PATIENT SAFETY PLAN

Nevada Oral & Facial Surgery/
OMFS Surgery Center
(702) 360-8918

6950 Smoke Ranch Rd.
Suite 200
Las Vegas, NV 89128

and

1525 W. Warm Springs Rd.
Suite 125
Henderson, NV 89014

The Safety Plan for Nevada Oral & Facial Surgery/OMFS Surgery Center encompasses the policies and procedures created by our management team after accreditation by The Joint Commission in 2012. We have maintained that accreditation and look forward to our next survey in 2024. As an oral surgery center, the management team wanted to create a culture of not only compliance with regulatory agencies but an ongoing enhancement of these policies to ensure the best outcomes for our patients and our staff.

Through a system of audits of compliance, safety drills, role plays, and monthly staff meetings the topic of safety is paramount in our mind and we encourage all stakeholders to be willing to indicate where errors may have occurred, objectively review the systems that were either not in use or used incorrectly, and discuss how to prevent the same from reoccurring.

Understanding that our patients have a role in their best outcome for care, we ask our patients at the first visit how best they learn about their care options. We encourage them to ask questions to the providers and staff and are part of the "Speak Up" program. When patients or their caregivers have a concern or critique of our systems, we diligently seek to listen to their concerns, apologize for deficiencies when appropriate, discuss with the staff and implement changes and thank the patient for bringing the concern to our attention.

We adhere to the Joint Commission's National Patient Safety Goals (see next page).

The practice has elected to convert all patient records to EMR (electronic medical record) for staff and providers to easily access and view patient information, treatment provided, medications prescribed, lab results and details of patient communications with staff and providers. All patient information that a patient fills out is scanned and saved into the EMR. We routinely audit the patient original documents with the EMR, especially medications taken, allergy notations, and new medication prescribed.

A monthly system of Walk-Throughs thoroughly documents all areas of the practice for safety concerns: the physical premises and parking lot, ADA compliance for patient access, expiration dates on medicines used, recalls of medicines, fire safety, emergency preparedness, signage, use of PPE, sterilization monitoring, etc.

All staff are encouraged to participate in annual flu vaccinations which the organization pays for. All clinical staff must have vaccines for (or declinations signed and placed in the individual staff medical files) Hepatitis, COVID-19. TB tests are done prior to employment and an annual screening takes place thereafter and is also placed in the employee personnel medical file.

Hand hygiene is meticulously observed to reduce the likelihood of infection. Both soap and sanitizer is available in every area of patient encounter for both staff and patients. Signs are posted as reminders for everyone to do their part in reducing the spread of bacteria. Clinical supervisors monitor their staff for compliance.

All staff involved in radiation are required to be trained prior to using the equipment, updating the training annually with documentation of same placed in their personnel files. Lead aprons are inspected annually to ensure they are safe.

The practice has compiled the following detailed manuals: Clinical Policies and Procedures, Infection Control Manual, Safety Manual, Anesthesia Manual, Governance Manual, Administrative Manual, Audits of Compliance, and Personnel Policies Manual.

The following pages are excerpts from our Manuals to illustrate some of our policies.

2023 Hospital National Patient Safety Goals

The purpose of the National Patient Safety Goals is to improve patient safety. The goals focus on problems in health care safety and how to solve them.

Identify patients correctly

NPSG.01.01.01	Use at least two ways to identify patients. For example, use the patient's name *and* date of birth. This is done to make sure that each patient gets the correct medicine and treatment.

Improve staff communication

NPSG.02.03.01	Get important test results to the right staff person on time.

Use medicines safely

NPSG.03.04.01	Before a procedure, label medicines that are not labeled. For example, medicines in syringes, cups and basins. Do this in the area where medicines and supplies are set up.
NPSG.03.05.01	Take extra care with patients who take medicines to thin their blood.
NPSG.03.06.01	Record and pass along correct information about a patient's medicines. Find out what medicines the patient is taking. Compare those medicines to new medicines given to the patient. Give the patient written information about the medicines they need to take. Tell the patient it is important to bring their up-to-date list of medicines every time they visit a doctor.

Use alarms safely

NPSG.06.01.01	Make improvements to ensure that alarms on medical equipment are heard and responded to on time.

Prevent infection

NPSG.07.01.01	Use the hand cleaning guidelines from the Centers for Disease Control and Prevention or the World Health Organization. Set goals for improving hand cleaning. Use the goals to improve hand cleaning.

Identify patient safety risks

NPSG.15.01.01	Reduce the risk for suicide.

Prevent mistakes in surgery

UP.01.01.01	Make sure that the correct surgery is done on the correct patient and at the correct place on the patient's body.
UP.01.02.01	Mark the correct place on the patient's body where the surgery is to be done.
UP.01.03.01	Pause before the surgery to make sure that a mistake is not being made.

The Joint Commission

This is an easy-to-read document. It has been created for the public. The exact language of the goals can be found at www.jointcommission.org.

Safety Management Plan

Policy:

This organization participates in ongoing efforts to provide a safe environment for all employees, patients, and visitors.

The purpose of this plan is to insure an environment free of potential hazards and safety concerns that could affect the patients served and employees within the facility.

The following are objectives of the organization:

- Providing awareness, monitor, and evaluate the safety issues surrounding the building, grounds, equipment, and occupants.

