Allied Health Competencies

Surgical Staff Initial Appointment and Annual Competencies Include:

a. Fire Safety–Perioperative Services and Procedural Areas Policy (Mishawaka and Plymouth)

b. Emergency Preparedness in Surgical Services (Mishawaka and Plymouth)

c. Code Blue Policy (Mishawaka and Plymouth)

d. Electrosurgical Safety Policy (Mishawaka and Plymouth)

e. Malignant Hyperthermia Crisis Policy (Mishawaka and Plymouth)

f. Surgical Hand Scrub and Sterile Gowning and Gloving Policy (Mishawaka and Plymouth)

g. Universal Protocol for Preventing Wrong Site, Wrong Procedure and Wrong Person Surgery Policy (Mishawaka and Plymouth)

h. Violence and Threats in the Workplace Policy (Mishawaka and Plymouth)

SAINT JOSEPH HEALTH SYSTEM

Version #: 2

Title: Fire Safety - Perioperative Service & Procedural Areas

Document Owner: Stephanie Luther	PI Team:	Date Created: 07/22/2017
Approver(s): Constance Nichols, Loretta Schmidt, Suzanne Risner		Date Approved: 07/22/2017
Location: Saint Joseph Health System (SJHS)		Department: Cardiac Cath lab-angioplasti (14030_13230), Cardiac Cath lab-angioplasti (14035_13230), Interventional Radiology (14030_21350), Operating Room (14030_37020), Operating Room (14035_37020)

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

POLICY:

1. Fire Safety depends upon each individual taking an active part in fire prevention. In order to provide a safe environment for our staff, patients, and visitors, SJRMC will strive to maintain an environment free from the hazard of fire. Should a fire emergency take place, the intent is to take advantage of the fire response procedures in addition to fire safety features constructed into our facilities
2. To provide an organized response in the event of a fire, staff is trained upon hire in the fire plan procedures and to further enhance these efforts, staff participates in fire drills throughout the year. Hospital fires are a serious hazard. The loss of life and property is minimized when well organized procedures have been established, and when all persons involved have carried out their instructions in a systematic organized and effective manner.
3. In order to provide a safe working environment for our associates and a safe haven for our patients and visitors, Saint Joseph Regional Medical Center will strive to maintain an environment free from the hazard of fire.
4. Should a fire occur, the main hospital is supplied with automatic sprinkler and smoke detection devices. All hallway doors are fire resistant and close automatically to contain a fire.
5. To provide an organized response in the event of a fire, all associates are fully trained upon hire in the fire plan procedures and use of a fire extinguisher and again through annual education training. To further enhance these efforts, associates participate in fire drills one per shift per quarter throughout the year.
6. Hospital fires are a serious hazard. The loss of life and property is minimized when well-organized procedures have been established, and when all persons involved has carried out their instructions in a systematic organized and effective manner. For this reason, associates are educated to fully acquaint themselves with this plan.

PROCEDURE:

SJRMC Holy Cross Pkwy location:

A. **STAFF MEMBER DISCOVERING A FIRE OR SMOKE**

1) Do not panic

2) Remember RACE

R - Rescue persons in immediate danger

A - Alarm/Alert by sounding the closest fire alarm or notify the operator by dialing "55555"

C - Contain the fire by closing door

E - Extinguish fire (attempt) with closest fire extinguisher or evacuate area, (do not put yourself at risk)

3) To use a fire extinguisher, remember PASS

P - Pull the safety pin

A - Aim at the base of the fire

S - Squeeze the handle

S - Sweep from side to side until the fire is out or extinguisher has been exhausted

4) Dry Chemical ABC extinguishers are used for Class A, B, or C fires and is an all-purpose extinguisher.

5) CO2 fire extinguishers are used for Class B (oil, grease or gasoline) or C (electrical) fires.

B. **REPORTING A FIRE ALARM**

1) Using the nearest fire alarm pull station and pull the lever down and release.

2) Remain at the fire alarm pull station to give exact location of the fire. If a telephone is within easy access dial "55555" and give the exact location and nature of the fire. DO NOT hang up the telephone; stay on the line until the "all clear" is given.

3) In the event you are not able to access a fire alarm pull station, dial "55555" and give the exact location and nature of the fire. DO NOT hang up the telephone.

4) Audible fire alarm sounds and strobes flash throughout the facility once the pull station is activated.

5) Alarm signal appears on the Switchboard and Fire Command Center alarm screen detailing the location in which the alarm was triggered.

C. **ARRIVAL OF FIRE DEPARTMENT**

1) Once Fire Alarm is announced, Security will meet the Mishawaka Fire Department at the Fire Command Center (Level 1, far South side of ED) to direct them to the location of the fire.

2) The Fire Department will assume command of the scene upon arrival.

STAFF RESPONSE TO FIRE ALARM

A. **SWITCHBOARD OPERATOR RESPONSIBILITIES -** When notified of a fire by phone or fire alarm, the switchboard operator will:

1) Over the public address system, announce the Code F and its location as indicated on the Edwards Fire System and/or as called on extension "55555". Switchboard Operator will announce **"Attention please, Code F, (location given on screen or by caller)** and then repeat this phrase three times.

2) Notify security

3) Contact the Mishawaka Fire Department using the Red phone or 911. Give the location of the fire and any additional information if known.

4) Notify the Administrator on-call, Administrative Supervisor, Safety Officer, Manager of Plant Operations, and/or designees.

5) Keep one outside line free for emergency use.
6) Once the fire has been extinguished, under the advisement of the Mishawaka Fire Department the Administrator On-Call, Administrative Supervisor, Safety Officer or their designee will direct the switchboard operator to announce "All Clear" over the in-house public address system. The switchboard operator may not accept the "All Clear" direction from any other staff member.
7) Reset the Fire system when instructed to do so by the authorized person.

B. **ADMINISTRATOR ON-CALL, ADMINISTRATIVE SUPERVISOR, SAFETY OFFICER RESPONSIBILITIES**

1) Report to the scene of the fire.
2) Directs all SJRMC fire emergency activities in conjunction with the Mishawaka Fire Department.
3) In the event that medical gasses must be shut off, ONLY THE CHARGE NURSE/PERSON or RESPIRATORY THERAPY can authorize the shutoff of medical gasses. Anyone can be directed to turn the shutoff valve, but ONLY THE CHARGE NURSE/PERSON or RESPIRATORY THERAPY can authorize it.
4) May initiate Incident Command System (refer to Incident Command System Procedures).
5) Under the advisement of the Mishawaka Fire Department, notify the switchboard operator to give the "all clear" announcement.

C. **SECURITY RESPONSIBILITIES**

1) Meet the Mishawaka Fire Department at the Fire Command Center (Level 1, far South side of ED).
2) Provide backup support to the Administrator On-Call.
3) Complete a fire alarm evaluation.
4) Ensure all used fire extinguishers are picked up and scheduled for recharging.

D. **EMERGENCY RESPONSE GROUP RESPONSIBILITIES**

1) The following staff will **report immediately** to the announced area:
   a) All designated Plant Operations associates
   b) All designated Environmental Services associates
   c) All Security associates
2) Respond to all fire alarms with extinguishers.
3) Contain fire by assuring all corridor fire doors, doors, and windows in the immediate area are closed.
4) Assist the fire department and nursing unit as needed.
5) Protect equipment from unnecessary water damage.
6) Once the "all clear" is given, ensure all extinguishers with intact seals are returned to the point from which they were obtained.
7) Plant Operations, shut off air supply and air exhaust/return unit to area affected by the fire.

E. **STAFF RESPONSE TO FIRE ALARM – AT FIRE POINT OF ORIGIN**

1) In the event the fire or smoke is present in your work area, the following steps should be taken during a Fire Alarm:
   a) Practice **RACE**
      (1) **R**escue persons in immediate danger (room evacuation).
      (2) **A**larm by pulling the closest fire alarm pull station or directing a co-worker to dial "55555".
      (3) **C**ontain the fire by closing the door to the room or area.
      (4) **E**xtinguish the fire by using a portable fire extinguisher and the PASS acronym if you are able; do not put yourself at risk.
   b) In the event the fire is in a patient care area, and can be contained to a room or area without causing harm to other patients, visitors, or staff, associates should begin closing doors and windows to other patient rooms.
   c) In the event the fire is in a patient care area, and cannot be contained to a room or area without causing harm to other patients, visitors, or staff, associates should immediately begin moving patients and visitors through egress routes past smoke/fire doors (horizontal or vertical evacuation).
   d) When evacuating an area, you need to move patients and visitors through one set of fire doors before evacuating vertically.
   e) Take a count of patients (use patient census report if able) and visitors in your department.
   f) Supply medical gas masks via portable tanks to those in need.
   g) Portable medical gas tanks should be moved away from fire area to a place of safety.
   h) Wall medical gas system will be shut off as directed: **ONLY THE CHARGE NURSE/PERSON or RESPIRATORY THERAPY** can authorize the shutoff of medical gasses. Anyone can be directed to turn the shutoff valve, but **ONLY** the Charge Nurse/Person or Respiratory Therapy can authorize it.

F. **STAFF RESPONSE TO FIRE ALARM – AWAY FROM FIRE POINT OF ORIGIN**

1) In the event the fire or smoke is **not** present in your work area, the following steps should be taken during a Fire Alarm:
   a) Comply with specific duties assigned by this plan and your department director/supervisor.
   b) Close all doors and windows in your area.
   c) Contain patients and visitors to an area of safety within your department.
   d) Take a count of patients (use patient census report if able) and visitors in your department.
   e) Begin taking steps to prepare/talk through evacuation. If the fire alarm is in an adjacent area, prepare to evacuate.
   f) When evacuating an area, you need to move patients and visitors through one set of fire doors before evacuating vertically.

G. **TERMINATION – "ALL CLEAR" ANNOUNCEMENT**

1) Once the fire has been extinguished and/or the alarm assessed, under the advisement of the Mishawaka Fire Department, the Administrator On-Call, Administrative Supervisor, Safety Officer or their designee will direct the telephone operator to announce "all clear".
2) Operator will announce, "Attention Please, Fire Alarm All Clear", (repeat phrase three times)

H. **STAFF EDUCATION**

1) During the new hire orientation process each new associate will receive education on the Fire Plan.
2) Staff receives annual Environment of Care education through HealthStream.
3) Staff receives annual fire extinguisher training through HealthStream.
4) In addition, staff also receives education by participating in fire drills held throughout the year.

