Patient Safety Plan

Patient Safety Check List and Patient Safety Policies

1 Medical Safety

- VTE Risk Factor Checklist
- Pre-op order checklist
- Patient Safety Check List
- Hand Hygiene
- Patient Identification
- Surgical Site Marking
- Surgical Time Out
- Anesthesia Services
- Patient Positioning
- Electrosurgery Policy and Procedures
- Electrosurgery Safety Checklist
- Surgical closing procedure
- Post-op instructions
- Discharge policy

2 Emergency-Medical

- Return to OR
- Emergency Call System
- Incapacitated Medical Personnel
- Emergency Procedures-code team
- Code blue form
- Defibrillation
- EKG monitor
- Cardiac Arrest and CPR
- BLS
- Death
- Emergency Transfer
- Transfer of Patient Records
- Rationale and Use of Critical Indicators and Report
- Critical Indicator Report

Sierra Center for Foot Surgery

Patient Safety Plan

Patient Safety Committee

The goal of the Sierra Center for Foot Surgery's internal patient safety plan is to improve the health and safety of patients who are treated at the medical facility. It is developed in consultation with the actual providers of health care to the facility's patients. SCFS safety plan consists of Patient Safety Check Lists, Patient Safety Policies, and the Program for the Prevention and Control of Infections.

Patient Safety Plan

Patient Safety Check List and Patient Safety Policies

- Risk Factor Checklist
- Pre-op order checklist
- Post-op/ Discharge check list, instructions, policy
- Patient Identification
- Surgical Time Out
- Surgical Site Marking
- Patient Positioning
- Anesthesia Services
- Hand hygiene
- Surgery Closing Procedure
- Emergency Call System
- Safe Use of Electrical Equipment
- Surgical Area Safety
- Facility Maintenance and Safety Policy
- Facility Safety Checklist
- Daily Check List
- Equipment Safety Log Policy
- Compressed Gas Cylinders
- Emergency Drills:
    - Fire Drills
    - Disaster Drills
    - Earthquake Drills
    - Bomb Threats
    - Policy for Violent and Abusive Patient/Visitor

Program for The Prevention and Control of Infections and Communicable Diseases

(Reference the binder specifically for the Program for the Prevention and Control of Infections and Communicable Diseases for policies related to this program)

- Medication Safety
- Single Dose vials
- Multi-dose vials
- Anesthesia Services
- Syringe and Needle Use
- IV Infusions
- Disinfection
- Sterilization
- Aseptic Technique
- Communicable Diseases and Resistant Infections
- Hand Hygiene
- Gloves

SCFS infection control and patient safety policies and procedures are reviewed and approved at least annually. Infection control and communicable disease policies and procedures, patient safety checklists, and patient safety policies are reinforced via annual face to face training. If new and improved infection control practices, patient safety practices or new information on communicable disease control and/or prevention are discovered before that time they are discussed and reviewed with the Director of Nursing, medical director and any pertinent staff members. Training will then be conducted on those policies and put into effect at that time.

Patient Safety Committee:

Sierra Center for Foot Surgery has designated Danielle Taylor, RN to serve as the center's Patient Safety Officer. She has the responsibility to serve on the patient safety committee, supervise the reporting of all sentinel events, take action as deemed necessary to ensure patient safety at the facility and report any action taken to the patient safety committee.

Pursuant to NAC 439.920, a medical facility that has fewer than 25 employees and contractors shall establish a patient safety committee composed of: the patient safety officer, at least two providers of health care who treat patients at the medical facility, including, one member of the medical staff and one member of the nursing staff and the chief executive officer or chief financial officer.

The members are as follows:

Patient Safety Officer: .

Medical:

Nursing:

CFO/Administrator:

A patient safety committee established pursuant to this section must meet at least once every calendar quarter.

The patient safety committee shall (pursuant to NRS 439.875):

- Receive reports from the patient safety officer (pursuant to NRS 439.870)
- Evaluate actions of the patient safety officer in connection with all reports of sentinel events alleged to have occurred at the medical facility.
- Review and evaluate the quality of measures carried out by the medical facility to improve the safety of patients who receive treatment at the medical facility.
- Review and evaluate the quality of measures carried out by the medical facility to prevent and control infections at the medical facility.
- Make recommendations to the executive or governing body of the medical facility to reduce the number and severity of sentinel events that occur at the medical facility.
- At least once each calendar quarter, report to the executive or governing body of the medical facility regarding:
    - The number of sentinel events that occurred at the medical facility during the preceding calendar quarter.
    - The number and severity of infections that occurred at the medical facility during the preceding calendar quarter
    - Any recommendations to reduce the number and severity of sentinel events and infections that occur at the medical facility.
- Adopt patient safety checklists and patient safety policies as required by NRS 439.877, review the checklists and policies annually and revise the checklists and policies as the patient safety committee determines necessary.

Medical Safety

VTE Risk Assessment and Prophylaxis Orders

Each Risk Factor Represents 1 Point

- Age 41- 60 years old
- Swollen legs (current), varicose veins
- BMI >35
- Minor surgery planned (<1 hour)
- Sepsis in past 30 days
- Serious acute lung disease (<30days)
- Congestive heart failure in past 30 days
- Current bed rest pre-operatively
- Inflammatory bowel disease
- Oral contraceptives or HRT
- Pregnancy or post-partum (<30 days)
- Unexplained stillborn, ≥3 spontaneous abortions, premature/LBW/toxemia
- Acute myocardial infarction
- Major surgery in past 30 days
- COPD

Subtotal_____

Each Risk Factor Represents 2 Points

- Age 61-74 years
- Arthroscopic surgery planned
- Malignancy
- Confined to bed >72 hours
- Immobilizing plaster cast (1 month)
- Central venous access
- Major surgery planned (>1 hour)

Subtotal_____

Each Risk Factor Represents 3 Points

- Age 75 years
- H/o VTE/PE (personal or 1st degree relative)
- Stroke in past 30 days
- Elective major lower extremity arthroplasty
- Thrombophilia -Type_____
- Hip, pelvis, or leg fracture past 30days
- Acute SCI + paralysis in past 30 days

Subtotal_____

Total Risk Factor Score_____

0 Points= Very Low Risk:

- Early ambulation

1- 2 Points= Low Risk: Consider

- Sequential compression devices

3 - 4 Points= Moderate Risk: Choose One

- Sequential compression device
- Heparin 5000 U SQ TID
- Enoxaparin SQ: (see dosage guidelines).