- Preventive maintenance on all equipment

- Specifying a safety officer and maintaining a safety committee.

- Reporting and investigating all incidents that involve property damage, occupational illness, and patient, employee, or visitor injury.

- Requiring safety policies that are taught, understood, and enforced.

- Review and evaluate the scope, objective, and effectiveness of safety policies as needed, but no less than annually.

- Maintain on going hazard surveillance and

Correct Site Surgery - Universal Protocol 2022-2023

POLICY:

UP 01.01.01 Conduct a pre-procedure verification process as described in the Universal Protocol Verification of the correct person, procedure, and site should occur during the following

The preprocedure verification is an ongoing process of information gathering and confirmation. The purpose of the preprocedure verification process is to make sure that all relevant documents and related information or equipment are:

- Available prior to the start of the procedure
- Correctly identified, labeled, and matched to the patient's identifiers
- Reviewed and are consistent with the patient's expectations and with the team's understanding of the intended patient, procedure,and site

Preprocedure verification may occur at more than one time and place before the procedure. Data about the patient will be collected at different intervals and by different staff but shall be done:

- When the procedure is scheduled
- At the time of preadmission testing and assessment
- At the time of admission or entry into the facility for a procedure
- Before the patient leaves the preprocedure area or enters the procedure room

Missing information or discrepancies are addressed before starting the procedure.

EP 1 Implement a pre procedure process to verify the correct procedure, for the correct patient, at the correct site. The patient is involved in the verification process when possible.

EP 2. Identify the items that must be available for the procedure and use a standardized list to verify their availability. At a minimum, these items include the following:

- Relevant documentation (for example, health history and referral slip, signed procedure consent form.

- Labeled diagnostic and radiology test results (for example, radiology images and scans, or pathology and biopsy reports) that are properly displayed

- Any required blood products, implants, devices, and/or special equipment for the procedure

EP 3. Match the items that are to be available in the procedure area to the patient.

.01.02.01 Mark the procedure site

Because this organization provides oral surgery services only, standard site marking does not apply. As an alternative, the surgeon will discuss with the patient which tooth/area needs to be addressed, as well as visual confirmation, x-rays, and confirmation of referral order.

The time out is consistently initiated by a designated member of the team and includes active communication among all relevant members of the procedure team. The procedure is not started until all questions or concerns are resolved.

A time out is conducted prior to starting the procedure and the organization may decide to perform the time out prior to or after induction of anesthesia (including general/regional, local and spinal anesthesia) and also may conduct more that one time out if desired.

EP 1 Conduct a time-out immediately before starting the invasive procedure or making the incision.

EP 2. The timeout has the following characteristics:

a. It is standardized
b. It is initiated by a designated member of the team
c. It involves all immediate members of the procedure team including the proceduralist(s), the anesthesia providers, and all other active participants who will be participating in the procedure

EP 3 When two or more procedures are being performed on the same patient, and the person performing the procedure changes, perform a time-out before each procedure is initiated.

EP 4 During the time-out, the team members agree, at a minimum, on the following:

- Correct patient identity
- The correct site

- The procedure to be done

EP 5 Document the completion of the time-out.

Should there be a discrepancy on any of the above information, any necessary corrections will be made and the time out will be started again. If after a second time out there is still a discrepancy, a decision will be made regarding cancelling the procedure.

Adverse Drug Reaction Definition And Process

POLICY:

An Adverse Drug Reaction (ADR) is defined as a detrimental response to a medication which is undesired, unintended or unexpected in doses accepted as the community standard and that results in a complication of the disease state or drug discontinuation, a change of therapy (including dosage reduction), or initiation of supportive treatment.

PROCEDURE:

The surgeon is immediately notified of the adverse drug reaction by the clinical staff. The reaction is documented in the patient's EMR chart and an incident report is completed. There will be verification that the medication that was administered was the correct medication based on the order and product label; given via the correct route, correct dose and proper time. The medication was stable based on visual examination for particulates or discoloration and the medication had not expired.

The ordering surgeon, when available or other senior clinical staff will discuss the adverse reaction with the patient and when appropriate the patient's family.

The adverse drug reaction will be tracked and trended utilizing the sequella monitoring record.

Every adverse drug reaction is reviewed by the Medical Director, and clinical staff; following their

review, the matter will be turned over to the Safety Committee. The Committee will identify opportunities for

improvement and make recommendations pertaining to continuing education for all levels of the facility staff involved with drug delivery.

Any adverse drug reaction meeting the following criteria will be reported to the FDA:

1. Reaction directly or indirectly led to the death of a patient, or was life threatening or permanently disabling;

2. Reaction was attributed to an investigational drug;

3. Reaction was not listed in the package insert; or

4. Suspected drug causing the reaction has been on the market for less than two years.

An adverse drug reaction or event or a medication error will be reported to the prescriber either by documented telephone conversation or via U.S. mail. Should this be a provider error; this incident will become part of the providers peer review process for the quarter in which it occurred.

Pre-Surgical Evaluation and Peri-Operative Monitoring of the Surgical Patient

POLICY:

Patients will be monitored on a peri-operative basis in a manner appropriate to the level of anesthesia used. There is also a specific protocol for each level of post-procedure monitoring, again indexed to the level of the anesthetic agent.

