does physical effort make you so breathless that you need to stop: If so, what would bring it on?

☐ Less than 1 flight of stairs ☐ About 1 flight of stairs ☐ About 2 flights of stairs

☐ ☐ Do you get breathless lying flat? (eg. through the night) If Yes, how many pillows do you sleep with?

_____

☐ ☐ Do you get chest pain with physical effort? If so what would bring this on?

☐ Less than 1 flight of stairs ☐ About 1 flight of stairs ☐ About 2 flights of stairs

☐ ☐ List any regular physical activity you are involved in

_____

☐ ☐ Are there any other conditions not mentioned above?

_____

☐ ☐ Are there any medical conditions that run in the family?

_____

☐ ☐ Do you drink alcohol? If Yes, how much? _____

how often? _____

☐ ☐ Do you take street drugs or narcotics other than those prescribed for you?, If Yes, please list

_____

_____

☐ ☐ Do you have any special needs, questions or concerns about your anaesthetic?
If Yes, please write them down here, or ask to speak to the nurse

_____

_____

_____

PATIENT INFORMATION

☐ Pre-surgery information pack has been given to patient

☐ Received

Patient Signature Nurse Signature

_____ _____

All clinical pages to be dated, timed and signed

HEALTH QUESTIONNAIRE

COUNTIES MANUKAU HEALTH

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HEALTH QUESTIONNAIRE PATIENT TO FILL IN

SOCIAL ISSUES

Yes	No		Comments
☐	☐	Do you live alone?	
☐	☐	Do you look after anyone at home? (eg. partner/children/pets)	
☐	☐	Do you receive any help from community agencies? (eg. home help, meals on wheels)	
☐	☐	Do you have any concerns re your operation/hospitalisation?	

Please Specify _____

Are you planning an overseas trip in the next five months?

Please Specify _____

After your operation there may be some restriction on your activities (ie. no air travel)

Who is going to look after you when you go home from hospital?

Name: _____

Phone: _____

Who is going to collect you when you leave hospital?

Name: _____

Phone: _____

In an emergency who do we contact?

Name: _____

Phone: _____

ASSESSMENT OF SMOKE EXPOSURE OF PATIENTS

Smoking Status

☐ Currently smokes
☐ Non-smoker

Advice & Cessation Support

Tick all that apply

☐ Offered advice to quit
☐ Offered nicotine replacement or other cessation medication
Accepted? ☐ Yes ☐ No
☐ Cessation referral offered?

Patients Signature	Patients Name
Interpreters Signature	Interpreters Name
Date	

All clinical pages to be dated, timed and signed

HEALTH QUESTIONNAIRE

Summary of
Discharge Information Given Verbally to Patients

- Wound dressings are changed prior to discharge from the ward.
- See your own GP for a wound review ONE-week post-operation.
    - Patients who have “non-absorbable stitches” follow same advice re: GP, but will need to make appointment for removal of stitches (this can be done by Practise Nurse).
    - Patients with “Absorbable stitches” should still see GP one-week post-operation.
- If before the ONE week mark – patient sees signs of “redness or any offensive ooze from wound” - Seek GP Immediately
- Patients can shower with the waterproof dressing on, and that can be removed 5 days post-discharge (or before if starts to peel). This dressing doesn’t need a replacement.
    - Post-showering especially with stitches – pat wound sites dry and avoid direct soap on site until fully healed and stitches removed.
    - ‘non-stitches’ cases – can shower as normal
- Take pain relief/ analgesia as prescribed if needed
- Can eat and drink as normal
- Generally stay off work for at least one week, and if needing further time off discuss with the GP at the one-week review.