_____Ambulatory Surgery- No VTE Prophylaxis Required

_____VTE Prophylaxis Contraindicated. Reason: _____

Physician Signature_____Date_____

Physician Name:

Processed by (if other than physician)_____

*Caprini VTE Risk Factor Assessment *Tool* is designed for use in Elective General Surgery Patients. In Ambulatory Surgery Patients. prophylaxis is not required. We are using this as a general screening and to help guide ***optional*** prophylaxis.

*All lower extremity surgery patients are counseled regarding early ambulation, frequent active lower extremity joint motion, elevation with calf support, compression, +/- ASA, risk factor mitigation.

Patient Name: **Pre-Op Date:**

Pre-Operative Orders

1. ☐ CBC
   ☐ Glucose
   ☐ Bun
   ☐ Creatinine
   ☐ CMP
   ☐ EKG
   ☐ Chest X-Ray
   ☐ Electrolytes
   ☐ Surgical Clearance
2. ☐ _____
3. ☐ Upon arrival at ASC, vital signs taken. Blood pressure and pulse will be taken and recorded every 15 minutes during surgery and again before leaving the ASC.
4. ☐ Pulse Oximeter placed on finger. Nasal cannula with O_2
5. ☐ Routine skin prep to surgical area.
6. ☐ _____

Signature _____ D.P.M

Post-Operative /Discharge

1. ☐ Discharge with post op shoe or surgical boot: RT LT
2. ☐ Continue taking medications as ordered pre-operatively.
3. ☐ Patient discharged to family member or another responsible adult.
4. ☐ Complete discharge instructions given to patient and responsible adult.

Signature _____ D.P.M Date _____

Post Op Instructions for Foot Surgery

- **Do not** get your bandages wet. We strongly recommend using a shower cast protector (can be purchased here).
- **Do not** remove your surgical bandages. Please call for instructions if bandage is too tight or causing pain.
- Wear your post-operative shoe or boot at all times, unless the doctor permits you to remove it while resting. **Do not stand or walk without them**.
- If you were instructed **not** to step on your foot, that means not at all, **not even one step.**
- Elevate your foot and leg at or above the height of your chest. Elevate at least 95% of the time for the first few days.
- Use a surgical ice pack, frozen gel pack, bag of frozen vegetables, or cold therapy machine. Do this 20 minutes on and 20 minutes off while you are awake. Avoid bags of ice as they will get your bandage wet.
- Take your first dose of pain medication no less than 1-2 hours after surgery, as soon as you have eaten, and while your foot is still numb.
- To help prevent potentially dangerous blood clots, frequently bend your knees and rotate your ankles. If you are wearing a stiff boot, you can still bend your knees and contract/squeeze the muscles in your legs.

What to do if:

- **Excessive bleeding:** Moderate bleeding is expected. Most of it occurs when walking to the car and into the house after surgery, and any time your foot is not elevated during the day and night following surgery. You may re-inforce the bandage with gauze and coban. Elevate and ice the foot and leg. Call the office if most or the entire bandage is saturated with blood.
- **Nausea or vomiting from pain medication:** Be sure to eat food before taking pain medication. Try regular strength Benadryl (diphenhydramine) 25mg by mouth 15 minutes before taking pain meds. If still nauseous or vomiting, call the office.
- **Pain is severe or poorly controlled:** Try adding Benadryl as above. Next, try adding ibuprofen (Advil, Motrin) or naproxen (Alleve). Elevate and ice. If still painful, your bandage is probably too tight. Call the office for instructions on how to loosen your **outer** bandage.
- **Fever, chills, or night sweats:** Take your oral temperature twice a day and record it. If your temperature is above 101 degrees Fahrenheit, please call the office.
- **Infection:** If there is redness (or red streaking), heat, and swelling that extends beyond your bandage, especially with sustained fever and increasing pain, please call the office.
- **Injury to surgical area:** If injury is forceful, or if followed by increased pain, please call the office.
- **Medical emergency:** for severe allergic reaction, trouble breathing, chest pain, severe uncontrolled bleeding, altered mental status, **call 911 or go to Emergency Room**

PATIENT SIGNATURE: _____ **DATE:** _____

WITNESS: _____**DATE:** _____

DISCHARGE POLICY AND PROCEDURE

SIERRA CENTER FOR FOOT SURGERY

PURPOSE:

To establish consistent criteria for the discharge of patients when stable post-procedure from the Sierra Center for Foot Surgery.

Patients not receiving sedation:

1. May be discharged when vital signs are stable (i.e., Systolic B.P. and pulse are within +/- 20 points of admitting vital signs).
2. Non sedated patients should be observed for 15 minutes for signs of complications.

Patients receiving sedation may be discharged when the following criteria are met:

- Awake, alert and oriented.
- Vital signs are stable (see above)
- Color is pink and skin is warm and dry or within patient's own normal limits.
- Dressings are clean and dry.
- Patient is able to take fluids without nausea.
- Patient denies pain.
- Responsible party is here to drive patient and patient (or driver) is able to understand discharge instructions.
- Patient has follow-up appointment for post-operative care.
- Post-operative call can be made by a physician's designated person or the physician.

Patients shall be discharged only upon written order of the attending physician. Patients are transported from the facility by wheelchair to a waiting vehicle driven by a responsible adult.

If any patient insists upon leaving the surgical center against medical advice, the attending physician may request that the patient sign a statement relieving the physician and the surgical center of any responsibility for the results of the action.

Patient Identification

All patients must be identified appropriately before providing treatment. Each patient will be identified with at least two personal identifiers before each interaction with a provider of health care. The personal identifiers will include, without limitation, the name and date of birth of the patient.

Surgical Timeout

The Surgical time out will include, but is not limited to:

I. It is the policy of Sierra Center for Foot Surgery to perform a "Surgical Time Out" before each surgical case. To ensure that the time out is completed, the blades and gauze for the case will not be added to the sterile tray until the time out is completed. This way the surgeon will not be able to incise and begin surgery.

II. Pre-operative verification: review by the operating room team of medical records, imaging studies, and any implants identified. Missing information and or discrepancies are addressed before commencing with the surgical procedure.

III. Marking the operative site: Marked by the physician before sedation. Right or left distinction, multiple structures. Marking should still be visible after patient has been prepared and draped.

IV. Immediately before surgical procedure, 2 members of the team will confirm:

- The patients' name
- Patients' allergies
- Planned or possible surgical procedures
- Which foot: right, left or bilateral
- If antibiotics have been administered
- If the sterile indicators on the sterile trays indicate that the instruments were sterilized
- Identify any fuels present (alcohol-based skin antiseptic agents, drapes, gowns, endotracheal tubes)
- Identify any ignition sources present (active electrocautery devices, lasers, or fiber optic light cords)
- Implants, if applicable.
- Any special equipment that may be applicable.