Intra-operative physiologic monitoring must include continuous use of a pulse oximeter as well as blood pressure readings at frequent intervals. EKG monitoring will be immediately available

All patients receiving local anesthesia administered by the surgeon will be monitored by appropriate personnel during time in the operating room or the procedure room; such monitoring shall be documented on the operative report.

PROCEDURE:

1. Vital signs monitoring shall be recorded prior to start of the surgical procedure and at appropriate intervals thereafter until transfer to recovery room or direct discharge. At the request of the surgeon, EKG monitoring shall be done throughout the procedure.

2. Oxygen may be administered as needed; rate and method of administration to be documented.

3. Type, dosage and times of administration of anesthesia agents shall be documented on the anesthesia/operative report.

4. Any IV administration shall be documented on anesthesia record.

5. Procedure performed, surgeon, nursing staff assisting, and pre-operative and post-operative diagnoses shall be documented on operative report.

6. Clinical personnel may monitor the patient while performing other interruptible duties in the room.

7. Monitoring shall include pulse rate, blood pressure, respiratory rate, pulse oximetry, skin characteristics (color/temperature/dryness), and level of consciousness. (Level of consciousness will only be verified and documented when the anesthesia level is recorded as local anesthesia only.

   For patients undergoing moderate sedation/analgesia, deep sedation/analgesia, regional anesthesia, or general anesthesia:

   A. A patient's oxygenation, ventilation, and circulation
      must be continually evaluated and documented.
   B. Peri-operative physiologic monitoring must include continuous use of a pulse oximeter, EKG monitoring, and blood pressure determination at frequent intervals.
   C. From the American Society of Anesthesiologist, House of Delegates, effective date July 1, 2011 During moderate or deep sedation the adequacy of ventilation shall be evaluated by continual observation of qualitative clinical signs and monitoring for the

presence of exhaled carbon dioxide unless precluded or invalidated by the nature of the patient, procedure, or equipment.

8. Prior to the procedure, the anesthesia provider shall perform a pre-operative assessment of the patient including, but not limited to, the following:

   A. A listing of medications (with dosages) taken by patient,
   B. Disclosure of any known allergies,
   C. Discussion of any significant medical problems with the requirement of consent for surgery by the patient's primary care physician if there are significant clinical diagnoses present, and
   D. Performance of pre-operative vital signs.

   Additional elements of the pre-operative assessment will be indexed to the level of anesthesia anticipated.

9. If appropriate to the procedure scheduled, each patient shall have a patent IV prior to the administration of any medications. All IV tubing and fluid bags are single patient use only.

10. Emergency equipment shall be available in the area, including a device to measure body temperature.

11. Except in the case of patients having only local anesthesia, all patients shall be monitored for at least 30 minutes after the last administration of any medication or until discharge criteria are met.

    In the case of patients having only local anesthesia,

patient may be discharged directly from the procedure room unless the attending physician, upon evaluation, requests that the patient receive additional monitoring before discharge.

Recovery is a process, not a geographic location; a patient may participate in the recovery process without leaving the procedure room or operating room. Any patient admitted to Recovery, will be monitored for at least 30 minutes after the last administration of any medication or until discharge criteria are met.

12. This organization is cognizant of the problems attendant to management of post-procedure pain, both pre- and post-discharge. Staff members monitoring patients in Recovery are trained to use a screening mechanism (an actual tool or verbal description) which provides assessment of pain experienced by the patient. This includes measuring the level of pain at periodic intervals during the recovery phase. The patient is educated regarding acceptable levels of pain and the level at which clinical intervention is desirable in order to facilitate the recovery process. The patient, and the patient's caregiver, are instructed regarding progressive means of pain relief and the means of contacting the surgeon should more aggressive pain relief be in order.

13. At the request of the surgeon, times of anesthesia and surgery shall be documented.

14. The nurse monitoring the patient will sign appropriate entries on the medical record.

15. Discharge criteria is outlined in the Clinical Manual.

Care and Cleaning of Anesthesia Equipment

POLICY:

The anesthesia provider is responsible for anesthesia infection control and care of equipment and materials. If there is no anesthesia provider on site, these responsibilities will be assumed by appropriate clinical staff.

PROCEDURE:

Anesthesia equipment that comes in contact with the vascular system or sterile body tissue should be sterile at the time of use.

Aseptic technique will be used when preparing medications.

1. Prior to this proper hand hygiene will be performed.
2. Vial stoppers will be cleaned with an alcohol swab before puncturing
3. No transference of syringes of unused medication between patients
4. Use multiple needles to withdraw medication into multiple syringes

Anesthesia equipment that comes in contact with mucous membranes should be sterilized or undergo high-level disinfection before use.

1. Reusable items (e.g. airways, breathing circuits, connectors, fiberoptic endoscopes, forceps, laryngoscope blades, masks, self inflating bags, some laryngeal mask airways (LMAs), transducer tubing, trans-esophageal probes are considered semi-critical. The CDC has

determined that their potential for transmitting infectious agents is significant and has classified these items as semi-critical.