SPECIFIC DEPARTMENTAL DUTIES - Operating Room, Labor and Delivery, Anesthesia

POLICY:

A. To identify key concepts for fire prevention and define the response to surgical/procedural fires.

B. These guidelines apply to all procedural areas where there is a potential fire risk. Including but not limited to the operating rooms (OR's), labor and delivery, interventional radiology and catheterization lab.

C. Medical, nursing and ancillary colleagues working in the perioperative/ procedural environment will adhere to these guidelines.

D. Preventing fires and associated risks to the patient and colleagues is the responsibility of all perioperative colleagues. All colleagues have the responsibility to be aware of prevention strategies.

E. All OR fires will be fully investigated by conducting a complete root cause analysis (RCA).

F. Colleagues will complete mandatory annual fire safety education/competency and will also receive fire education/competency as part of orientation.

1) Colleagues will be aware of the risks and components of the fire triangle:

a) Heat: (electrocautery, laser, light sources, electrical equipment).

b) Fuel: (drapes, clothing, linens, alcohol based skin preps, collodion, tinctures, patient hair and GI gases, shoe covers etc.).

c) Oxidizer: (oxygen, nitrous oxide).

2) Colleagues will be knowledgeable of, and implement interventions for:

a) Controlling ignition sources

b) Managing fuel sources

c) Minimizing oxidizers

d) Be aware of RACE and responses for each.

(1) Rescue

(2) Alarm

(3) Confine

(4) Extinguish

e) Location and proper use of fire extinguishers (PASS).

(1) Pull pin

(2) Aim at base of flame

(3) Squeeze handle

(4) Sweep

f) Location of medical gas shut off valve.

g) Egress locations.

h) Evacuation procedures.

Note: Respond to fire- follow your emergency preparedness policy.

G. Fire Risk Assessment

1) Perioperative / procedural colleagues and anesthesia will conduct a fire risk assessment at the beginning of each procedure.

2) Appropriate fire safety prevention strategies will be utilized to ensure patient and colleague safety.

3) Active communication among all colleagues and physicians will occur regarding the potential use of an ignition source in an oxygen enriched environment and where alcohol based skin preps are used.

H. All OR colleagues, physicians and anesthesia will utilize the following operating/procedural fire prevention strategies.

1) Heat- Ignition source

a) Electrocautery Unit (ESU)

(1) Place the patient return electrode on a large muscle mass close to the surgical site.

(2) Store the ESU pencil in a plastic holder when not use.

(3) Keep surgical drapes or linens away from an activated ESU.

(4) Moisten drapes if absorbent towels and sponges will be used in close proximity to the ESU active electrode.

(5) Do not use an ignition source to enter the bowel when distended with gas.

(6) Keep ESU active electrode away from oxygen or nitrous oxide.

(7) Keep the ESU tip clean.

(8) Use active electrodes or return electrodes that are manufacturer approved for the ESU being used.

(9) Use approved protective covers as insulator on the active electrode tip. Not red rubber catheter or packing material.

(10) Activate ESU only in close proximity to target tissue and away from other metal objects.

(11) Inspect minimally invasive electrosurgical electrodes for impaired insulation; remove electrode from service if not intact.

(12) Use cut or blend settings instead of coagulation.

(13) Use lowest power setting for the ESU.

(14) Only the person controlling the active electrode activates the ESU.

(15) Remove active electrode from electrosurgical or electrocautery unit before discarding.

b) Laser:

(1) Use a laser-resistant endotracheal tube when using laser during upper airway procedures.

(2) Consider placing wet sponges around the tube cuff if operating in close proximity to the ET tube.

(3) Use wet sponges or towels around the surgical site

(4) Only the person controlling the laser beam activates the laser.

(5) Have water and the appropriate type fire extinguisher available.

c) Light sources and other electrical equipment.

(1) Place the light source in standby mode or turn off when not in use.

(2) Inspect light cables before use and remove from service if broken light bundles are visible.

(3) Select defibrillator paddles that are correct size

(4) Use only manufacturer recommended defibrillator paddle lubricant.

(5) Place defibrillator paddle appropriately.

(6) Inspect electrical cords and plugs for integrity and remove from service if broken.

(7) Check biomedical inspection stickers on equipment for a current inspection date and remove from service if not current.

(8) Do not bypass or disable equipment safety features.

(9) Follow manufacturer's recommendations for use.

(10) Keep fluids off electrical equipment.

2) Fuel Source:

a) Safe use of alcohol based (flammable) skin preparation agents

(1) Alcohol skin preps are to be used with extreme caution on head and neck procedures. Adequate time must be allotted to allow all liquids and fumes to dry and dissipate. Extended dry times may be needed.

(2) Conduct a skin prep "time out" to ensure the prep is completely dry.

(3) Allow skin-prep agents to dry completely according to manufacturer's recommendations- extend dry times to areas with skin folds and hair.

(4) Use appropriate size prep for surgical area.

(5) Prevent pooling of skin prep solutions.

(6) Remove prep-soaked linen and disposable prepping drapes.

(7) Allow fumes to dissipate before draping.

(8) Allow chemicals (e.g., alcohol, collodion, tinctures) to dry completely.

(9) Use moist towels around the surgical site when using a laser.

(10) Consider using moist sponges to pack the throat during throat procedures.

(11) Use water based ointment (i.e. KY) and not oil based ointment in facial hair and other hair near the surgical site.

b) Caution is to be used for all materials described as non-flammable (all non-flammable material will burn under the right conditions).

I. Oxidizers- Oxygen (air), Nitrogen, Oxygen Enriched Atmosphere (OEA).

1) Stop supplemental 02 or nitrous oxide 1 minute before using ignition source.

2) If >30% concentration required, intubate or use laryngeal mask airway.

3) Tent drapes to allow for free air flow.

4) Keep oxygen percentage as low as possible.

5) Use an adhesive incise drape.

6) Inflate endotracheal tube cuff with tinted saline for oropharynx or airway type procedures.

7) Evacuate surgical smoke from small or enclosed spaces.

8) Consider packing wet sponges around the back of the throat for oropharynx or airway type procedures.

9) If supplemental O2 is used -suction the oropharynx deeply before using ignition source for oropharynx procedures.

10) Check anesthesia circuits for possible leaks.

11) Turn off O2 at end of each procedure.

REFERENCES/STANDARDS:

- AORN (2013). Fire prevention in the perioperative setting. *Association of periOperative Registered Nurses*. Retrieved from http://www.aorn.org/PracticeResources/ToolKits/FireSafetyToolKit/
- CMS (2013), State Operations Manual , Appendix A - Survey Protocol, Regulations and Interpretive Guidelines for Hospitals http://cms.gov/manuals/Downloads/som107ap_a_hospitals.pdf
- FDA (2011). Recommendations for healthcare professionals on preventing surgical fires. FDA US Food and Drug Administration. Retrieved from http://www.fda.gov/MedicalDevices/Safety/AlertsandNotices/ucm275189.

SAINT JOSEPH
Regional Medical
Center

Version #: 4

Title: EMERGENCY PREPAREDNESS IN SURGICAL SERVICES

Document Owner: Lynne Lehman	PI Team: Environment of Care, OR	Date Created: May 1, 1994
Approver(s): Nichols, Constance; Risner, Suzanne; Schmidt, Loretta; Taylor, Luther		Date Approved: 07/22/2017 June 30, 2011
Location: Saint Joseph Regional Medical Center (SJRMC)		Department: Surgery

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

FIRE AND EVACUATION PLAN FOR SURGERY

POLICY:

1. Safe practices will be followed by all associates for the prevention of fires, the reduction of the spread of fire, and safe evacuation of patients and staff.

PROCEDURE:

Fire Prevention Safe Practices in the Operating Room

A. Ignition sources should be controlled. These include but not limited to:
   1) The active electrode tip of the electrosurgical unit (ESU) should be kept clean and in a holster when not in use.
   2) Lasers should be used with wet towels placed around the surgical site and after flammable prep solutions have dried.
   3) The ends of an active fiber-optic light cable should not come in contact with surgical drapes.
   4) Light cables should be connected before activating the light source.
   5) The light source should be placed into a stand-by mode when not in use to prevent ignition.

B. Personnel should move any equipment that emits smoke at any time, whether in use or not, to a safe area.

C. Fuel sources should be controlled. These include but not limited to:
   1) Waterless, brushless, surgical-scrub solutions should be allowed to dry completely to decrease the potential to produce ignition by static electricity or sparks.
   2) Storing of flammable products (e.g., surgical prep agents) in flammable cabinet.
   3) Provide adequate time for the flammable surgical prep solution to dry completely and any fumes to dissipate before applying surgical drapes, before using the active electrode or laser, or before activating a fiber-optic light cable.
   4) Prevent prep solutions from pooling by:
      a) Using towels to absorb excess solutions during application,
      b) Removing materials saturated with prep solution before draping the patient, and
      c) Wicking excess solution with a sterile towel to facilitate the surgical prep area drying completely.

D. Oxidizers should be controlled. These include but not limited to:
   1) Anesthesia circuits should be free of leaks.
   2) Oxygen –enriched environments are created when the oxygen concentration is greater than 21%. Oxygen concentration under drapers should be minimized by

a) Tenting of drapes, and
b) Using the lowest possible oxygen concentration that provides adequate patient oxygen saturation.

3) For surgeries involving the head and neck, water-soluble substances should be used to cover facial hair.
4) Suction should be used to evacuate anesthetic gas accumulation.
5) ESU and lasers should be used with caution where oxygen is flowing.
6) Precautions should be taken when operating in the gastrointestinal tract because hydrogen and methane, which are flammable gases, may be present.

E. Carbon dioxide fire extinguishers shall be available outside of the operating rooms.

Responsibilities of Personnel During a Fire in Surgery at SJRMC

A. ANYONE discovering smoke or fire will immediately notify the Manager/charge nurse and will follow the fire response protocol R.A.C.E.
   1) Rescue
   2) Alarm – pull nearest fire alarm, call and report fire (Fire Alarm will be announced overhead)
      a) Mishawaka – call 55555
      b) Plymouth-call call 2525
   3) One staff member will stay on the phone to the operator and another staff member will call the main OR desk to report the fire. The supervisor/charge nurse will send a staff member to pull the Fire Alarm nearest to the room where the fire is located.
   4) Contain – if possible, place wet towels at the base of the doors
   5) Extinguish – if possible and Evacuate the Operating Room

B. Roles of the surgical team
   1) The Surgeon should
      a) Remove from the patient materials that may be on fire and help put out the fire;
      b) Control bleeding and prepare the patient for evacuation if necessary;
      c) Conclude the procedure as soon as possible;
      d) Place sterile towels or covers over the surgical site; and
      e) If the patient is no in immediate danger, help move the patient if necessary.
   2) The anesthesia care provider should
      a) Shut off the flow of oxygen/nitrous oxide to the patient or field and maintain breathing for the patient with a valve mask respirator (i.e. ambu bag);
      b) Collaborate with the circulating nurse on the need to turn off the medical gas shutoff valves;
      c) Disconnect all electrically powered equipment on the anesthesia machine;
      d) Disconnect any leads, lines, or other equipment that may be anchoring the patient to the area;
      e) Maintain the patient's anesthetic state and collect the necessary medications to continue anesthesia during transport; and
      f) Place additional IV fluids on the bed for transport with the patient, if time permits.