V. The surgical time out will be documented in the surgical chart prior to the procedure.

Surgical Site Marking

The surgical site will be marked by the operating physician. Each procedure will be marked. The surgical site will also be marked with the patient's name and birthdate to ensure patient identification during time out.

Refusal of Site Marking

It is the responsibility of the Director of Nursing or D.P.M to explain why site marking is appropriate and desirable, and the implications of refusal so that patients can make an informed decision. However, the patient always has the right to refuse.

Such situations should be handled the same way as for any other refusal by a patient offered care, treatment or services. A refusal to have site marking should not result in the procedure being cancelled; however, the refusal must be documented in the patient's medical record.

Patient Positioning in Surgery

The position in which the patient is placed is determined by the surgeon and /or anesthesia personnel according to the operation to be performed.

It must:

- Allow good access to the operative site.
- Be consistent with the vital function of respiration and circulation.
- Protect the patient against nerve and blood vessel injury.
- Avoid strain on muscles of all parts of the body.

When in correct position:

- The surgeon has best possible exposure of the operative site.
- The patient is adequately supported and stabilized to maintain the most comfortable and safest position possible throughout the operation.

The patient is positioned by the circulating nurse, anesthesiologist, CRNA or surgeon.

- Nurses should therefore know and execute:
  - Protective Measures:
    - Movement of anesthetized patient must be gentle and slow
    - Maintain open airway
    - Neck and head always supported
    - Protect patients from unnecessary exposure
    - All braces and straps must be padded
    - Additional support supplies as needed, i.e., knee elevation pillow

- Mechanics of operating table.
- Correct body positions.

Anesthesia Policy and Procedure Statement

As an anesthesia provider at Sierra Center for Foot Surgery, I agree to follow all basic standards of care as set forth by the American Society of Anesthesiologists (ASA). These standards will include, but are not limited to thefollowing:

1) Pre-operative evaluation: all patients to receive any type of anesthetic will be interviewed by the anesthesia provider prior to induction. At a minimum this includes: basic H&P, NPO status, drug allergies, review of baseline vital signs. Provider is to ensure patient is safe to proceed with anesthetic.
2) Ensure that Anesthesia informed consent has been signed (can be included in surgical consent).
3) Patient monitoring: all patients will have continuous monitoring of respirations, 0_2 saturation, BP and EKG throughout entire administration of propofol. At no time may the anesthesia provider leave the patient unattended during anesthesia delivery.
4) BP and HR must be taken and recorded at a minimum of every 5 minutes.
5) Anesthesia provider will adhere to strict standards regarding infection control. This will include all ASA guidelines, universal precautions, etc. and will includespecifically:

- All syringes, needles, IV tubing, anesthesia tubing and propofol vials are to be used on one patient only. There will be no transfer of any of these items for use on another patient. I understand that my failure to adhere to thisguideline may lead to the spread of infectious disease from one patient to another and is in strict violation of ASA practice guidelines and the guidelines of this surgery center.
- Provider will ensure that anesthesia work area is clean betweencases.
- Oxygen delivery devices such as masks and nasal cannulas are one-time use items.

6) Anesthesia provider agrees to remain at the facility until all patients having received an anesthetic have met discharge criteria and patient care can safely be transferred to a physician or registered nurse.
7) Anesthesia provider to have current licensure to practice anesthesia.

I understand that I have been consulted to provide anesthesia services for Sierra Center for Foot Surgery and in so doing agree to follow basic standards of care as set out by the ASA. I have current knowledge and understanding of these guidelines and understand that any failure on my part to follow these guidelines may result in harm to the patient. I will not hold Sierra Center for Foot Surgery or its employees responsible for any negligence on my part in providing anesthesia.

Signed:_____Date:_____

Hand Hygiene

Hand hygiene is a critical step in preventing infections and the spread of infections, is of critical importance for the entire health care team, and remains the most effective and least expensive measure to prevent the transmission of microorganisms and health care associated infections. It is the single most important step in the prevention of infections.

Surgical hand antisepsis refers to the antiseptic surgical scrub or antiseptic hand rub performed before donning sterile attire preoperatively. For a description of this procedure see "Masking and Scrubbing Technique"

General hand hygiene refers to decontamination of the hands by one of two methods: hand washing with either an antimicrobial or plain soap and water, or use of an antiseptic hand rub.

- All personnel shall practice general hand hygiene:
- Immediately before and after patient contact
- After removing gloves
- Any time there is a possibility that there has been contact with blood or other potentially infectious materials
- Before and after eating
- After using the restroom

Wearing gloves is not a substitute for hand hygiene

Alcohol based hand rub is preferred to hand washing, unless the hands are visibly soiled.

If hands are visibly soiled wash them as soon as possible with plain or antimicrobial soap and water as follows:

- Wet hands with warm water
- Apply soap to the hands according to the manufacturer's written instructions, if given
- Rub hands together vigorously for at least 20 seconds, covering all surfaces of the
- hands and fingers. Pay particular attention to the back of the hands, finger tips, the
- thumb and inner web.
- Rinse hands with warm water and dry thoroughly with a disposable towel.
- Use towel to turn off faucet.

If hands are NOT visibly soiled an alcohol-based hand rub (60-95% alcohol) may be used for routine decontamination of hands. Follow manufacturer's written directions for product application.

To prevent the spread of infection and to aid in the effectiveness of Hand Hygiene:

- Fingernails should be kept short, clean and healthy.
- Nail polish may be worn if it is in good condition, freshly applied, and not chipped.

- Artificial nails should not be worn.
- Cuticles, hands and forearms should be free of open lesions and breaks in skin integrity.
- Rings, watches and bracelets should be removed before performing hand hygiene.
- Lotions, if used, should be chosen based on infection control practices, approved by infection control professionals, and compatible with the hand antimicrobial agent and gloves used.

Surgical Closing Procedure

The following items will be reviewed, checked for completion and recorded as the physician completes the surgical procedures.

- Procedures scheduled verses completed
- Record implants
- Medicine used and wasted
- Supply Count. Provided vs Used
- Specimens labeled and forms completed
- Final Fluoroscan
- Bleeding of hose for power instruments
- Equipment problems to be addressed
- End time
- Reminder to call driver
- Debriefing: changes to instruments, performance, what we could do better
- Review of reminders for patient specific requests
    - Keep fixation
    - Extra numbing shot
    - Callous trimmed
    - Other

Electrosurgery Policy and Procedures

Sierra Center for Foot Surgery has implemented the use of electrosurgery to reduce surgical time and improve patient safety. Electrosurgery is used to quickly control bleeding in the surgical site. By using cautery instead of tying off each vessel the surgical time is reduced which reduces the time under anesthesia therefore improving patient safety.