2. Reusable semi-critical devices are cleaned by pre-rinsing with cold water, washed with an enzymatic detergent, scrubbed with a brush, rinsed, and dried, as the first step in re-processing. Rigid laryngoscopes should be disassembled and all components cleaned, including handles. Brushes used for cleaning should be disposable or should be cleaned and sterilized or undergo high-level disinfection at least daily.
3. The cleaned, semi-critical reusable items should be processed by high-level disinfection, (which is tested prior to use for potency and dated for expiration) pasteurization, or sterilization with a US Food and Drug Administration (FDA)-approved agent. Written instructions from the manufacturers of reprocessing equipment, chemicals, and instruments should be followed. When using liquid disinfectants for high-level disinfection, all internal and external surfaces must be in contact with an EPA registered disinfectant for the time indicated by the manufacturer.
4. Residual chemicals should be removed and the reprocessed item thoroughly dried before storage or use on a patient. Failure to remove residual chemicals have led to allergic reactions and tissue burns. The items should be stored in a manner that prevents recontamination or damage. Sterile water should be used when rinsing the equipment. If tap water is used for rinsing the equipment this process should be followed by a 70 percent alcohol rinse.
5. Personnel should be trained in the reprocessing procedures and equipment. Training personnel regarding

the complexities of the equipment, chemicals, and processes used minimizes the risk of human error. Also all personal must understand the infection control process and utilize personal protective equipment to reduce the risk of exposure to pathogens, injury and exposure to cleaning agents. Personnel must be apprised of the hazards in the workplace, including chemicals used for reprocessing anesthesia equipment. Personnel that are responsible for this process will have competency in the reprocessing method and all of its facets, proven as part of their initial and annual employee review.

Anesthesia equipment contacting intact skin should be cleaned at the time of use.

1. Items such as blood pressure cuffs, electro-cardiogram leads, and oximeter probes that contact only intact skin are considered non-critical. These items and surfaces contacting intact skin should be cleaned between use on patients and any time they may become contaminated.
2. Reusable laryngoscope handles should be cleaned and low-level disinfected (wiped with a germicide) between patients. Laryngoscope handles can become contaminated during airway management.
3. Reusable non-critical items should be low-level disinfected between patients with a EPA registered germicide.
4. Surfaces of anesthesia equipment that are touched by personnel while they are providing patient care or handling contaminated items should be cleaned and low-level disinfected between use on patients, according to manufacturers' written instructions.
5. A germicidal solution will be used to clean all

surfaces of the anesthesia equipment and the anesthesia cart on a daily basis, additional to cleaning at any time equipment may have become contaminated.

Single-use items should be used once and discarded in accordance with local, state, and federal regulations.

1. Single-use items should be used for a single patient and not reused on subsequent patients.
2. Additionally, bio-hazardous waste should be placed in a bio-hazardous waste bag as indicated.
3. Sharps should be handed in a manner that minimizes the risk of percutaneous injury. To minimize the risk of injury from contaminated sharps, OSHA requires that puncture-resistant sharps containers be located at the point of use. Sharps should be placed directly into the container.

Anesthesia equipment should be handled, cleaned, processed, or discarded in the same manner in all areas of the practices setting.

1. Equipment that is located in satellite areas or offices is treated in the same manner as equipment located in the main facility.

Internal components of the anesthesia machine breathing circuit should be cleaned regularly

1. Anesthesia ventilator bellows should be cleaned regularly according to manufacturers' written instructions.
2. Soda-lime canisters are to be changed according to the manufacturer's written instructions.

No items should be considered reusable when used with an infected patient. All items, including soda-lime, are to be discarded at the conclusion of a case on a patient with a known infection.

Mechanisms for the Provision of, and the Administration of, Anesthetic Agents

POLICY:

Anesthetic agents employed at this facility will be consistent with the needs of the patient relative to the procedure to be performed. The provision of all anesthetic agents will be consistent with the highest standards of practice; clinical guidelines.

PROCEDURE:

1. All medications administered must be ordered by an appropriately-licensed clinical person. A certified registered nurse anesthetist, under the supervision of a medical doctor, osteopathic physician, podiatric physician or dentist licensed in this state, and under conditions in which timely, on-site consultation by such medical doctor, osteopathic physician, podiatric physician or dentist is available, shall be authorized, pursuant to rules adopted by the Board of Nursing, to order, select, obtain, and administer legend drugs, Schedules II through V controlled substances, devices, and medical gases only when engaged in the preanesthetic preparation and evaluation; anesthesia induction, maintenance and emergence; and post-anesthesia care. A certified registered nurse anesthetist may order, select, obtain and administer drugs only during the perioperative period.

2. Anesthesia is administered by anesthesiologists, other qualified physicians, dentists, certified registered nurse anesthetists, other qualified individuals supervised by a physician or dentist and credentialed pursuant to the Medical Staff bylaws, or supervised

trainees in an approved educational program.

3. A RN or a nominated surgical assistant under the doctor's supervision may monitor the patient while performing other interruptible duties in the room.

4. From the American Society of Anesthesiologist, House of Delegates, effective date July 1, 2011 During moderate or deep sedation the adequacy of ventilation shall be evaluated by continual observation of qualitative clinical signs and monitoring for the presence of exhaled carbon dioxide unless precluded or invalidated by the nature of the patient, procedure, or equipment.