3) The scrub person should
   a) Remove from the patient materials that may be on fire and help put out the fire;
   b) Assist with the conclusion of the procedure if possible;
   c) Obtain sterile towels or covers for the surgical site and instruments;
   d) Gather a minimal number of instruments onto a tray or basin and place them with the patient for transport; and
   e) Assist with patient transfer from the OR table to a stretcher/bed for transport out of the OR.
4) The perioperative RN circulating should
   a) Ensure the patient's safety by remaining with him or her and comforting him or her;
   b) Activate the fire alarm system and call the fire code to alert all necessary personnel;
   c) Extinguish small fires or douse them with liquid if appropriate;
   d) Remove any burning material from the patient or sterile field, and extinguish it on the floor;
   e) Prevent fire from spreading to shoes or surgical clothing by not stepping on it;
   f) Provide the scrub person and anesthesia care provider with needed supplies;
   g) Collaborate with the anesthesia care provider on the need to turn off the medical gas shutoff valve;
   h) Carefully unplug all equipment if the fire is electrical;
   i) Be aware of the safest route for escape;
   j) Obtain a transport stretcher if necessary;
   k) Remove IV solutions from poles and place them with the patient for transporting out of the OR;
   l) Help the anesthesia care provider disconnect any leads, lines, or other equipment that may be needed for transporting the patient; and
   m) Not delay leaving the OR suite.
5) The perioperative registered nurse in charge/designee should
   a) Notify the safety officer, telephone operator, or designated person of a fire and its location;
   b) Document the time the fire started;
   c) Determine how many people are in the department and account for everyone;
      (1) May want to assign a staff member to check each room .
   d) Set up a communication point and identify a person to staff it;
      (1) This person will assist with facilitating the flow of communication as people come and go through the surgery department including the Fire Department.
   e) Determine the state of ongoing surgery/procedures in each area
   f) Consult with the anesthesia care provider in charge on how to handle each patient;
   g) Assign personnel to assist where needed
   h) Ask visitors to leave if necessary; and
   i) Notify receiving unit staff of possible evacuation of the operating rooms and evacuate patients who may need to be moved immediately. If receiving unit is blocked, an alternative area will be designated.
      (1) Mishawaka – Outpatient surgery unit is the designated area for evacuation of patients.
      (2) Plymouth-PACU and/or OB LDR room

6) Ancillary personnel should (i.e. specialty techs, SPD techs)
   a) Help clear corridors for evacuation;
   b) Secure equipment for transporting the patient as directed by the circulating nurse
   c) Help prepare a safe area to transfer patients to, if this is needed;
   d) Follow instructions for evacuating the patient if needed; and
   e) Assist where directed.
7) People and patients should be evacuated to a safe area through at least two fire doors. The last person through the doors shall close the door to contain the fire and lay a moistened towel across the base of the door.
8) When necessary, the surgical team will return to a safe operating room to complete the surgical procedure.
9) When there is no immediate danger, the surgical team will continue the procedure and "defend in place" awaiting further instructions. Moisten towels may be needed to place at the bottom of the doors.
10) After a fire, everything should be left in place so the safety officer and the fire department can conduct a thorough investigation of the cause of the fire.

C. Fire Safety Education
   1) All associates will do an annual departmental fire safety competency review, including evacuation procedures.
   2) Periodic evacuation fire drills will be conducted in the department.
   3) Healthcare Industry personnel and students shall be included in fire safety education. This shall include location of fire extinguishers and fire alarm pull downs.

DISASTER PLAN FOR SURGICAL SERVICES

POLICY:

1. Surgical Services shall have a plan of action in the event of a disaster.
2. The department shall retain a notebook with staff addresses and phone numbers that can be utilized to contact staff in the event of a disaster.

PROCEDURE:

A. During the hospital wide **Disaster Phase 2**(Preparation Phase), the Director of Surgical Services or designee shall:
   1) Communicate with the chairperson of Surgical Services regarding the casualties.
   2) Initiate a call plan as needed.
   3) Maintain communication between the operating room and the other departments within the facility, including other surgical services directors, managers, and supervisors.
   4) Notify surgeons as necessary.
   5) Designate a surgeon to categorize and triage casualties arriving in the operating room.

6) Assign staff to work phones, maintain supplies, and assist in record keeping and request dietary supplements as necessary.
7) Coordinate the disaster activities for the operating room and maintain direct contact with triage area by telephone.

B. During the hospital wide **Disaster Phase 2**(Preparation Phase), the Chairperson of Anesthesia or designee shall:
1) Communicate with the Director of Surgical Services or designee and develop a plan to call in and assign anesthesia personnel as needed.
2) Designate a person to assign anesthesia personnel to evaluate casualties prior to surgery.
3) Coordinate activities with the laboratories and blood bank.

C. During the hospital wide **Disaster Phase 2**(Preparation Phase), the Department Manager/Supervisor/ or designee shall:
1) Assume the responsibilities of the Director of Surgical Services in his/her absence.
2) Communicate with the Director of Surgical Services and Chairperson of anesthesia to assess the need for Surgical Services personnel.
3) Initiate call plan for additional staffing as needed.
4) Make assignments as staff becomes available.
5) Assign surgical services staff to check levels of supplies/instruments, medications, and obtain needed items.
6) Assign surgical services staff to prepare operating rooms for anticipated surgeries.
7) Assign ancillary staff to stock supplies, obtain blood, transport patients and perform other duties as necessary.

D. During the hospital wide **Disaster Phase 2**(Preparation Phase), the Manager of OPS/PACU or designee shall:
1) Assess the need for Post Anesthesia Care Unit personnel and for intensive care unit beds, confer with the chairperson of surgery and anesthesia regarding transfer of patients to theses areas.

E. On-call anesthesiologist shall coordinate activities on off hours until chairperson is present.

F. During the hospital wide **Disaster Phase 3**(Transportation of Victims), the Director of Surgical Services or designee shall:
1) Discuss with the Chief of Surgery and Anesthesia the cancellation of elective surgeries and notify surgeons with cases in progress that surgery should be completed as quickly as possible.

G. During the hospital wide **Disaster Phase 3**(Transportation of Victims), the Department Manager/Supervisor/ or designee shall:
1) Assess for staffing relief as necessary (consideration for food and rest)

H. Surgical services staff shall:
1) Remain in their work areas to be available for arriving patients.
2) Perform work duties as assigned.
3) Keep phone lines open.
4) Utilize ancillary staff to obtain needed supplies and services.
5) Remove any unnecessary clutter from the area.
6) Ensure emergency equipment is ready and available.

7) Remain calm and work as quietly and efficiently as possible.
8) Provide support to patients, families and staff.

POWER FAILURE

POLICY:

1. The surgery department will go on emergency generator power when power failure occurs.

PROCEDURE:

A. When on generator power, procedures in progress shall finish as soon as possible and no additional procedures may start until the department is restored to full power.
B. Electrical items must be plugged into "red" outlets when on generator power.
C. Flashlights shall be stored in each procedure room. Batteries shall be checked routinely.
D. When phone lines are not in operation, the designated RED emergency phone is located:

ELECTRICAL FAILURE (LINE ISOLATION)

PROCEDURE:

A. The monitoring system shall have visual and audible warning signals to indicate when total hazard current has exceeded allowable limits.
B. When line-isolation monitors indicate a fault (alarm visually and audibly):
   1) Remove last electrical item plugged in. If alarm ceases:
      a) Remove that item from the room.
      b) Label that item as being non-functional.
      c) Notify biomedical department that equipment needs repair.
      d) Equipment will not be used until defect is remedied.
   2) If alarm does not cease:
      a) Continue to unplug equipment until hazard alarm ceases.
      b) Notify maintenance department.
         (1) The involved room, as soon as the case is completed, will not be used until the defect is found and remedied.

References/Standards:

- 2017 Perioperative Standards and Recommended Practices, Association of PeriOperative Registered Nurses, Inc., Denver, CO, 2017.

SAINT JOSEPH
Regional Medical Center

Version #: 4

Title: Code Blue Resuscitation Plan

Document Owner: Jeannie Bowlin	PI Team: POC	Date Created: 07/01/92
Approver(s): Loretta Schmidt		Date Approved: 10/22/2019
Location: Saint Joseph Regional Medical Center (SJRMC)		Department: Nursing Admin (14030_10005)

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

POLICY:

1. Every effort will be made to resuscitate a patient when a Code Blue is called, in the absence of a written "Do Not Resuscitate" (DNR) order in the patient's medical record.
2. Code Blue resuscitation efforts utilizing American Heart Association Advanced Cardiac Life Support (AHA ACLS) will continue unless terminated by a physician.
3. DNR orders will be rescinded when patients receive general anesthesia. The primary physician or anesthesiologist will discuss this with the patient or patient representative and document on the Physician Order Sheet.
4. The Code Blue Team will respond to Code Blue calls within the main Medical Center, MRI Center, Cardiac Rehab, and Breast Center. Code Blue Team will assist in other areas within the Medical Office Building (MOB) until EMS arrives, 24 hours/day, 7-days/week.
5. Code Blues in procedural areas (OR, IR, Cath Lab, Endo Lab) will be managed by the department. Code Blue Team will be called if more assistance is required.
6. All off sites, including SJRMC Rehabilitation Institute on Elm Road, Medical Offices, and Clinics, will start BLS (Basic Life Support) and call 911.
7. Code Blue Team RNs will have certification in one or more of the following: Advanced Cardiac Life Support (ACLS), Pediatric Advanced Life Support (PALS), or Neonatal Resuscitation Provider (NRP).
8. ED RN and pediatric/neonatal RN will respond to Pediatric/Neonatal Code Blues. The pediatric/neonatal RN will assume the role of code leader.
   A. The ED RN will bring the Broselow cart to pediatric codes occurring in units other than PACU, ED, and pediatrics.
9. Intubation to be performed by a physician or respiratory therapist
10. An anesthesiologist will respond upon request as available.
11. Floor nurse or designee will call the Chaplain at 335-4422 when needed
12. Family members (1-2) may remain at the bedside during the Code Blue if they wish to do so. The family member must be supported by a Chaplain, Nurse Leader, or other individual not participating in the care of the patient. *If family members interfere with the work of the Code Blue team they will be escorted out by the employee who is supporting them.*

PROCEDURE:

Initiating Code Blue:

A. The person discovering the Code Blue situation will:

Title: Code Blue Resuscitation Plan

1) Activate the Code Blue call button. If Code Blue button not available call 5-5555. Provide the exact location of the arrest and indicate if the patient is pediatric or neonatal.
   a) Pediatric: children under the age of twelve
   b) Neonatal: infants under the age of 28 days
2) Begin BLS interventions
3) In the event of a Nurse Call system or Code Blue button failure, Clinical Engineering will be contacted to identify the failure, test the system, and restore to full functionality.

