Neurosurgery On-Call Protocol

1. Standardized On-Call Report Structure

Every daily on-call report must include:

SURGERIES

- **Patient ID / Age / Referring site**
- **Diagnosis**
- **Procedure performed**: technique, laterality, complications
- **Immediate postoperative status**: GCS, imaging, drains, destination unit

ADMISSIONS

- **Reason for admission and working diagnosis**
- **Neurological exam and baseline status**
- **Imaging findings**
- **Clear clinical plan**: observation, scheduled surgery, pending decisions

NOT ADMITTED / REDIRECTED

- **Precise clinical justification**
- **Destination service and accepting physician** (name, department)

ICU / CRITICAL PATIENTS

- **Relevant acute events** (e.g. mydriasis, ICP spikes, coma)
- **Action taken**: medical/surgical response
- **Follow-up plan**: re-evaluation, imaging, surgical reconsideration

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2. Supervision and Responsibility

- The **on-call neurosurgeon** must endorse all surgical and critical decisions.
- **ICU and comatose patients** must be formally re-evaluated by neurosurgery daily.
- The **on-call coordinator or senior consultant** reviews all reports within 48 hours.

⚙ 3. Technical and Logistic Readiness

- **Daily verification of essential devices**: valve programmers, external drains, shunts.
- **Checklist for surgical readiness**: OR availability, drains, emergency CT access.

- **Formal inter-hospital communication protocols** with nearby centers (e.g. Elche, Orihuela).

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4. Monthly Quality Review

- Monthly audit of on-call reports by the head of department.
- Identification of recurring issues: vague reports, unclear plans, protocol breaches.
- Summary report sent to the medical director with key indicators:
  - Number of surgeries
  - Avoidable admissions
  - Incidents or adverse events