5. General anesthesia will not be administered to any patient unless there is at least one health care provider present additional to the surgeon and the anesthesia provider. This organization will adhere to this paraphrase from the Guidelines of the American Society of Anesthesiologists: 'Because sedation is a continuum, it is not always possible to predict how an individual patient will respond. Individuals intending to produce a certain level of anesthesia, should be able to rescue (i.e., to support the respiratory and cardiovascular system) patients whose level of sedation becomes deeper than intended.'

6. Documentation on the record of an accurate weight is essential to the administration of the proper dosage of many medications.

7. Discharge may occur when the patient:
   A. Is oriented to person, place and time or a level of consciousness consistent with baseline.

B. Displays stable vital signs for 30 minutes after last dose of medication.
C. Demonstrates appropriate protective reflexes
D. Has cardiac rhythm consistent with baseline with blood pressure and heart rate within 20 percent of baseline
E. Has oxygen saturation of 95% on room air or consistent with baseline
F. Has a responsible adult available to accompany the patient home (may be modified by physician to allow use of shuttle service, limousine, or taxi)
G. Has been discharged by the M.D.

8. All medications given shall be documented on the patient record. This documentation shall include name, dosage, route, and time given. Excepting those patients who have received only local anesthesia, all patients and their responsible adult shall receive easily understood written and verbal post operative instructions prior to discharge, including
   A. Instructions not to drive, operate mechanical equipment or make important decisions for at least 24 hours after the procedure.
   B. Instructions regarding the management of post operative pain; including medication instructions.
   C. Instructions regarding post operative wound care.
   D. Instructions to include a description of untoward events which should trigger a telephone call to the physician.
   E. Instructions regarding post operative activities
   F. Instructions regarding post operative follow up appointment.

9. Emergency equipment shall be available in the area where anesthesia is being administered, including a device to measure body temperature.

Patient Assessment Prior to Administration of Any Anesthetic Agent

POLICY:

An appropriate history and physical examination shall be completed in a timely manner, i.e., within the 30 calendar days preceding the procedure.

A history will include documentation of indications/symptoms for surgical procedure; a list of current medications and dosages; any known allergies, and a list of any existing co-morbid conditions.

The surgeon will contact the patient's primary care physician regarding serious pre-existing medical conditions for clearance prior to surgery. Any written documents received from the primary care physician will be filed into the patient's medical record. Verbal or telephonic reports from the primary care physician will be documented in the History and Physical report or as a part of the pre-operative anesthesia evaluation.

On the day of the procedure, a physical assessment will be performed. This physical examination should be reflective of, and indexed to, the type of anesthesia planned.

PROCEDURE:

The pre-operative assessment will include the following:

1. A listing of medications (with dosages) taken by patient,

2. Disclosure of any known allergies,

3. Discussion of any significant medical problems with the

requirement of consent for surgery by the patient's primary care physician if there are significant clinical diagnoses present, and

4. Performance of pre-operative vital signs.

The physical examination will be indexed to the planned intervention, as described below:

IF NO ANESTHESIA OR TOPICAL, LOCAL, OR REGIONAL BLOCK: assessment of mental status and an examination of the area proposed for the procedure.

IF IV SEDATION: assessment of mental status, examination of the area proposed for the procedure, and examination of the heart and lungs by auscultation.

IF GENERAL, SPINAL OR EPIDURAL ANESTHESIA: assessment of mental status, examination of the area proposed for the procedure, examination of the heart and lungs by auscultation, and assessment and written statement about the patient's general condition.

There must be a pre-procedure examination on the day of the surgery by a physician, operating practitioner, or anesthesia provider evaluating the risks of anesthesia and the procedure to be performed.

Assessment of Patient Learning Needs

POLICY:

Individuals learn in a variety of ways; some people are tactile, while others respond to verbal cues, written instructions or require demonstration (i.e., 'see one, do one'). Patients and caregivers often need education regarding pre and post-procedure instructions and other medical aspects of care.

PROCEDURE:

This organization is sensitive to the needs of patient to learn in the manner which is most familiar and most comfortable to the individual. Employees will assure that the information which needs to be conveyed to the patient/caregiver is conveyed in a manner which allows the patient to comprehend the issue being taught. Should clinical personnel or the physician provider feel that additional instruction is needed or if the patient requests additional information regarding any phase of his/her procedure, necessary time will be allotted prior to the patients surgery or procedure.

Clinical staff members shall conduct appropriate patient teaching activities consistent with the specialties represented and procedures performed at this organization. As a specialty organization, this organization is ready to provide information adjunctive to the services we provide to our patients, other members of our medical community, and to the community at large.

During the pre-admission interview, the person conducting the evaluation will provide pre-operative/pre-procedural teaching

subsequent to evaluating the patient's identified learning need, barriers (religious, cultural, emotional), and limitations to learning.

The ability of the patient and the patient's support person(s) to learn and the effectiveness of the teaching methods utilized will be recorded on the organizational tool for this assessment, evaluation, and reevaluation. The Learning Needs Assessment tool will follow the patient from the initial pre procedural contact to discharge from the organization. The tool consists of two parts. The initial learning assessment, completed by the patient and the ongoing teaching/learning needs identifier which follows the patient throughout their time within the organization. The tool provides the staff with a method for intra communication regarding topics covered and the patient's ability to identify areas of concern within the patient education process,

The patient and family education process is collaborative and interdisciplinary, as appropriate to the plan of care.