The Center will be using a Bovie Aaron 950 Electrosurgical Generator. The most common setting will be monopolar with one time use blade electrodes on blend setting. A reusable patient return electrode (grounding pad) with a conductive gel specifically designed for electrosurgery will be used as well as one-time use patient return electrodes, depending on patient need. The hand piece will be sterilized according to the manufacture's recommendations.

Electrosurgical unit devices present risks for patient injury if important safety steps are not performed. By following the standards set forth by the manufacturer and AORN recommendations the unit can be safely used. The following are the steps that the center will follow to ensure the safe use of the Electrosurgical device.

The most common form of patient injury is a burn under the return electrode. To avoid this the Center must ensure the return electrode is placed correctly.

- On an area with well-perfused muscle.
- On skin that is clean, dry and intact.
- Ensure that return electrode has uniform contact with the patient's skin before the surgery begins. If there is poor contact remove oils, lotions, hair or moisture that is interfering with contact.
- Position the electrode to provide a direct current route between the surgical site and the return electrode. For unilateral cases place the electrode on the same side as the surgery, for bilateral cases place the return electrode higher and make sure there are no skin-to-skin contact points.
- Do NOT place over bony prominences, scar tissue, hair, weight-bearing surfaces, potential pressure points, tattoos or a metal prothesis, distal to a tourniquet or near a warming device.

- Make sure to use the correct size of return electrode for individual patients. One-time use pads should not be cut, folded or altered in any way.
- Tape should NOT be used to hold the return electrode in place.
- The return electrode should be placed after final positioning. If the patient is re-positioned during surgery, verify that the electrode is still in contact with the patient's skin.

- Avoid skin to skin contact points such as fingers touching leg, legs touching legs. Place 2-3 inches of dry gauze between contact points to ensure that contact doesn't occur.
- Make sure that the patients DOES NOT have any contact with metal devices such as the bed, positioning devices, safety strap buckles to prevent a possible burn from directed current.
- Patient jewelry that is between the active electrode and return electrode should be removed.
- Make sure all alcohol-based prep has been allowed to completely dry before using the unit.
- Make sure that the cautery is a safe distance from any concentrated oxygen sources.
- Electrosurgery should not be used in the presence of external or internal pacemakers or Implantable Cardioverter Defibrillators. Electrosurgical devices can cause these devices to malfunction.
- If there is a request by the surgeon to increase the power, or if the unit is not performing as expected, check the return electrode and all connections before continuing the case. There may be a malfunction causing the need for additional power.
- When activating the unit, do not allow direct skin contact between the patient and the physician or assistant.
- When not using active accessories place them in a holster or in a clean, dry, non-conductive and highly visible area not in contact with the patient. Inadvertent contact with the patient may cause burns.
- NEVER silence the alarms.

Direct coupling is the contact of an energized active electrode tip with another metal instrument or object in the surgical field, thus energizing that instrument. Care should be taken to keep all metal away from the surgical field while using the active electrode.

A Safety Check List shall be completed if electrosurgery is planned for a surgical case. This check list will become a part of the patient's medical record.

A surgical smoke evacuator with ULPA filter should be used during active use of electrocautery whenever smoke plum is expected.

Electrosurgery Safety Checklist

Patients Name: _____ Date: _____

Pre-operative check:

- ☐ Remove all jewelry below the grounding plate.
- ☐ Does the patient have a pacemaker or Implantable Cardioverter Defibrillator? Y_ N_
- ☐ Return Electrode (Grounding plate or pad) Applied:

  Location: _____

  Is the site clean, intact and free of tattoos, scars? _____

  Is the site an area with well perfused muscle? _____

  Is the pad or plate in uniform contact with the skin? _____

  Is the site on the same side as the surgical site (unilateral)?
- ☐ If alcohol prep was used, is it completely dry? _____
- ☐ Are there any points of skin-to-skin contact? _____
  - If yes place a towel or gauze between these points.
- ☐ Is the patient touching any metal? _____
  - If yes, re-position the patient or place a barrier between the patient and the metal.
- ☐ Surgical smoke evacuator in place with single use tubing

Post-operative check:

- ☐ Remove the grounding plate/pad.
- ☐ Any burns or redness? _____
- ☐ Check the skin between the ground plate/pad and the surgical site.
- ☐ Any burns or injury? _____
- ☐ Surgical smoke evacuator used.

_____

Signature, Title Date

RP: Safe Environment of Care

Recommendation II

Potential hazards associated with fire safety in the practice setting should be identified, and safe practices for communication, prevention, suppression, and evacuation should be established and followed.

Fire is a risk to both patients and personnel in the OR because all three elements of the fire triangle (Figure 1) that are necessary for a fire—fuel, oxidizer, ignition source—typically are present.[35,36] Surgical fires are estimated to occur in the United States about 550 to 650 times a year.[36,37] The ECRI Institute states that surgical fires occur most frequently on the patient (70%), and 29% occur in the patient. Forty-four percent of fires occurring on the patient involve the head, neck, and upper chest, and 26% occur elsewhere. Twenty-one percent of fires are located in the airway, and 8% occur at other locations in the body.[36] The majority of fatal fires are airway fires.[37] Fires have been reported to occur during different types of surgical procedures (eg, coronary bypass graft, otolaryngology procedures).[38-40] One explosion was reportedly caused by cutting the wires from the battery pack of a battery-operated lavage system.[41]

II.a. A written fire prevention and management plan should be developed by a multidisciplinary group composed of key stakeholders within the organization such as
- perioperative RNs,
- perioperative unlicensed assistive personnel,
- anesthesia professionals,
- physicians,
- a local fire department representative,
- risk management personnel,
- the safety officer, and
- facilities/engineering personnel.[35]

[2: Moderate Evidence]

II.a.1. The fire prevention and management plan should include
- perioperative team members' responsibilities, including communication;
- methods of prevention;
- processes to safely manage different fire scenarios;
- alarm activation procedures;
- methods to extinguish a fire;
- the preferred routes and levels of evacuation;
- a description of the facility's fire risk assessment tool (Figure 2); and
- the required content for and frequency of fire safety education, including frequency of and procedures for fire drills.[35]

II.b. A fire risk assessment should be completed and communicated to the entire perioperative team before beginning a surgical procedure. *[2: Moderate Evidence]*