Telephone Operator Response:

A. Initiate Code Blue tones over the public address system, followed by the announcement repeated 3 times:
   1) "Code Blue, location (location (lakeside or garden side) including room numbers)" (state pediatric/ neonatal as indicated),

B. If public address system is not working, call:
   1) Intensive Care Unit 5-3125
   2) Intensive Care Respiratory Therapist 5-7107
   3) Surgical Intensive Care Unit 5-2140
   4) Progressive Care Unit 5-3140
   5) Laboratory 5-6270
   6) Emergency Department 5-1110 (for Code Blue in all non-patient areas)
   7) Respiratory ED Therapist 5-7109
   8) Nursing Supervisor 5-7000
   9) IV Therapy 5-6115

Code Blue Team Personnel and Roles:

CORE PERSONNEL Remain at the bedside	SUPPORT PERSONNEL Remain outside the room
1. ICU nurse: Charge Nurse • Bring RSI box • Assign team member roles • Sign Resuscitation Record at end of code • Monitor / defibrillator (if only one ICU nurse present at code)	1. Administrative Supervisor • Clear room of extra personnel • Remind team to send copy of Code Blue form to Critical Care Director • Notify other ancillary services/ departments as needed (i.e. anesthesia, radiology, ECG, etc.) anesthesia as required o Major surgery 52110 o FBP 57430 o ED 51110 • Facilitate transfer to critical care • Assign nurse to return med tray to Pharmacy at the end of the code, if Pharmacist is not present

Title: Code Blue Resuscitation Plan

2. Patient's Primary Nurse: • Ask someone to bring code cart into the patient room and apply AED pads, place patient on backboard, and start CPR • Remain in room during the code • Assist in transfer of patient, Hand off to receiving RN, return equipment to floor • Attach patient identification to medication tray for charges • If in Emergency Department it is the responsibility of the primary nurse to return the med tray to Pharmacy after the code with patient identification attached for charges.	2. Chaplain • Notify and support patient's family • Facilitate communication between family and team members • One or two family members may remain at the bedside to observe the Code Blue accompanied by the Chaplain or designee
3. Pharmacist: • Medications • Between the hours of 2300 to 0700 to take the code cart from Critical Care Progressive– S and deliver to unit	3. Laboratory Technician • Labs draws • ISTAT
4. Physician/Resident: Code Leader • Follow AHA ACLS guidelines, unless medical necessity prevails • Sign Resuscitation Record at end of code	4. Charge Nurse or • Attach patient identification to medication tray for charges • Call for Crash Cart Replacement • Place patient sticker on laminated sheet attached to crash cart • Call distribution post code to pick up code cart (make sure all pieces to the code cart are back on before distribution picking up – i.e. Backboard, Clipboard, Step Stool, and Med Drawer Cover and that Crash Cart has been cleaned of visible soil • Take medication drawer with patient label affixed to Pharmacy (must be done by RN)
5. Critical Care – Progressive Nurse: documentation (not needed in procedural areas: OR, Cath Lab, IR, Endo Lab) • Sign Resuscitation Record • Submit completed Resuscitation Record and code evaluation to Unit Manager then to Critical Care Manager	5. IV Therapist when available • IV site starts if needed

• If code in MOB need to take code cart from respiratory area to MOB location	
6. Respiratory Therapist: • Airway/ ventilation	6. Distribution Staff Member (when available) • Take replacement crash cart to code area
7. Pediatric nurse, NICU NNP, Pediatric Hospitalist, Emergency Department nurse (as applicable for Pediatric Code Blue)	

Following Code Blue Announcement:

A. Units with crash carts are responsible to bring crash cart to Code Blues on their unit.

B. Distribution will deliver a back-up crash cart to the Code Blue location.

C. Response to a Code Blue in a non-clinical area within the main Medical Center structure:

1) ED staff is responsible to bring stretcher to codes in non-clinical areas.

2) Physician and Charge Nurse will accompany the patient to the Emergency Department or the appropriate Critical Care Unit (only if primary care physician unavailable to admit patient)

3) Crash cart will be delivered from the appropriate area. For the MOB the code cart will be stored 3rd floor SJRMC Respiratory area.

Documentation:

A. **Significant Event**

B. **Nurse's Notes:** document initiation of resuscitation and outcome.

C. **Resuscitation Record:**

1) Attach sample rhythm strips to the Cardiopulmonary Resuscitation Record. These may be obtained through the code summary on the defibrillator monitor.

a) Initial cardiac rhythm

b) Cardiac rhythm following successful cardioversion/ defibrillation/pacing

c) Cardiac rhythm upon completion of resuscitation efforts

2) Use second Resuscitation Record if additional space is required.

Code Blue documentation

A. "Resuscitation Record" is part of the permanent medical record.

1) Information recorded on this record replaces physician orders during the Code Blue resuscitation period.

2) Patient Sticker present on all three copies of Resuscitation Record

3) Must be signed by the Responding Physician, primary Nurse, Recorder, ICU RN, RT, and Pharmacist.

B. White Copy of the Resuscitation Record is scanned by the Primary Nurse or designees and sent to designated confidential email in HIM; then original White Copy is placed in paper chart.

C. Yellow/Pink copy is sent to manager of the recorder to review for completeness, and then sent to ICU Manager within 24 hours for distribution to Get With the Guidelines (GWTG) data recorders.

D. Send Code information from Zoll Series R via web link on monitor

Code Blue for the patient in Isolation:

A. Crash cart is handled only by the medication nurse/pharmacist, who will avoid direct patient care to prevent contamination of the equipment.

B. All equipment coming into contact with the patient in isolation will be disinfected upon leaving the room per infection control policy.

Standardized Crash Carts

A. SPD will stock supplies.

B. Pharmacy will stock medications and supply cart locking devices.

1) A tag listing the name and date of the medication that expires the earliest will be affixed to the sealed medication tray.

CODE CART PROCEDURE:

A. Charge Nurse or designee:

1) Place patient label on medication tray and return to Pharmacy
2) Place patient sticker on laminated sheet attached to Crash Cart
3) Assure that all four items are present before used crash cart is picked up:
   a) Backboard
   b) Stepstool
   c) Drug Tray Cover
   d) Clipboard
4) Crash Cart must be clean of visible soil

B. SPD:

1) Complete Crash Cart Inventory form
2) Restock crash cart and document on Crash Cart Inventory form.
3) Deliver clean, restocked crash cart to Pharmacy to insert medication tray and lock cart.

SAINT JOSEPH
Regional Medical Center

Version #: 5

Title: ELECTROSURGICAL SAFETY

Document Owner: Stephanie Luther	PI Team: Environment of Care, Provision of Care	Date Created: 08/01/92
Approver(s): Constance Nichols, Loretta Schmidt, Suzanne Risner		Date Approved: 03/13/2020
Location: Saint Joseph Regional Medical Center (SJRMC)		Department: Operating Room (14030_37020)

POLICY:

1. To provide guidelines to perioperative staff in the use and care of the electrosurgical equipment.
   A. Personnel working with electrosurgery equipment shall be knowledgeable about the principles of electrosurgery, risks to patients and measures to minimize these risks and corrective actions to employ in the event of a fire or injury.
   B. In all procedures involving the use of electrosurgical equipment, patients and personnel must be protected from hazards associated with electrosurgery.

PROCEDURE:

A. Personnel selecting new and refurbished electrosurgical units (ESU) and accessories for purchase or use shall make decisions based on safety features to minimize risks to patients and personnel.

B. The ESU shall be used in a manner that minimized the potential for injuries.
   1) Instructions for ESU use, warranties and a manual for maintenance and inspections shall be obtained from the manufacturer and be readily available to users.
      a) Operating instructions specific for the device shall be on or attached to each ESU.
   2) The ESU shall be securely mounted on a tip-resistant cart or shelf and shall not be used as a shelf or table.
   3) The ESU shall be protected from liquids.
      a) Liquids shall not be place on top of the ESU.
      b) Foot pedal accessories shall be encased in a clean, impervious cover when there is potential for fluid spills on the floor.
   4) Safety and warning alarms and activation indicators shall be operational, audible, and visible at all times.
   5) The ESU shall be visually inspected and the return electrode monitor tested according to manufacturer's instructions before use.
   6) Settings should be based on the operator's preference consistent with the intended application and the manufacturer's written instructions for patient size, active electrode type, and return electrode placement.
   7) The circulating nurse shall confirm the power settings with the operator before activation of the ESU.
   8) The ESU shall be operated at the lowest effective power setting needed to achieve the desired tissue effect.

9) If the operator requests a continual increase in power, personnel shall check the entire ESU and accessories circuit for adequate placement of the dispersive electrode and cord connections.
10) The electrode tip shall be visually inspected before each use and replaced if damaged.
11) Perioperative registered nurses shall be aware of potential patient safety hazards associated with specific internal implanted electronic devices (IED) and the appropriate patient care interventions required to protect the patient from injury. These devices may include cardiac pacemakers, implanted cardioverter defibrillators (ICD), neurostimulators, implantable hearing devices, implantable infusion pumps, and osteogenic stimulators.
12) After use, personnel shall
    a) Turn off the ESU;
    b) Dispose of single use items;
    c) Clean all reusable parts and accessories according to the manufacturer's directions
    d) Inspect accessories and parts for damage, function, and cleanliness.
13) An ESU that is not working properly or is damaged shall be removed from service immediately and reported to Biomed.