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Your facility name here
Your Doctors name here

Issued MM/YY
Dates of Review_MM/YY_____

Your Name_____
Date_____

INITIAL LEARNING ASSESSMENT

During your visit with our organization you will be presented with information that may be new to you. To aid in providing the best care possible please answer the following questions. Then return this form to the front desk. Thank you.

How do you like to learn new things? Please check all that apply

	Reading		Pictures/Diagrams
	Discussion		Hands On/Demonstration
	Videotapes		Self-study
	Audiotapes		Other

Factors that can affect learning:	**Yes**	**NO**	**Comments**
Do you speak English in your home?			If no what language do you speak? Name of interpreter:
Can you read English?			
Can you write English?			
Do you hear well?			If no, do you utilize a hearing device? ☐ Yes ☐ No
Do you see well?			If no, do you utilize glasses or contacts? ☐ Yes ☐ No
Do you have any cultural or religious practice/beliefs that may affect your care or treatment?			If Yes, explain

Other comments

_____

_____

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Death of Patient

PROCEDURE:

1. In the event of a death at this organization, clinical employees will immediately notify the most-readily-available doctor; the patient will be pronounced by the doctor or transported by EMS personnel.

2. The doctor will document the time of death and how the death was determined.

3. The coroner's office will be notified of the death by the appropriate clinical person. All medical equipment, lines, etc. must remain attached to the patient until the coroner authorizes removal.

4. The patient's doctor shall notify the patient's family of the death.

5. Disposition of the body will be handled according to regulations of the County Coroner's Office.

6. Personal belongings of the deceased shall be surrendered to the person responsible for the patient, upon receipt of a signed inventory. This shall be kept on patient's chart.

7. The completed patient medical record shall be secured and reviewed by the appropriate Quality Management personnel and by the Medical Director.

8. As required by State law and by accrediting agency standards the proper organizations will be contacted and notified of a patient death.

Drug Product Defects

POLICY:

Drugs will be subjected to a visual inspection before being dispensed. Any medication which appears suspicious due to discrepancy in color, shape, or appearance will not be dispensed.

If the clinical person preparing to dispense the drug believes that a drug has been mis-packaged or mis-labeled, this medication will not be given.

PROCEDURE:

1. Any drug which appears to be defective will be removed from stock for possible return to the manufacturer or for destruction.

2. Problems with drug quality, strength, purity, packaging and/or labeling will similarly be removed from stock.

3. Therapeutic failures, bioinequivalence and tampering will be returned to the manufacturer.

4. A general notice will be issued to the surgeons whenever a drug is discovered to be defective; should the possibility exist that a defective drug has been administered to any patient, the attending surgeon will be notified immediately so that the patient can be observed for possible drug reaction.

Drug, Equipment, Medical Devices, and Other Recalls

POLICY:

In the event of a drug recall, (which includes sample medications, medications dispensed by the organization, and vaccines), medical devices,
equipment, supplies or food it is the responsibility of the Medical Director in coordination with the appropriate staff members to discern if the identified recalled product is contained within the facility. Once it has been determined the product is part of the organization's medication system, equipment inventory, supplies, food, etc. the following will occur:

PROCEDURE:

Within 24 hours after the receipt of recall notice from a manufacturer, FDA, CDC, State, Federal or other reputable sources, such as medical suppliers the recalled product(s) will be removed from the location(s) within the facility by appropriate staff.

If the product was utilized on a patient or dispensed to a patient, notification of patients as appropriate will also commence by various means; i.e. telephone calls, email, or U.S. mail.

The recalled product will be returned to the appropriate organization or department as determined by the manufacturer, FDA, CDC, etc. The return process will follow all specified directions regarding packaging, shipping, and tracking.

Notification of all recalls shall be kept for a
period of at least one (1) year and will contain documentation of actions and results.

Emergency Return to the Operating Room

POLICY:

Any patient exhibiting symptoms indicative of an emergency condition which may be a complication of surgery will be returned to the Operating Room for immediate treatment.

PROCEDURE

Any emergent complication, such as bleeding, wound dehiscence, change in patient status, which may indicate a complication of surgery will be treated as an emergency and the patient will be readied for return to the Operating Room.

The surgeon and anesthesia personnel will be notified immediately and immediate evaluation of the patient will commence in order that a decision be made regarding further treatment. At the discretion of the surgeon or the anesthesia provider, the patient may be returned to the OR at this organization or transported to the Hospital for admission to an acute level of care.

The OR staff will commence appropriate preparations and stand by until a decision is made regarding the disposition of the patient.

In the event of an emergency secondary procedure:

A. Anesthesia personnel will be notified and asked to prepare for the procedure.
B. The surgeon will inform the patient and the patient's family of the secondary surgery.
C. Designated personnel will prepare the patient physically (maintain NPO status, monitoring of vital signs, patent IV, etc.) And set up the operating room.

Guidelines: Discharge of Patient and Related Discharge Instructions

POLICY:

A member of the Provider Staff (must be DDS or M.D) will authorize the discharge of all patients via a written, signed order. At the discretion of the provider performing the procedure, a patient may be discharged by a competent clinical employee through the use of previously-established criteria. The patient is responsible for his/her transportation home and for provision of an adult caretaker; any exception to this policy must be ordered in writing by the attending Provider Staff member. Such Staff member may refuse to discharge a patient, regardless of physical condition, not accompanied by a responsible party or for whom the safety of home care arrangements is in question.