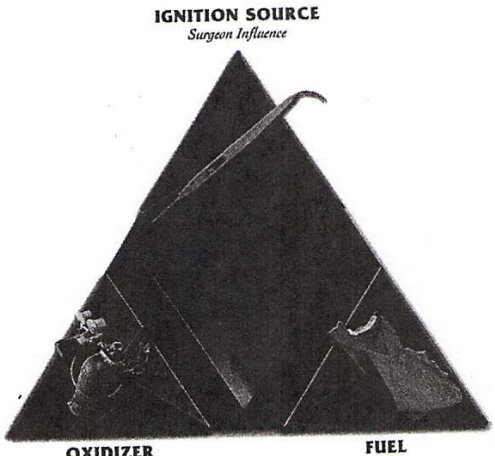
Fire prevention experts and professional associations support the importance of completing the risk assessment.[35,42] In one case report that involved a fire caused by the electrosurgical electrode igniting a sponge during open heart surgery, a lack of communication may have contributed to the fire. In this situation, there was a delay in communicating to the surgeon a decrease in the tidal volumes that was caused by a ruptured bleb. The rupture caused oxygen to leak into the patient's chest cavity and created an oxygen-enriched environment.[39]

II.b.1. The fire risk assessment should identify
- fuels that are present,
- ignition sources that are present,
- the potential for the presence of an oxygen-enriched environment,
- the specific type of fire extinguisher that is required based on the fuel and involvement of electrical current, and
- additional preventive measures that are required as determined by the location of the fire and fuel sources.

II.c. Ignition sources (eg, active electrosurgical electrodes, lasers, electrocautery devices, fiber-optic light cords) should be used according to manufacturers' instructions for use and AORN recommended practices.[9,43,44] *[2: Moderate Evidence]*

Manufacturers' written instructions for use and labels include fire safety information, such as the laser resistance of the endotracheal tube and methods of disposal for equipment (eg, battery packs).[37,41,45] Electrosurgical units provide the ignition source, especially when they are used in the presence of oxidizers, flammable solutions, or volatile or combustible chemicals or liquids.[36,44] Lasers provide the ignition source

FIGURE 1. AORN FIRE TRIANGLE



The AORN Fire Triangle illustrates the three elements necessary for a fire and the members of the perioperative team who frequently influence the element.

when they are used in the presence of oxidizers, flammable solutions, or volatile or combustible chemicals or liquids.[36,37,43] Fiber-optic light cables may provide an ignition source if they are disconnected from the working element and are allowed to remain in contact with drapes, sponges, or other fuel sources.[9,46]

II.c.1. Saline should be used to cool devices that create heat during use (eg, drills, burrs, saw blades).[36]

II.c.2. Defibrillator paddles and pads should be an appropriate size for the patient and applied using only manufacturer-recommended lubricants.

Using paddles that are the correct size and with manufacturer-recommended lubricants decreases both sparking and the amount of energy required for defibrillation.[36]

II.d. Fuels (eg, alcohol-based skin antiseptic agents, collodion, drapes, gowns, endotracheal tubes) should be managed to prevent contact with ignition sources. *[2: Moderate Evidence]*

Preventing contact between fuels and ignition sources breaks the fire triangle, thereby preventing fire.[47] Many potential fuels that will not burn in ambient air will burn in an oxygen-enriched environment, which may be present in the OR.[36,37,42]

II.d.1. The flammable or combustible rating of a skin antiseptic agent should be determined by reviewing the applicable material safety data sheet (MSDS) or safety data sheet (SDS).

Prep solutions can be rated as "flammable" or "combustible" on the MSDS or SDS. A combustible solution will burn but requires a higher temperature to cause ignition. A rating of "flammable" indicates a solution that has a flash point of less than 100° F (37.8° C). A solution with a rating of "combustible" has a flash point of greater than 100° F (37.8° C).[48]

II.d.2. Flammable skin antiseptic agents should be prevented from pooling or soaking into linens or the patient's hair by

- using reusable or disposable sterile towels to absorb drips and excess solution during application,
- removing materials that are saturated with the skin antiseptic agent before draping the patient, and
- wicking excess solution with a sterile towel to help dry the surgical prep area completely.[36,37,42]

II.d.3. Adequate time should be provided to allow flammable skin antiseptic agents to dry completely and to allow any fumes to dissipate before applying surgical drapes or using a potential ignition source.[35,42]

FIGURE 2. AORN FIRE RISK ASSESSMENT TOOL

AORN

Fire Risk Assessment Tool

A. Is an alcohol-based skin antiseptic or other flammable solution being used preoperatively?
- ❑ Yes
- ❑ No

B. Is the operative or other invasive procedure being performed above the xiphoid process or in the oropharynx?
- ❑ Yes
- ❑ No

C. Is open oxygen or nitrous oxide being administered?
- ❑ Yes
- ❑ No

D. Is an electrosurgical unit, laser, or fiber-optic light being used?
- ❑ Yes
- ❑ No

E. Are there other possible contributors (eg, defibrillators, drills, saws, burrs)?
- ❑ Yes
- ❑ No

The AORN Fire Risk Assessment Tool illustrates components that should be included in an assessment tool.

Allowing adequate time for skin antiseptic agents to dry before applying drapes helps prevent the accumulation of volatile fumes beneath the drapes.[47] The volatile fumes are flammable and may ignite without a connection between the ignition source and the actual surgical antiseptic agent.[36,37]

II.d.4. For surgical procedures that involve the head or neck, a water-soluble gel should be used to cover the patient's facial hair, and any eye lubricants that are used should be water based.

The patient's hair is a fuel source, and covering facial hair with water-soluble gel decreases the risk of combustion because it raises the temperature that is required for ignition.[36]

II.d.5. Local and state fire regulations should be followed regarding the storage of flammable liquids (eg, alcohol-based skin antiseptic solutions, hand sanitizer, alcohol, acetone, collodion) and the location of dispensers.[42,49-51]

when they are used in the presence of oxidizers, flammable solutions, or volatile or combustible chemicals or liquids.[36,37,43] Fiber-optic light cables may provide an ignition source if they are disconnected from the working element and are allowed to remain in contact with drapes, sponges, or other fuel sources.[9,46]

II.c.1. Saline should be used to cool devices that create heat during use (eg, drills, burrs, saw blades).[36]

II.c.2. Defibrillator paddles and pads should be an appropriate size for the patient and applied using only manufacturer-recommended lubricants.

Using paddles that are the correct size and with manufacturer-recommended lubricants decreases both sparking and the amount of energy required for defibrillation.[36]

II.d. Fuels (eg, alcohol-based skin antiseptic agents, collodion, drapes, gowns, endotracheal tubes) should be managed to prevent contact with ignition sources. *[2: Moderate Evidence]*

Preventing contact between fuels and ignition sources breaks the fire triangle, thereby preventing fire.[47] Many potential fuels that will not burn in ambient air will burn in an oxygen-enriched environment, which may be present in the OR.[36,37,42]

II.d.1. The flammable or combustible rating of a skin antiseptic agent should be determined by reviewing the applicable material safety data sheet (MSDS) or safety data sheet (SDS).