C. The electrical cords and plugs of the ESU shall be handled in a manner that minimizes the potential for damage and subsequent patient and user injuries.
    1) The ESU electric cord shall be adequate in length and flexibility to reach the electrical outlet without stress or the use of an extension cord.
    2) The ESU shall be placed near the sterile field, and the cord shall reach the wall or column outlet without stress on the cord and without blocking a traffic path.
    3) The electrical cord shall be free of kinks, knots, and bends.
    4) The ESU plug, not the cord, shall be held when it is removed from the outlet.
    5) The ESU's cord should be kept dry.
    6) The ESU's cord shall be inspected or electrically tested for outer insulation damage.
        a) The ESU shall be removed from use if there is any evidence of breaks, nicks, or cracks in the outer insulation coating of the electrical cord.

D. The active electrode shall be used in a manner that minimizes the potential for injuries.
    1) The active electrode shall be visually inspected at the surgical field before use. Inspection shall include but not limited to
        a) Identifying any apparent damage to the cord or hand piece; and
        b) Ensuring compatibility of the active electrode, accessories, the ESU, and the procedure.
    2) A damaged and/or incompatible active electrode, accessory, or ESU shall be immediately removed from use.
    3) When not in use, the active electrode should be placed in a clean, dry, non-conductive safety holster. A plastic or other non-conductive device should be used to secure the active electrode cord to the sterile drapes.
        a) The protective cap of a battery-powered cautery should be in place when the cautery is not in use.

4) The electrode cord should be kept free of kinks and coils during use.
5) The active electrode should be connected directly into a designated receptacle on the ESU.
    a) When needed, only adaptors approved by the manufacturers of both the ESU and the accessory shall be used.
6) Only the user of the active electrode should activate the device whether it is hand or foot controlled.
7) Active electrode tips shall be used according to the manufacturer's instructions. The active electrode tip:
    a) Should be compatible with the ESU.
    b) Should be securely seated into the hand piece, and
    c) Should not be altered.
8) The active electrode tip should be cleaned away from the incision whenever there is visible eschar.
9) Methods to remove debris from the active electrode tip should include but not limited to;
    a) A moistened sponge or instrument wipe to clean non-stick electrosurgical tips on the sterile field, and
    b) Abrasive electrode cleaning pads to remove eschar from non-coated electrodes on the sterile field.
    c) The active electrode tip should not be cleaned with a scalpel blade.
10) If the active electrode becomes contaminated, it should be disconnected from the ESU and removed from the sterile field.
11) If an active monopolar electrode is being used in a fluid-filled cavity, the fluid used should be an electrically inert, near isotonic solution (e.g., dextra 10, dextran 70, glycine 1.5%, sorbitol, mannitol) unless the equipment manufacturer's written directions for use instruct otherwise.
12) The active electrode shall be placed on the mayo stand at the delivery time of the baby in the cesarean section operating room.
13) Fire safety measures shall be followed when electrosurgery is in use according to local, state, and federal regulations.
    a) Active electrodes shall not be activated in the presence of flammable agents (e.g. antimicrobial skin prep, de-fatting agents, uncured methyl methacrylate) until the agents are dry and vapors have dissipated.
    b) Caution shall be used during surgery on the head and neck when using active electrode in the presence of combustible anesthetic gases.
    c) Open suture packets containing alcohol shall be removed from the sterile field as soon as possible.
    d) Sponges used near the active electrode tip should be moist to prevent unintentional ignition.
    e) When battery-powered, hand-held cautery units are used, the batteries should be removed before disposal of the cautery unit
    f) Electrosurgery should not be used in the presence of gastrointestinal gases.

g) Electrosurgery should not be used in an oxygen-enriched environment.

(1) The lowest possible oxygen concentration that provides adequate patient oxygen saturation should be used.

(2) Surgical drapes should be arranged to minimize the buildup of oxidizers (eg oxygen and nitrous oxide) under the drapes, to allow air circulation, and to dilute the additional oxygen.

(3) The active electrode should be used as far from the oxygen source as possible.

h) Personnel should be prepared to immediately extinguish flames should they occur.

(1) Nonflammable material (e.g., wet towel, sterile saline, water) should be available on the sterile field to extinguish the fire.

E. When monopolar electrosurgery is used, a dispersive electrode shall be used in a manner that minimizes the potential for injuries.

1) The patient's skin condition shall be assessed and documented before and after ESU use.

2) Return-electrode contact quality monitoring should be furnished on general-purpose electrosurgery units. Dual return electrodes should be used.

3) Return-electrode continuity monitoring should be used if return-electrode contact quality monitoring is not available. If using return-electrode continuity, a single-foil electrode should be used.

4) Dispersive electrodes shall be compatible with the ESU.

5) A single-use dispersive electrode shall be used once and discarded. If a single-use dispersive electrode must be repositioned, a new single-use electrode shall be used.

6) Dispersive electrodes shall be an appropriate size for the patient (e.g., neonate, infant, pediatric, adult) and not altered (e.g., cut, folded).

7) Before the application of a single –use dispersive electrode,

a) The manufacturer's expiration date should be verified, and the dispersive electrode should not be used if it is past the manufacturer's date;

b) The package containing the dispersive electrode should be opened immediately before use; and

c) The integrity of the dispersive electrode should be checked for flaws, damage, discoloration, adhesiveness, and dryness.

8) The conductive and adhesive surfaces of the single-use dispersive electrodes should be placed on clean, dry skin over a large, well-perfused muscle mass on the surgical side and as close as possible to the surgical site according to the manufacturer's directions for use.

9) Single-use electrodes should not be placed over bony prominences, scar tissue, hair, weight-bearing surfaces, potential pressure points, or areas distal to tourniquets.

10) Hair should be removed following recommended practices (i.e., clipping) if it interferes with single-use electrode contact with the patient's skin.

11) The single-use electrode should not be placed over an implanted metal prosthesis including insulin pumps.

12) Placing the single-use electrode over a tattoo, many of which contain metallic dyes, should be avoided.
13) Following application of the single-use dispersive electrode, uniform contact with the skin should be verified.
14) Corrective measures for poor single-use dispersive electrode contact include, but not limited to
    a) Removing oil, lotion, moisture, or prep solution;
    b) Removing excessive hair; changing sites; and
    c) Applying a new pad.
15) The single-use dispersive electrode should be placed on the patient after final positioning.
    a) If tension is applied to the dispersive electrode cord, the perioperative registered nurse should reassess the integrity of the dispersive electrode, its contact with the patient's skin, and the connection to the ESU.
    b) If the patient is repositioned, the perioperative registered nurse should verify that the dispersive electrode is in full contact with the patient's skin.
16) The single-use dispersive electrode should be placed away from a warming device.
17) Dispersive electrodes should be kept dry and protected from fluids seeping or pooling under the electrode.
18) Contact between the patient and metal devices should be avoided.
    a) Patient's metal jewelry that is between the active and dispersive electrode should be removed.
    b) Patient's monitoring electrodes (e.g., electrocardiogram, oximetry, fetal) should be placed as far away from the surgical site as possible.
    c) Needle electrodes for monitoring or non-surgical functions should be avoided.
    d) When use of needle monitoring electrodes is medically necessary, alternate electrosurgery technologies (e.g., bipolar, laser) should be considered.
19) When multiple ESU are used simultaneously during a surgical procedure, the compatibility of equipment and proper functioning of corresponding electrode monitoring systems should be verified with the manufacturer.
    a) Separate single-use dispersive electrodes should be used for each ESU.
    b) The dispersive electrodes should be placed as close as possible to their respective surgical sites and the single-use dispersive electrodes should not overlap.
20) During high-current, long-activation-time, radio-frequency (RF) ablations and other electrosurgical procedures (e.g., tumor ablation, bulk tissue resection), considerations should include, but not limited to;
    a) Identifying surgical procedures that require the use of high-current, long-activation-time RF ablation and electrosurgical techniques;
    b) Taking inventory of RF generators that require special or multiple dispersive electrodes;
    c) Following the manufacturer's recommendations for use of large-size dispersive electrodes or multiple dispersive electrodes;
    d) Ensuring proper placement and full patient contact of the dispersive electrode;

e) Reviewing the manufacturer's directions for use and requirements for accessories;

f) Using and selecting the appropriate non-conductive, near-isotonic solutions (e.g., sorbitol, mannitol, dextran 10 or 70, glycine) for irrigation or distention unless contraindicated by manufacturer's directions; and

g) Using the lowest possible power settings and minimum activation time for obtaining the desired tissue effect.

h) When a single dispersive electrode does not adequately disperse high current and there are not specific manufacturer's directions, a second dispersive electrode with an adaptor or return electrode with a larger conductive surface may be considered for use.

21) When removing the single-use dispersive electrode, the adjacent skin should be held in place and the dispersive electrode peeled back slowly.

F. **Personnel shall take additional precautions when using electrosurgery during minimally invasive surgery**.

1) Personnel should verify that the insufflation gas is nonflammable.

2) Conductive trocar systems should be used.

3) Minimally invasive surgery electrodes shall be examined for impaired insulation before use.

a) Active electrode insulation integrity testers that use high DC voltage to detect full thickness insulation breaks shall be used.

b) The lowest power setting that achieves the desired result should be selected.

4) The active electrode should not be activated until it is in close proximity to the tissue.

5) Patients should be instructed to immediately report any postoperative signs or symptoms of electrosurgical injury. Patient postoperative care instructions should include symptoms to look for, including but not limited to

a) Fever

b) Inability to void

c) Lower gastrointestinal bleeding

d) Abdominal pain

e) Abdominal distention

f) Nausea

g) Vomiting

h) Diarrhea

G. Bipolar active electrodes, including vessel-occluding devices, shall be used in a manner that minimizes the potential for injuries.

1) Molded, fixed-position pin placement bipolar cord should be used. Bipolar and monopolar plugs should be differentiated to prevent misconnections of active and return electrodes.

2) Dispersive electrodes are not needed with bipolar active electrodes.

H. Ultrasonic electrosurgical devices shall be used in a manner that minimizes potential for injuries.

1) When using an ultrasonic electrosurgical device, a dispersive electrode should not be used.

2) Inhalation of aerosols generated by an ultrasonic electrosurgical hand piece should be minimized by implementing control measures, including but not limited to smoke evacuation systems and wall suction with an in-line ultra low penetration air (ULPA) filter.

I. Argon enhanced coagulation (AEC) technology poses unique risks to patient and personnel safety and shall be used in a manner that minimized the potential for injury.

1) All safety measures for monopolar electrosurgery should be used when using AEC technology.