A DDS or MD must be present until the medical discharge of the patient. Medical discharge refers to discharging a patient following clinical recovery from surgery and anesthesia.

Licensed Personnel qualified in advanced resuscitative techniques are present until all patients operated on that day have been physically discharged.

PROCEDURE:

1. Competent clinical personnel determines if the patient adequately meets all discharge criteria, including:

   A. Full consciousness and awareness
   B. Cardiovascular stability
   C. Absence of active hemorrhage
   D. Orthostatic vascular stability (able to tolerate

sitting without dizziness and able to ambulate at pre-operative level, unless precluded by surgical intervention)

E. Gastrointestinal stability

2. At the request of the provider of care, the Post Anesthesia Score Sheet will be employed; the Discharge Score Sheet Consists of the following; no patient will be discharged with a score of less than 10:

Respiration
- Able to breathe deep and cough..... 2
- Limited effort--splinting and dyspnea..... 1
- No spontaneous effort..... 0

Color
- Normal skin color and appearance.....2
- Pale, dusky, jaundice..... 1
- Frank 0

Consciousness
- Fully awake..... 2
- Arousable by calling..... 1
- Unresponsive..... 0

Activity
- Able to move all extremities..... 2
- Able to move two extremities..... 1
- Not able to move upon demand.....0

Circulation
- BP 20% preanesthetic level..... 2
- BP 20-50% preanesthetic level..... 1
- BP 50% preanesthetic level 0

3. Staff will verify discharge order with the physician.

4. Staff will verify that the patient and caregiver receive written and verbal instructions and document receipt of such instructions for self-care, activity, diet, treatments, exercise, use of equipment, medications, follow-up appointment with physician, who to call in case of emergency, and dressing care; as applicable. These instructions will also include information regarding the best means to contact the surgeon following discharge. The instructions will be explained to the patient and the caregiver with adequate oportunity given for questions.

Patient Transfer to Hospital

POLICY:

It is the policy of the facility to transfer patients with the following conditions to a general acute care hospital:

1. Patients who have received CPR.

2. Patients whose recovery is going to be prolonged.

3. Patients whose medical condition cannot be treated at our organization.

4. Patients who have received or are in need of emergency treatment.

PROCEDURE:

1. The surgeon in charge will give the order for transfer.

2. The surgical assistant will call for emergency medical service or transport personnel, if indicated.

3. The Hospital will be notified of the planned transfer.

4. The receiving physician will be notified of the transfer.

5. The family will be notified of the plan to transfer.

6. Personal effects will be given to family.

7. A copy of the Resuscitation Record, if appropriate, will be transferred with the patient. Copies of the medical record will be forwarded to the Hospital, as appropriate.

Patient Transfer to Hospital

This will include a copy of the history and physical, medication and anesthesia records, diagnostic test results, explanation of precipitating incident necessitating transfer (including records of medications administered, and demographic and insurance information).

The Medical Director or physician will call and obtain name of the physician accepting the patient at the Hospital and will document this on the transfer form. The Medical Director or surgeon will also be available to communicate with other physicians providing care to the patient.
In the case of suspected abuse, all evidentiary material released by a victim must be collected, retained, and safeguarded until released to emergency services that will accept/collect such evidence.

Sample Medications

Due to the constraints of reporting as legislated by the State of Nevada, our organization no longer offers any sample medications.

OMFS SURGERY CENTER, LLC
Nevada Oral & Facial Surgery

RADIATION PROTECTION PROGRAM (NAC 459.321)

This program is applicable to all persons working under Nevada Radiation Machine Registration number

PURPOSE: To protect workers and the public from unnecessary exposure to radiation and to keep all exposures below the limits specified in Chapter 459 of the Nevada Administrative Code.

REQUIREMENTS: IMPLEMENTATION & MAINTENANCE OF A RADIATION PROTECTION PROGRAM

We are required to:

1. Provide the following instruction to each worker prior to the worker's engagement in work with a source of radiation:
   a. Use of time, distance and shielding to keep exposure to radiation to a minimum.
   b. Knowledge of the exact location of the source(s) of radiation in the restricted area.
   c. Safe conduct of any operations or procedures in which the worker will be involved.
   d. Regulations of the Health Division that apply to the particular type of radiation or radioactive material used in the facility.

2. Furnish the following equipment to the worker:
   a. Personnel monitoring equipment if the potential level of radiation exposure to the worker is as much as 10% of the annual dosage limit specified in the regulations or to any employee who requests a badge
   b. Protective clothing such as lead aprons, lead gloves, thyroid shields, leaded glasses, respirators and decontamination clothing, etc..., to keep exposure of the worker as low as reasonably achievable (ALARA).

3. Prevent any member of the public:
   a. From entering a restricted area.
   b. From being unnecessarily exposed to radiation or radioactive material.

   Note that a patient is not a member of the public when undergoing a procedure involving the diagnostic or therapeutic use of radiation or radioactive materials.