Prep solutions can be rated as "flammable" or "combustible" on the MSDS or SDS. A combustible solution will burn but requires a higher temperature to cause ignition. A rating of "flammable" indicates a solution that has a flash point of less than 100° F (37.8° C). A solution with a rating of "combustible" has a flash point of greater than 100° F (37.8° C).[48]

II.d.2. Flammable skin antiseptic agents should be prevented from pooling or soaking into linens or the patient's hair by

- using reusable or disposable sterile towels to absorb drips and excess solution during application,
- removing materials that are saturated with the skin antiseptic agent before draping the patient, and
- wicking excess solution with a sterile towel to help dry the surgical prep area completely.[36,37,42]

II.d.3. Adequate time should be provided to allow flammable skin antiseptic agents to dry completely and to allow any fumes to dissipate before applying surgical drapes or using a potential ignition source.[35,42]

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- ❑ No

D. Is an electrosurgical unit, laser, or fiber-optic light being used?
- ❑ Yes
- ❑ No

E. Are there other possible contributors (eg, defibrillators, drills, saws, burrs)?
- ❑ Yes
- ❑ No

The AORN Fire Risk Assessment Tool illustrates components that should be included in an assessment tool.

Allowing adequate time for skin antiseptic agents to dry before applying drapes helps prevent the accumulation of volatile fumes beneath the drapes.[47] The volatile fumes are flammable and may ignite without a connection between the ignition source and the actual surgical antiseptic agent.[36,37]

II.d.4. For surgical procedures that involve the head or neck, a water-soluble gel should be used to cover the patient's facial hair, and any eye lubricants that are used should be water based.

The patient's hair is a fuel source, and covering facial hair with water-soluble gel decreases the risk of combustion because it raises the temperature that is required for ignition.[36]

II.d.5. Local and state fire regulations should be followed regarding the storage of flammable liquids (eg, alcohol-based skin antiseptic solutions, hand sanitizer, alcohol, acetone, collodion) and the location of dispensers.[42,49-51]

Emergency Medical Procedures

Patient Transfer Log

Patient's Name: _____ DOB: _____ Date: _____

Procedure: _____

_____

Reason for Transfer:

_____

_____

_____

Transferred to: _____

Patient's Name: _____ DOB: _____ Date: _____

Procedure: _____

_____

Reason for Transfer:

_____

_____

_____

Transferred to: _____

Patient's Name: _____ DOB: _____ Date: _____

Procedure: _____

_____

Reason for Transfer:

_____

_____

_____

Transferred to: _____

Patient's Name: _____ DOB: _____ Date: _____

Procedure: _____

_____

Reason for Transfer:

_____

_____

_____

Transferred to: _____

Return to OR for Emergencies

In the event there is an emergent situation and a return to the OR is required, the following procedures will be followed.

The surgical team will repeat the surgical prep. The OR will quickly be cleaned and prepared. New sterile drapes and gowns will be provided. The patient will be re-anesthetized and a surgical scrub will be performed. The family will be informed of the event and consent will be obtained if possible.

EMERGENCY CALL SYSTEM

The Emergency Call System of the ASC is located in the Operating Room and in the Patient's changing ROOM.

1. **Operating Room:** The emergency plate is located on the West wall of the OR near the door. Emergency call buttons are also located on the wall behind each bed in the Pre and Post op areas. When pushed, the system is activated and a loud buzzer is heard and the panel at the nurse's station lights up. An alarm will also sound at the front desk in the clinic side. This alerts the staff that an emergency is taking place in the Operating Room. All staff are to respond immediately.

2. **Patient Changing Room:** The Emergency call system is located on the wall of the changing room. When activated, a loud buzzer is heard. For the patient's convenience and ease of handling, the activation device is a long cord with a button on the end. This cord is to be demonstrated to each patient when he/she first enters the changing room.

Incapacitated Medical Personnel

In the unlikely event the surgeon should become incapacitated for any reason, the assistant will apply a wet gauze dressing to the surgical site. The patient will be taken off anesthesia and transferred to the hospital to complete the surgery.

In the unlikely event the CRNA becomes incapacitated for any reason, the anesthesia will be turned off and the patient will be monitored by the operating room R.N. until they qualify for discharge. The surgeon will complete the surgery if possible. If not possible, a wet gauze dressing will be placed over the surgical site and the patient will be transferred to the hospital to complete the surgery.

If an R.N. becomes incapacitated for any reason, the other R.N. will take her place and the surgery will be completed as soon as possible.

Emergency Procedures

Code Team

Team Leader- Anesthesia Personnel

Airway Management- Anesthesia Personnel

Chest Compressions-Physician (to be rotated w/ other BLS certified staff every 2 minutes)

Access and draw up Emergency Medications as directed. - Circulating nurse.

Recorder- Pre-op/post-op nurse

AED- Surgical tech

Initiate call to 911- Assistant Surgical Tech

Monitoring of other surgical patients- Assistant Surgical Tech

Ambulance chaser- Front office personnel

Family support- Front office personnel

Preparation of CCR- Front office personnel

CODE BLUE FORM

Patient Details:

Patient Name _____Gender____ DOB _____Age_____

Date and Time of code: _____ 911 called Y/N Time: _____

Diagnosis (pre-arrest): _____

Any pre-arrest intervention: _____

Condition at time of code activation: ☐ Unresponsive ☐Apnea ☐No Pulse ☐Gasping

Other _____

Resuscitation Measures

Start time of CPR _____ Duration: _____ min

Intubation given? Yes/No Time _____ LMA? Yes/No Time _____

Medication	Time/Dose	Time/Dose	Time/Dose	Time/Dose	Time/Dose	Time/Dose	Time/Dose
Epinephrine							
Lidocaine							
Atropine							
Diphenhydramine							
Dexamethasone							
Adenosine							

AED Shock/Time	Shock/Time	Shock/Time	Shock/Time

Vitals

Time	B/P	Pulse	P O_2	Respiratory	Temp.

Patient Transferred to: CTH CORONOR OTHER_____

AED Instructions

Standard protocol will be followed for using the AED.

Objective:

To provide an external method of restoring normal cardiac activity following cardiac fibrillation.

Procedure:

1. Prepare the patient
    a. Remove clothing from chest
    b. Make sure the skin is dry.
2. Place pads, that are connected to the AED, to the patient in the correct location.
3. Stop touching patient so AED can analyze patients heart rhythm.
4. AED will prompt if a shock should be delivered or not
5. AED will prompt when it is safe to touch the patient.
6. AED will continue with prompts on conducting CPR.