2) Air should be purged from the argon gas line and electrode by activating the system before use, after moderate delays between activations, and between uses.

3) The argon gas flow should be limited to the lowest level possible that will provide the desired clinical effect. **WARNING**: The Argon gas flow must be turned down to 4L (or as low as possible for laparoscopy. **IT MUST NEVER BE USED IN THE UTERUS.**

4) The active electrode should not be placed in direct contact with tissue and should be moved away from the patient's tissue after each activation.

5) When using the AEC unit during minimally invasive surgical procedures, personnel should follow all safety measures identified for AEC technology.

a) Endoscopic CO2 insufflators should be equipped with audible and visual over-pressurization alarms that cannot be deactivated.

b) The active electrode and argon gas line should be purged according to the manufacturer's recommendations.

c) The patient's intra-abdominal cavity should be flushed with several liters of CO2 between extended activation periods.

6) Personnel using the AEC technology should be knowledgeable about signs, symptoms, and treatment of venous emboli.

a) Patient monitoring should include devices that are considered effective for early detection of gas emboli (e.g., end tidal CO2).

J. Potential hazards associated with surgical smoke generated in the practice setting shall be identified, and safe practices established.

1) Surgical smoke should be removed by use of a smoke evacuation system in both open and laparoscopic procedures.

a) When large amounts of plume are generated, an individual smoke evacuation unit with a ULPA filter should be used to remove surgical smoke.

b) The suction wand of the smoke evacuation system should be no greater than two inches from the source of the smoke generation.

c) Smoke evacuation units and accessories should be used according to manufacturer's written instructions.

d) When a minimal amount of plume is generated, a central suction system with an in-line ULPA filter may be used to evacuate the plume.

e) When a centralized system dedicated for smoke evacuation is available, the smoke evacuator lines should be flushed according to the manufacturer's instructions to ensure particulate matter buildup does not occur.

f) Used smoke evacuator filters, tubing, and wands should be disposed of as potentially infectious waste following standard precautions.

g) Personnel should wear high-filtration surgical masks during procedures that generate surgical smoke.

K. Personnel shall receive initial education and competency validation on procedures and shall receive additional training when new equipment, instruments, supplies or procedures are introduced.

L. Documentation shall include, but not limited to:

1) Electrosurgical system identification serial number
2) Range of settings used
3) Dispersive electrode placement
4) Patient's skin condition before dispersive electrode placement
5) Patient's skin condition after removal of dispersive electrode
6) Adjunct electrosurgical devices used (e.g., ultrasonic scalpel, bipolar forceps)

References/Standards:

- 2016 Perioperative Standards and Recommended Practices, Association of PeriOperative Registered Nurses, Inc, Denver, CO.
- Rothrock, Jane C., Alexander's Care Of The Patient In Surgery, 16th ed., Mosby, St. Louis, Missouri, 2018.

SAINT JOSEPH
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Center

Version #: 4

Title: MALIGNANT HYPERTHERMIA CRISIS

Document Owner: David Kwak	PI Team: Provision of Care	Date Created: July 1, 1996
Approver(s): Nichols, Constance; Risner, Suzanne; Schmidt, Loretta		Date Approved: 03/20/2018 June 30, 2011
Location: Saint Joseph Regional Medical Center (SJRMC)		Department: Cardiac Cath lab-angioplasti (14030_13230), Cardiac Intervention Unit (14030_37070), Emergency Medical Service (14030_86230), Emergency Room Services (14030_36000), GI Lab (14030_37200), Operating Room (14030_37020), Post Op Phase II (14030_37040), Recovery Room (PACU) (14030_37500)

POLICY:

1. Registered nurses, and the surgical technologists in perioperative areas, critical care, emergency department, Family Birthplace and House Administrative Supervisors shall be knowledgeable about malignant hyperthermia. Anesthesiologists shall manage the patient in a malignant hyperthermia crisis and the perioperative nursing team shall assist the anesthesiologist during a malignant hyperthermia crisis.

PROCEDURE:

A. Suggested M.H.A.U.S. (Malignant Hyperthermia Association of the United States protocol for malignant hyperthermia management shall be available in the perioperative department and on the malignant hyperthermia cart.
   1) This protocol may provide guidelines for patient management but may not apply to every patient and out of necessity must be altered according to specific patient needs.

B. The malignant hyperthermia hotline phone number shall be available on the malignant hyperthermia cart.

C. Malignant hyperthermia crisis cart with supplies shall be available in Surgical Services. Additional medication is located in Family Birthplace and in the Pharmacy.
   1) If a malignant hyperthermia event occurs outside Surgical Services staff should immediately call 5-5555 to initiate the emergency response "Malignant Hyperthermia Code" to their specific location.
      a) The operator will overhead "Malignant Hyperthermia Code" and the location.
      b) The operator will call the House Supervisor, Pharmacy, Surgery Charge at 5-2110 and OB Anesthesia.
      c) Plymouth Campus notify the Administrative Supervisor
   2) The house supervisor will retrieve the Malignant Hyperthermia Cart and cool fluids from PACU and deliver it to the location. As available, surgery staff will be sent to support the care and treatment of the patient. As available, an anesthesiologist will also be sent.

3) Supplies shall include but not limited to:
   a) Drugs: Dantrium (Dantrolene) x 36 vials and sterile water for mixing Dantrium
   b) Equipment: Syringes, needles, Foley catheter kit, urometer, nasogastric tubes (varied sizes, rectal tube, tubes and labels for blood studies.
4) An assigned person shall restock outdated medications and supplies on a routine basis.
5) The crash cart shall be used along with the Malignant Hyperthermia cart during a crisis.

D. Refrigerated supplies that may be needed to bring body temperature down will be kept in the department. These supplies include but not limited to:
   1) Humulin - regular
   2) Normal Saline solution for irrigation and infusion.
   3) Ice packs for application to the head, axilla, groin and underneath patient, if possible.

E. If a patient is known to be a susceptible malignant hyperthermia patient:
   1) Notify the surgeon and anesthesiologist of patient's history.
   2) Have malignant hyperthermia supplies readily available.
   3) Have the crash cart readily available.
   4) Using the patient's weight, calculate initial Dantrium dose to be used if crisis occurs.

F. Employee education:
   1) All staff in each department who care for post-surgical patients including registered nurses, licensed practical nurses, surgical technologists, specialist techs and assistive personnel shall read and know this policy with its associated procedure and complete annual education on malignant hyperthermia.
   2) The Director of Surgical Services and Medical Director of Anesthesia shall approve appropriate literature for review.
   3) Malignant hyperthermia literature for review shall include but not limited to:
      a) Pathophysiology
      b) Agents capable of triggering malignant hyperthermia
      c) Clinical signs of malignant hyperthermia
      d) Treatment
      e) Drug of choice
      f) Staff response to a malignant hyperthermia crisis

References/Standards:

- 2015 Perioperative Standards and Recommended Practices, Association of PeriOperative Registered Nurses, Inc., Denver, CO, 2012.
- "Emergency Therapy for Malignant Hyperthermia", Malignant Hyperthermia Association of the United States (mhaus), Sherburne, NY, February 2015.

SAINT JOSEPH
Regional Medical Center

Version #: 4

Title: SURGICAL HAND SCRUB AND STERILE GOWNING AND GLOVING

Document Owner: Stephanie Luther	PI Team: Infection Prevention, OR	Date Created: May 1, 1996
Approver(s): Anna Roe, Constance Nichols, Loretta Schmidt, Suzanne Risner		Date Approved: 04/13/2017 June 30, 2011
Location: Saint Joseph Regional Medical Center		Department: Operating Room (14030_37020)

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

POLICY:

1. A surgical hand scrub shall be done prior to sterile gowning and gloving for a surgical procedure.
2. Only sterile surgical gowns made from a material that has proven to be an effective barrier against the passage of microorganisms from nonsterile to sterile areas may be worn for surgical procedures.

PROCEDURE:

A. All personnel shall practice general hand hygiene.
   1) Hand hygiene shall be immediately before and after patient contact.
   2) Fingernails shall be kept short, clean and healthy.
      a) Nails shall not extend beyond the fingertips.
      b) Nail polish may be worn but must not be chipped or worn longer than 4 days.
   3) Clinical surgical services personnel shall not wear artificial nails.
   4) Cuticles, hands, and forearms should be free of open lesions and breaks in skin integrity.
   5) Rings, watches, and bracelets shall be removed before performing hand hygiene.
   6) Basic hand washing shall consist of washing with antimicrobial soap and water when hands are visibly soiled or using an alcohol based hand rub when hands are not visibly soiled.

B. An FDA-compliant surgical hand antiseptic agent (i.e., surgical hand scrub/rub) approved by the hospital infection control personnel shall be used for all surgical hand antisepsis/hand scrubs.
   1) Reusable containers shall be washed and dried thoroughly before refilling. Reusable containers shall not be topped off.
   2) All surgical hand scrubs/rubs shall be used according to the manufacturer's written instructions.
   3) Approved solutions to use for the surgical hand scrub/rub include but not limited to: Povidone-Iodine 7.5%, Chlorahexidine Gluconate 1% solution with Ethyl Alcohol 61% (Avaguard), 80% Ethyl Alcohol with emollients (Sterillium Rub), Chlorahexidine Gluconate Solution 2% (Endure 420).

C. Surgical hand asepsis/hand scrub shall be performed before donning sterile gloves for surgical or other invasive procedures.
   1) Rings, watches, and bracelets shall be removed before beginning the surgical hand scrub.
   2) Hands shall be washed with plain or antimicrobial soap and running water immediately before beginning the surgical hand antisepsis/scrub.

D. A traditional, standardized, anatomical, timed method or a counted stroke method may be used for surgical hand antisepsis/hand scrubs.