4. **Review the radiation protection program at least on an annual basis:**
   a. To determine whether the content and scope of the program is adequate to meet the purpose of the program.

b. To make any necessary changes in the program if it is found to be inadequate to meet the purpose of the program.
c. To determine whether the program is in constant effective use.
d. To make a record of the date of each review and the findings with respect to items 4.a., 4.b.,4.c. and sign the report.

Each employee of Nevada Oral & Facial Surgery/OMFS Surgery Center is required to:

1. Learn the instructions provided by the registrant.
2. Employ all safety procedures in daily work to avoid unnecessary exposure to radiation.
3. Sign a statement that the employee has studied the instruction, associated regulations and that any questions have been answered to his/her satisfaction by a registrant.
4. Prevent, any unnecessary radiation exposure to a fellow worker or to a member of the public

OMFS SURGERY CENTER, LLC
Nevada Oral & Facial Surgery

I have reviewed the radiation protection program and have found the content and scope to be adequate to meet the purpose of the program and no further changes are necessary at this time.

The program is in constant and effective use.

_____ Date: _____

Brendan G. Johnson, DDS
Medical Director

PROCEDURE:

1. All articles to be sterilized are to be cleaned.

2. The use of pins, paper clips, staples and similar items in conjunction with processing supplies should not be permitted.

3. The function of a package containing a sterile medical item is to insure that the sterility of the contents is maintained up to the time the package is intentionally opened, and that provision is made for the contents to be removed without contamination.

4. Materials used should be suitable for the sterilization method used, provide a barrier to micro-organisms and their vehicles and be free of toxic ingredients and non-fast dyes.

   A. Non-woven wrap sequentially with two wrappers.
   B. Mixture-wrap sequentially with one double thickness muslin and one non-woven wrapper.
   C. All items with sharp edges or points must be protected or covered.
   D. Large items or groups of items should be double-wrapped, first in a sealed peel pack and then inside of another peel pack to retain sterility upon opening.

5. Materials capable of holding water must be positioned in such a way as to allow condensate elimination (usually positioned on its side).

6. Sterilized articles should be handled with great care and as little as possible. They should be stored in a well-ventilated area with controlled temperature and humidity.

7. All wrapped sterilized items remain in the sterilizer until items are adequately cooled so the items can be removed from the sterilizer without the possibility of burn and the minimum accumulation of condensate.

8. Any sterilized package that is dropped, torn or has come in contact with moisture or extreme pressure is considered contaminated.

9. The number of items contained by any drawer or shelf should not exceed the amount that may affect the integrity of the package or seal.

10. Sterilized packages are identified on the outside of the package by writing the package contents, date the package was sterilized, and mode of sterilization.

11. Records of repairs and preventative maintenance are recorded.

12. Sterility indicators must be used within and on every package sterilized.

For further information please see the CDC Guideline for Disinfection and Sterilization in Healthcare Facilities. A link to this document is located in the Forms Repository, Web Resource Link Section.

Single Use Device; Single Dose Vial

A single use device is meant to be used one time for one patient only.

At present the single use devices in this organization consist of

- Needles
- Syringes
- IV tubing
- EKG pads
- Emergency equipment such as ET tubes, nasal and oral airways and defibrillator pads.

None of the above are ever reused. Additionally this organization does not practice reprocessing of single use devices.

Single Dose Vial

A single-dose or single-use vial is a vial of liquid medication intended for administration (injection or infusion) that is meant for use in a single patient for a single case/procedure/injection. Single-dose or single-use vials are labeled as such by the manufacturer and typically lack an antimicrobial preservative.

The safest practice is to enter a single-dose or single-use vial **only once** so as to prevent contamination of the vial and infection transmission. Single-dose or single-use vials should be used for a single patient and a single case/procedure/injection. Therefore, they should require only a single entry into the vial.

- If a single-dose or single-use vial has been opened or accessed (e.g., needle-punctured) the vial should be discarded according to the time the manufacturer specifies for the opened vial or at the end of the case/procedure for which it is being used, whichever comes first. **It should not be stored for future use.**

Reference: http://www.cdc.gov/injectionsafety/providers/provider_faqs_singlevials.html

Area for Storage of Medications

POLICY:

Appropriate space and security will be maintained for the safekeeping of all medical and surgical supply items; careful attention will be given to the appropriate storage of drugs.

PROCEDURE:

All medications will be kept in the appropriate storage area required by the class of medication. The storage area for medications kept under locked storage will be unlocked at the beginning of each surgical day. Controlled substances will be kept in the double-locked storage area.

All storage will be arranged in an orderly fashion and will be kept clean. All medications will be kept in labeled bins.

Special purpose medications and preparations will be placed away from other items in storage; such storage will be appropriately labeled.

Parenteral medications, oral medications and topicals will be stored separately. No concentrated electrolytes will be stored in patient care units or areas.

Medications that are easy to confuse; look or sound alike medications or reagents and chemicals that may be mistaken for medications are segregated.

The Medical Director and the Clinical Supervisor will have

access to the keys for all locked storage; keys will be locked in the facility at the end of each day.

All drugs will be stored at the proper temperature:

1. Room temperature is defined between 59F and 86F.
2. Thermo-labile preparations requiring refrigeration will be kept at a temperature that is maintained between 36F and 46F.

Outdated drugs will be removed from the medication cabinet, labeled as expired, and stored in a separate locked storage area until they can be disposed of or returned for credit.