Note: All personnel should stand well away from the patient's table, bed, and stretcher.

Additional precaution includes being certain that the personnel operating the AED is not standing on a wet floor.

EKG MONITOR

Use either Lead II or Modified Lead

II (MCLI)

LEAD II

Rt. Shoulder (RA)
white (-)
Left Shoulder (LA)
black (+)
Rt. Thorax (LL)
Red (G)

Gives upright P and QRS

CARDIAC ARREST AND CARDIOPULMONARY RESUSCITATION

To assure safe care of the surgical patient.

PROCEDURE:

1. **The CRNA or Anesthesiologist will:**
   a) Announce emergency and lead the code
   b) Use an Ambu bag, LMA, intubate, or perform a tracheotomy to secure the airway
   c) Note the time of emergency intubation.
2. **The Surgeon will**
   a) Begin chest compressions (1st).
3. **The Circulating Nurse will:**
   a) Move the crash cart within reach of the CRNA and patient and set up suction.
   b) Draw up drugs as directed by the physician or CRNA.
   c) Assist/ follow the CRNA's/ surgeon's orders.
   d) Assist with external chest compression (3rd).
4. **Pre-op/post-op nurse**
   a) Record time of emergency, medications administered, dose and time, and results of CPR
   b) Assist with external chest compression when necessary.
5. **Surgical Assist will:**
   a) prepare the surgical site for transfer of patient.
6. **The Surgical Tech will:**
   a) Use AED as directed.
   b) Assist surgeon with cardiac compressions (2nd).
   c) Obtain any necessary supplies and assist the circulating nurse as necessary.
7. **Assistant Surgical Tech will**:
   a) Call 911 as directed.
   b) Remove all objects which could impede traffic flow upon arrival of ambulance unit.
   c) Inform front office personnel to prepare patient information for transfer.
   d) Assist with other patients or with Code as directed.
8. **If the patient is to be transferred:**
   a) Surgical Assist: Adequately secure and cover the surgical site.
   b) Circulating Nurse: Complete the nurses notes and code blue forms.
   c) Surgeon and CRNA: Prepare patient for transfer to hospital
   d) Front Office Personnel: Prepare copy of patient's records to accompany patient during transfer or send electronically to transfer facility. (See Transfer of Patient's Records)

EMERGENCY TRANSFER

POLICY:

It is the policy of Sierra Center for Foot Surgery to transfer a patient in the following situations:

1. Patients who have received CPR or require emergency treatment.
2. Patients with prolonged recovery, at the discretion of the surgeon.
3. Patients whose presenting medical condition is one Sierra Center for Foot Surgery is not equipped to handle.
4. Disasters, such as a fire, making the facility unsafe for patients and staff.

PROCEDURE:

The physician will be in charge of all emergency procedures and will perform or delegate some of the following:

1. Call Paramedics to request transportation for the patient.
2. Anesthetist- (Depending upon the surgery and patient status) secure the airway or wake patient if appropriate. Assist the doctor in making the patient medically ready for transport.
3. Surgeon: Depending on surgery status, suture or bandage the incision to keep the site from bleeding. Cover the surgical site with wet gauze dressing
4. Call hospital to prepare for the arrival of an emergency admission.
5. Notify the family of the patient if needed.
6. A copy of the medical record is to accompany the patient. See transfer of patient records for specific items. Also include any other information that may be of help in providing continuous care to the patient and information requested by the physician.
7. Notify the patient's personal physician depending on nature of the emergency and the significance of any change in the condition of patient.

TRANSFER OF PATIENTS RECORDS

POLICY:

Assistant Surgical Tech is responsible for notifying the medical receptionist of a patient transfer.

OBJECTIVE:

To provide appropriate patient record transfer for continuity of care.

PROCEDURE:

1. A copy of the following documents must accompany the patient or be promptly sent electronically to the receiving facility.

    a. Advance Directive
    b. Patient Information sheet
    c. Medication list, Problem List
    d. Any surgical clearance notes from Primary Care Physician
    e. Pre-op note.
    f. EKG if applicable.
    g. Insurance information

2. The physician should communicate with the receiving physician any significant operative findings.

3. This transfer will be fully explained to the patient, the patient's family, or other person(s) designated as having a significant authority as to the patient's welfare, prior to the transfer unless the delay caused by explanation protocol might cause further risk to the life and safety of the patient.

Surgical Patients Amazing Charts Prep in case of emergency transfer to another facility

If there is an emergency situation in the surgery center and a patient needs to be transported to Carson Tahoe by ambulance, we need to be prepared for a quick transfer of patient information. If this is going to occur, the front office staff will be notified by the Assistant Surgical Tech.

1. Make a folder in Amazing Charts where the required information can be uploaded and easily found.
2. No later than the day after the pre-op appointment the following items need to be scanned and uploaded into AC

    a. Advance Directive pre-op form

    b. Patient Information sheet

    c. Any surgical clearance notes from Primary Care Physician

    d. Pre-op note.

    e. EKG if applicable.

    f. Insurance information

3. The day of surgery, if a patient does provide an Advance Directive, promptly scan into their AC file as well as make a copy for the surgery chart.

4. Be familiar with the steps for retrieving the above information and how to fax it to CTH ER so that it can be done quickly.
5. Items to go with the patient and paramedics- Patient information sheet, copy of insurance card, code blue form, advance directive.

AMERICAN HEART ASSOCIATION

BLS Performance Criteria

Adult 1 -Rescuer CPR

Performance Criteria

Performance Guidelines:

1. Establish unresponsiveness. Activate the emergency response system.

2. Open the airway (head tilt-chin lift or jaw thrust). Check breathing (look, listen, and feel). *

3. If breathing is absent or inadequate, give 2 slow breaths (2 seconds per breath), ** ensure adequate chest rise, and allow for exhalation between breaths.

4. Check for carotid pulse and other signs of circulation (breathing, coughing, or movement in response to the 2 rescue breaths). If signs of circulation are present but breathing is absent or inadequate, provide rescue breathing (1 breath every 5 seconds, about 10 to 12 breaths per minute). **

5. If no signs of circulation are present, begin cycles of 30 chest compressions (rate of about 100 compressions per minute) followed by 2 slow breaths. **

6. After 4 cycles of compressions and ventilations (30:2 ratio, about 1 minute), recheck for carotid pulse and other signs of circulation. If no signs of circulation are present, continue 30:2 cycles of compressions and ventilations, beginning with chest compressions. If signs of circulation are present but breathing is absent or inadequate, continue rescue breathing (1 breath every 5 seconds, or about 10 to 12 breaths per minute). * **

   If the victim is breathing or resumes adequate breathing and no trauma is suspected, place in the recovery position.