Title: SURGICAL HAND SCRUB AND STERILE GOWNING AND GLOVING

1) A traditional, standardized, surgical hand antisepsis scrub procedure shall include, but not limited to, the following:
   a) Wash hands and forearms with soap and running water immediately before beginning the surgical scrub.
   b) Clean the subungual areas of both hands under running water using a disposable nail cleaner.
   c) Rinse hands and forearms under running water.
   d) Dispense the approved antimicrobial scrub agent according to the manufacturers written instructions.
   e) Apply the antimicrobial agent to wet hands and forearms. Some manufacturers may recommend using a soft, nonabrasive sponge.
   f) Visualize each finger, hand, and arm as having four sides. Wash all four sides effectively. Repeat this process for opposite fingers, hand and arm.
   g) Repeat this process if directed to do so by the manufacturer's written directions for use.
   h) Avoid splashing surgical attire.
   i) For water conservation, turn water off when it is not directly in use, if possible.
   j) Hold hands higher that elbows and away from surgical attire.
   k) Discard sponges, if used, in appropriate containers.
   l) In the OR, dry hands and arms with a sterile towel before donning a sterile surgical gown and gloves.
   m) General hand hygiene shall be performed immediately after surgical gloves are removed and before any further activities are undertaken.
2) The use of a brush for surgical hand antisepsis/hand scrubs is not necessary for adequate reduction of bacterial counts.
3) A standardized alcohol-based surgical hand rub product (according to the manufacture's written directions) application shall include, but not limited to:
   a) Wash hands and forearms with soap and running water immediately before beginning the surgical hand antisepsis procedure.
   b) Clean the subungual areas of both hands under running water using a nail cleaner.
   c) Rinse hands and forearms under running water.
   d) Dry hands and forearms thoroughly with a paper towel.
   e) Dispense the manufacture-recommended amount of the surgical hand rub product.
   f) Apply the product to the hands and forearms, following the manufacturers written directions. Some manufacturers may require the use of water as part of the process.
   g) Rub thoroughly until dry.
   h) Repeat the product application process if indicated in the manufacturer's written directions.
   i) In the OR, don a sterile surgical gown and gloves.
   j) General hand hygiene shall be performed immediately after surgical gloves are removed and before any further activities are undertaken.

E. In cases of emergency, where time does not permit, the scrub procedure times may be modified.

F. Once a surgical gown is donned, it is considered sterile in front from the level of the axilla to table level and the sleeves from two inches above the elbow to gloves.

1) The back of the gown is not considered sterile.
2) Stockinet gown cuffs are not considered sterile once a hand has passed through them.

G. Gowns that become contaminated are changed or reinforced with sterile drapes or sleeves.

H. Scrub persons use closed gloving technique for initial donning of sterile gloves.

I. Gloves that develop a hole or become contaminated are changed as soon as possible using open glove technique or a sterile glove is applied over the contaminated glove.

J. When both gloves of a scrubbed person become contaminated the contaminated person needs to either regown and glove or be regloved by a sterile scrub person.

K. After donning non-sterile gloves the circulating nurses should remove the contaminated gloves of scrubbed persons.

References/Standards:

- 2011 Perioperative Standards and Recommended Practices, Association of PeriOperative Registered Nurses, Inc, Denver, CO, 2011.

SAINT JOSEPH
Regional Medical Center

Version #: 5

Title: UNIVERSAL PROTOCOL FOR PREVENTING WRONG SITE, WRONG PROCEDURE, AND WRONG PERSON SURGERY

Document Owner: Stephanie Luther	PI Team: POC	Date Created: 08/01/2001
Approver(s): Constance Nichols, Loretta Schmidt, Suzanne Risner	Date Approved with no Changes: 04/25/2019	Date Approved: 04/25/2019 6/14/2011
Location: Saint Joseph Regional Medical Center (SJRMC)		Department: Operating Room (14030_37020)

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

POLICY:

1. The Universal Protocol focuses on the safety for all procedures (that is, all surgical and nonsurgical invasive procedures that expose patients to more than minimal risk). Patient Safety can be enhanced by correctly identifying the patient, making a correct diagnosis, selecting the appropriate procedure, identifying the correct site of the procedure, positioning the patient properly before surgery, and providing all necessary equipment.
2. Saint Joseph Health System is committed to providing quality care to the patients of our community and strives to prevent undesired patient outcomes or occurrences. This commitment is reflected in the SJRMC patient care processes where the patient care team are committed to following the "universal protocol" for preventing wrong site, wrong procedure and wrong person surgery based on the following principles:
   A. A robust approach using multiple, complementary strategies is necessary to achieve the goal of eliminating all wrong-person, wrong-site, wrong-procedure events.
   B. Active involvement and use of effective methods to improve communication among all members of the procedure team are important for success.
   C. To the extent possible, the patient and as needed, the family, are involved in the process.
   D. Consistent implementation of a standardized protocol is most effective in achieving safety.
   E. The Universal Protocol applies to all procedures that expose patients to more than minimal risk, including procedures done in settings other than the operating room.
   F. Pre-procedure verification, site marking, and the time-out procedures should be as consistent as possible throughout the hospital, including the operating room and other locations where invasive procedures are performed. In the event of life threatening emergencies only, steps may be abbreviated or skipped.
   G. Saint Joseph Health System will have zero tolerance for not adhering to the site marking policy.

PROCEDURE:

Pre-Operative Verification Procedure:

The operative/procedural team ensures that all the relevant documents and studies are available prior to the start of the procedure and that they have been reviewed and are consistent with each other, with the patient's expectations and with the team's understanding of the intended patient, procedure, site and, as applicable any implants. The team must address missing information or discrepancies before starting any procedure.

A. Verification of the correct person, procedure and site will occur at the following times:
   1) at the time the surgery/procedure is scheduled by surgical scheduler

2) at the time of pre-admission screening
3) at the time of admission or entry into the facility for a procedure – elective or emergent
4) during the signing of consent and prior to taking patient into operating room or procedural area (or at bedside if bedside procedure)

B. Verification will be done by staff completing the following processes:
1) Patient's identification wristband is visually checked by staff member and verified verbally with patient or legal designee.
2) Patient or legal designate states patient's name, birth date, procedure, procedure site and physician performing procedure to staff member.
3) Site and procedure verification with the order for consent, the consent itself, the history and physical, the surgical or procedural schedule, pre-anesthesia assessment and ancillary/diagnostic tests for films. The site must be marked prior to the surgical incision or the initiation of any procedure. Relevant images and results are properly labeled and able to be appropriately displayed.
4) Any time the responsibility for care of the patient is transferred to another caregiver, including the anesthesia providers at the time of and during the procedure.
5) With the patient involved, awake and aware, if possible or with their legal designee.
6) If patient is unable to participate in this process (i.e., comatose, incompetent, etc.), the patient's legal guardian or healthcare representative should participate in the process.

C. Marking the operative site: The team, including the patient [if possible], identifies unambiguously the intended site of incision or insertion.
1) Site marking is required for surgical procedures involving right/left distinction, multiple structures (such as fingers, toes, and/or lesions) or levels in spinal surgery.
2) The mark must be made using a marker that is sufficiently permanent to remain visible after completion of the skin prep.
3) The mark must be positioned to be visible after the patient is skin is prepped, the patient is positioned, and sterile draping is completed. If the site marking is covered during the draping process, the site must be remarked by the LIP as outlined below in Item E.
4) Final verification of the site mark must take place during the "Time Out."

D. DO NOT MARK any non-operative site.

E. The procedure site must be marked with the initials of the licensed independent practitioner or other provider who is privileged or permitted by the hospital to perform the intended surgical or non-surgical invasive procedure. This individual will be involved directly in the procedure and will be present at the time the procedure is performed. This cannot be delegated to an RN.
1) Make the mark at or near the incision site.
a) Mark all cases involving incision, percutaneous instrumentation or placement of instruments through a natural orifice with specific attention to laterality, surface (flexor, extensor) level (spine) or specific digit or lesion to be treated.
b) For minimal access procedures that intend to treat a lateralized internal organ, whether percutaneous or through a natural orifice, the intended side is indicated by a mark at or

near the insertion site indicating laterality and remains visible after completion of the skin prep and sterile draping.

c) Mark the skin at or near the proposed incision/insertion site to indicate the correct side of the proposed procedure, even when the proposed incision insertion site is in the mid-line or through a natural body orifice.

d) The mark must be positioned to be visible after the patient is prepped and draped, unless it is technically or anatomically impossible or impractical to do so.

e) Any portions of the procedure listed on the consent as "possible" involving laterality will not be marked.

2) Spinal procedure marking is completed in two steps: a) Initial marking of the general spinal region and unilaterality if not stated bilateral, with surgeon initials prior to the patient going into the operating room. b) Intra-operative radiographic techniques must be used to mark the exact vertebral level(s)

3) Craniotomies will be site confirmed by intra-operative radiographic techniques to confirm the side and site. The surgeon will identify the site by clipping the hair or by parting the hair at the incision site.

4) For cystoscopy procedures, with laterality for stent placement or removal, the site will be determined using radiographic imaging.

5) An alternative process is in place for patients who cannot easily be marked under the following conditions:

a) Cases in which it is technically or anatomically impossible or impractical to mark the site, such as mucosal surfaces, perineum and premature infants (for whom marking may cause permanent tattooing), an alternative method for visually identifying the correct side and site is used. Possible alternatives include:

(1) Marking on intact skin adjacent to the mucosa to designate laterality.

(2) Use of armbands, stickers or temporary site marking tattoos.

b) For interventional procedure cases for which the catheter/instrument insertion site is not predetermined (for example, cardiac catheterization, pacemaker insertion).

c) For teeth, the operative tooth name(s) and number are indicated on documentation or the operative tooth (teeth) is marked on the dental radiographs or dental diagram. The documentation, images, and/or diagrams are available in the procedure room before the start of the procedure.

d) For premature infants, for whom the mark may cause a permanent tattoo.

e) Any radiological procedure due to prior imaging before a procedure is started, the breast will not be marked until the image is done. Then the radiologist performing the procedure will mark the breast with their initials and a timeout will occur prior to any invasive aspect of the procedure. The placement of the needle will suffice for the OR site marking.

6) Site marking is not required when the individual doing the procedure is continuously with the patient from the time of the decision to do the procedure through to the performance of the procedure. However, the requirement for final time-out verification still applies.

7) If patient refuses to allow site to be marked, staff member should document the refusal on the Surgical Safety Checklist (see attached) and complete a Refusal of Care or Treatment form

with reason for refusal and patient signature. Procedure may be cancelled after additional discussion if site marking refusal remains.

F. "Time Out" immediately before starting the surgical procedure

1) This final procedure verification step is conducted prior to starting the actual procedure but after draping is complete, in the location where the surgical procedure will be done, and with the patient properly positioned for the procedure.

2) It must involve the entire patient care team using active communication. During the "time out," other activities are suspended to the extent possible without compromising the safety of the patient, so that team members are focused on the active verification of the correct patient, procedure, site and other critical elements. No music will be playing in the procedural room until the time out is completed and the time out must be documented in the Surgical Safety Checklist.

3) In the event there is only one person performing the procedure, a brief pause to confirm the "Time Out" criterion is appropriate.

4) Immediately prior to the start of the surgery/procedure, a time out is performed as follows and the team verbally verifies:

a) There is a pause in all activities in the room

b) There is an introduction of team members

c) The following is confirmed:

(1) Patient identification

(2) Procedure

(3) Site

(4) Consents

d) Site marking is visible through draping

e) There is a review of critical or unexpected steps and procedural duration

f) Anticipated blood loss is reviewed

g) The following is reviewed:

(1) Sterility

(2) Any implants

(3) Any special equipment

h) It is reviewed whether antibiotics were given in the past 60 minutes

i) Administration of the antibiotics is confirmed and the potential need for re-dosing is addressed

j) Essential imaging and lab data is available and displayed if necessary

k) When flammable germicides or antiseptics are used during surgery utilizing electrosurgery, cautery, or lasers, the following are reviewed:

(1) Application site is dry prior to draping and use of surgical equipment

(2) Pooling of solution has not occurred or has been corrected

(3) Solution-soaked materials have been removed from the operating room prior to draping and use of surgical devices

l) When a regional block is indicated for the patient, the anesthesiologist shares the status of the block during timeout indicating if complete or if it will be completed post-op.

5) If any member of the surgical/procedural team has any questions or concerns regarding the correct patient, side and site, surgery/procedure to be done, positioning, availability of correct implants, or special equipment or requirements the procedure is not started until all questions and concerns are resolved.

6) If the physician leaves the room after the time out, but prior to the incision, another time out must occur prior to the initiation of the procedure.

7) In procedural sedation location the initial order for sedation may be obtained as part of the time out or immediately following.

G. The appropriate Director or administrative designee will be notified of any concerns or issues that were encountered and appropriate action taken.

H. When two or more procedures are being performed on the same patient, a "time out" is performed to verify each subsequent procedure before it is initiated.

1) When the second procedure is a distinct and separate procedure.

2) When a second surgeon is performing the second procedure.

3) An intra-operative consult involving a second surgeon does not require a timeout unless a separate procedure is started.

I. Procedures for non-operating room settings, including bedside procedure:

1) Site marking must be done for any procedure that involves laterality, multiple structures or levels, even if the procedure takes place outside the operating room.

2) Verification, site marking, and "time out" procedures will be consistent throughout the organization, including the Operating Room, Ambulatory Surgery, ADU, Emergency Room, Endoscopy, Cath Lab, IR, OB, and other locations where procedures are performed.

Management of Wrong Site Surgery/Procedure/Wrong Person:

If during the course of the surgery/procedure, or, after the surgery/procedure has been completed, it is determined that the surgery/procedure is being performed or has been performed on the wrong surgical site or person, the physician will:

A. Notify the appropriate department director when the event occurred and Risk Management.

B. Act in accord with the patient's best interests to promote the patient's well-being.

C. Take necessary/appropriate steps to return the patient, as nearly as possible, to the patient's preoperative condition.

D. Perform the planned surgery/procedure on the correct site, unless there are medical reasons not to proceed in this manner. For example, if proceeding with the planned surgery/procedure on the correct site would increase the risk associated with extending the length of the surgery/procedure or if the correct site surgery/procedure would likely result in an additional and unacceptable disability.

E. Advise the patient or the patient's legal representative, and the patient's family: (as outlined in the Responding Justly to Adverse Outcomes Policy)

1) of what occurred and of the likely consequences, if any, of the wrong site surgery/procedure;
2) of any recommendations to the patient/family of what, in the physician's best judgment, is the appropriate course for the patient to follow under the circumstances
3) of the physician's judgments in response to questions posed by the patient/family. Such consultation will take place as soon as reasonably possible following the occurrence.

F. If appropriate/necessary, the physician will proceed with immediate patient care interventions as consented to by the patient/family.

G. Record the events in the patient's medical record.

H. Provide necessary/appropriate information to the RN, who, in turn, will immediately complete a Midas Occurrence Report for physician related occurrences and a Voice for staff related occurrences.

I. An investigation will take place per the Sentinel Event Policy & Procedure

SAINT JOSEPH
Regional Medical
Center

Version #: 2

Title: Violence and Threats in the Workplace

Document Owner: Colpitts, Melissa	PI Team: Leadership	Date Created: 04/96
Approver(s): Hofstra, Donna		Date Approved: 06/19/2014 06/27/11
Location: Saint Joseph Regional Medical Center (SJRMC)		Department: Employee Benefits

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

POLICY:

1. To reiterate SJRMC's zero tolerance towards violence in the workplace. SJRMC is committed to preventing workplace violence and to maintaining a safe work environment. Given the increasing violence in society in general, SJRMC has adopted the following guidelines to deal with intimidation, harassment, or other threats of (or actual) violence that may occur on its premises.

PROCEDURE:

A. All employees (including supervisors and temporary employees), patients, guests and visitors shall be treated with courtesy and respect at all times. Employees are expected to refrain from disruptive behavior, fighting, "horseplay," or other conduct that may be dangerous or threatening to others.

B. Firearms, weapons, and other dangerous or hazardous devices or substances are prohibited on the premises of SJRMC or in possession of the employee when performing work for SJRMC while off premises, unless specifically needed to perform the essential functions of your job.

   1) Example: Sworn law enforcement officers may carry firearms on SRJMC premises while on duty or as a visitor.

C. Conduct or speech that threatens, intimidates, abuses, harms, or coerces another employee, a physician, a patient, or a member of the public is strictly prohibited by this policy and will not be tolerated. This prohibition includes, but is not limited to, all acts of intimidation, threats, coercion, force, violence, abuse, and harassment, including harassment that is based on an individual's sex, race, age, religion, nationality, disability or any characteristic protected by federal, state, or local law.

D. All prohibited conduct under this policy such as threats of (or actual) violence, both direct and indirect, should be reported as soon as possible to your immediate supervisor or any other member of management. This includes threats by employees, as well as threats by customers, vendors, solicitors, or other members of the public. When reporting prohibited conduct, the employee should be as specific and detailed as possible.

E. All suspicious individuals or activities should also be reported as soon as possible to a supervisor or to security. Do not place yourself in peril. If you see or hear a commotion or disturbance near your workstation, do not try to intercede or see what is happening, but report it to your leader.

F. SJRMC will promptly and thoroughly investigate all reports of threats of (or actual) violence and of suspicious individuals or activities. The identity of the SJRMC individual making a report will be protected as much as is practical. In order to maintain workplace safety and the integrity of its investigation, SJRMC may suspend employees, either with or without pay, pending investigation.

G. Consistent with this policy, SJRMC reiterates that all employees (including regular, contract or temporary), contractors, and agents are strictly prohibited from making or implying threats of

physical violence, engaging in threatening behavior or engaged in acts of violence during the course of their employment or agency relationship, while on SJRMC property or while acting as a representative of SJRMC. .

1) A threat or threatening behavior may consist of words or actions that create a perception that there may be intent to harm persons or property, or actions or words that actually bring about harm.
    a) A threat can be explicit or implied.
    b) A threat can be the result of verbal, written or non-verbal actions.
    c) Statements made in the guise of a joke may be considered threatening in appropriate circumstances.
    d) Examples of threats include but are not limited to:
        (1) Verbal or written statements that express intent to harm another person.
        (2) Comments such as "you'll get yours" or statements/or predictions that acts of violence may occur here or in other workplaces.
        (3) Gestures implying that physical contact will be used, such as gestures of punching, choking, stabbing or shooting a weapon.
        (4) Stalking behavior.
        (5) Possessing a weapon in the workplace or on SJRMC property.
    e) These examples are not all-inclusive; they are merely to assist the reader in understanding what behavior is prohibited and what may be construed to be threatening behavior in appropriate circumstances.
2) Actual physical violence is the unwanted touching of a person or their possessions with an intent to create fear or harm, or which does create fear or harm
    a) An act may constitute physical violence even if no injury or harm occurs.
    b) The use of an object to cause unwanted touching might also constitute physical violence.
3) Employees should notify their supervisor of any prohibited conduct that they have witnessed, received, or have been told that another person has witnessed or received. Employees may also immediately contact Human Resources, or report any threatening behavior to Trinity's 24-hour toll free Compliance Line. Any supervisor or manager who is advised of conduct prohibited under this policy r must contact Human Resources.
4) SJRMC reserves the right to inspect an employee's personal property (such as lunch containers, boxes, thermoses, purses, desks, lockers, cabinets, etc.) when there is reason to believe that this policy is being violated or other work related misconduct has occurred. Any employee who refuses to submit to a search, or found in possession of prohibited articles will be subject to disciplinary action up to and including termination from employment. Any unauthorized articles discovered may be taken into custody and may be turned over to law enforcement representatives.
5) In appropriate circumstances, as determined at the sole discretion of the Human Resources Department, an employee against whom a complaint is made may be suspended (with or without pay) pending the outcome of an investigation. Any employee found to have engaged in conduct in violation of this policy would be subject to disciplinary action up to and

including termination from employment. Any employee who fails to cooperate in an investigation may be subject to disciplinary action up to and including termination.

6) All investigations will be handled in as discreet and confidential fashion as possible. No person will be retaliated against in employment as a result of bringing or participating in an investigation under this policy.

7) Any form of retaliation against employees for making a report under this policy will not be tolerated.

8) Security personnel, Manager or designee will evaluate the appropriateness of one or more of the following actions:

   a) Escorting the person engaging in workplace violence or making the threat from the premises.

   b) Contacting local law enforcement

   c) Detaining the person accused of engaging in workplace violence or making the threat for questioning

   d) Increasing security for the affected area.

H. Reporting. Whenever an incident occurs management is to follow appropriate reporting procedures (computer or hard copy report form).

I. Security Service is provided at the majority of SJRMC's main hospital locations, 24 hours a day, 7 days a week. The local police department provides off-site and/or hospital service as identified by the hospital administration.

   1) Each off campus building should have a management person designated as a point person for immediate response to violent incidents. This person will provide occurrence reports to the Security and Risk Management offices that will forward data to the Environment of Care Committee for review and analysis.

References/Standards:

- Standards of Behaviors
- TJC Human Resources Standards
- Trinity System Policy
- Orientation - New Associate
- Annual Environment of Care (safety) education
- Policy Reviewed: 06/11
- Policy Revised: 02/07

The Senior Management Team of SJRMC reserves the right to unilaterally change, modify, amend, add, delete, or rescind any or all policies, at any time, as it determines appropriate in its sole discretion. No employee or manager of SJRMC except the Chief Executive Officer or Chief Human Resource Officer has the authority to modify any Human Resources Policies or Procedures, and any such modification must be in writing.