   ** If mouth-to-mask or bag-mask ventilation is provided with supplementary oxygen, smaller tidal volumes can be used but the chest should still rise. If ventilation is provided and there is a pulse, monitor oxygen saturation (if available).

Adult Bag - Mask
Ventilation
Performance Criteria

Performance Guidelines:

1. Establish unresponsiveness. Activate the emergency response system.

2. Open the airway (head tilt-chin lift or jaw thrust). Check breathing (look, listen, and feel). *

3. If breathing is absent or inadequate, properly position the mask to achieve an effective seal while holding the airway open.

4. Give 2 slow breaths (2 seconds per breath), ensure adequate chest rise, and allow for exhalation between breaths. *

5. Check for carotid pulse and other signs of circulation (breathing, coughing, movement in response to the 2 rescue breaths). If signs of circulation are present but breathing is absent or inadequate, provide rescue breathing (1 breath every 5 seconds, about 10 to 12 breaths per minute).**

* If the victim is breathing or resumes adequate breathing and no trauma is suspected, place in the recovery position.

** If mouth-to-mask or bag-mask ventilation is provided **with supplementary oxygen,** smaller tidal volumes can be used but the chest should still rise. If ventilation is provided and there is a pulse, monitor oxygen saturation (if available).

Adult 2 -Rescuer CPR
Performance Criteria

Performance Guidelines:

1. Establish unresponsiveness. One rescuer should activate the emergency response system.

Rescuer 1

2. Open the airway (head tilt-chin lift or jaw thrust). Check breathing (look, listen, and feel). *

3. If breathing is absent or inadequate, give 2 slow breaths (2 seconds per breath), ensure effective chest rise, and allow for exhalation between breaths.**

4. Check for carotid pulse and other signs of circulation (breathing, coughing, movement in response to the 2 rescue breaths). If signs of circulation are present but breathing is absent or inadequate, provide rescue breathing (1 breath every 5 seconds, about 10 to 12 breaths per minute).**

Rescuer 2

5. If no signs of circulation are present, give cycles of 30 chest compressions (rate of about 100 compressions per minute) followed by 2 slow breaths given by Rescuer 1. * Start compressions after chest rise (inspiration) from second breath.

6. After 4 cycles of compressions and breaths (30:2 ratio, about 1 minute), Rescuer 1 delivers 2 rescue breaths and rechecks for signs of circulation (carotid pulse, normal breathing, cough, movement, or response to stimulation). * If no signs of circulation

   are present, continue 30:2 cycles of compressions and ventilations, beginning with chest compressions until an AED or emergency medical response team arrives.

* If the victim is breathing or resumes adequate breathing and no trauma is suspected, place in the recovery position.

** If mouth-to-mask or bag-mask ventilation is provided **with supplementary oxygen,** smaller tidal volumes can be used but the chest should still rise. If ventilation is provided and there is a pulse, monitor oxygen saturation (if available).

Responsive and Unresponsive, Rescue Breathing
Performance Criteria

Performance Guidelines:

1. Ask "Are you choking?" If yes, ask "Can you speak?" If no, tell the victim you are going to help.

2. Give abdominal thrusts (chest thrusts for victim who is pregnant or obese) with the proper hand position (avoid xiphoid).

3. Repeat thrusts until the foreign body is expelled or the victim becomes unresponsive.

Victim becomes Unresponsive (After Several Abdominal Thrusts)

4. Activate the emergency response system *(rescuer is alone).*

5. Open the airway with a tongue-jaw lift, look for the object, perform a finger sweep *(no object seen or removed).*

6. Open the airway (head tilt-chin or jaw thrust) and try to ventilate *(chest does not rise).* Reopen the airway (reposition head and chin) and try to ventilate again *(chest does not rise).*

7. Perform 5 abdominal thrusts using the proper hand position (avoid xiphoid) with the victim supine.

8. Open the airway with a tongue-jaw lift and look for the object *(object seen).* Perform a finger sweep *(object removed).*

9. Open the airway and try to ventilate *(chest rises).*

10. Check pulse and other signs of circulation *(signs of circulation present, victim beginning to move).*

11. Check breathing *(no breathing).*

12. Perform rescue breathing for several breaths *(victim begins breathing normally).*

13. If no trauma is suspected, place the victim in the recovery position.

CPR and AED Performance Criteria Performance Criteria

Performance Guidelines:

I. Establish unresponsiveness - direct coworker to activate the emergency response system and get the AED.

2. Open the airway (head tilt-chin lift or, if trauma is suspected, jaw thrust) - check breathing (look, listen, and feel).

3. If breathing is absent or inadequate, give 2 slow breaths (2 seconds per breath) that cause the chest to rise (if chest does not rise, reposition, reattempt). Allow for adequate exhalation time.

4. Check carotid pulse and other signs of circulation ***(no signs of circulation).*** Start chest compressions (ratio of 30: 2 breaths at 100 compressions per minute).

AED Skills (AED arrives after 2 cycles of CPR)

5. Place the AED next to the victim (near victim's left ear). POWER ON the AED and begin timing for collapse-to-shock interval.

6. Attach electrode pads in the proper position (as pictured on each of the AED electrodes, sternum and apex, with proper contact and no overlap of pads).

7. Clear the victim and press the ANALYZE button, if present. *(AED advises shock and charges electrodes.)*

8. Clear the victim and press the SHOCK button, if not automated. Stop timing for collapse-to-shock interval. (May repeat 1 to 2 more analyze-shock cycles. Stop when AED gives *"no shock indicated"* message).

9. Check carotid pulse and other signs of circulation. *(Pulse, breathing, coughing, movement present.)*

10. Continue to monitor breathing and signs of circulation until advanced life support rescuers arrive. (If trauma is not suspected, place the victim in the recovery position with AED attached.)

CRITICAL ACTIONS

- Assess responsiveness.
- Activate the emergency response system; get the AED (or send second rescuer).
- Open the airway, check breathing.
- If breathing is absent or inadequate, provide 2 breaths (must cause the chest to rise).
- Check pulse and other signs of circulation.
- Begin chest compressions (must have proper hand placement).
- When AED arrives: POWER ON the AED.
- Attach electrode pads to patient's bare chest in proper location with adequate skin contact and no overlap of pads.
- Clear the victim before ANALYZE and SHOCK.
- Push SHOCK button (if not automated) to attempt defibrillation.
- Check breathing and signs of circulation after *"no shock indicated"*
- Interval from collapse to first shock is less than 3 minutes; interval from AED arrival to first shock is less than 90 seconds.

Infant and Child 2-Rescuer CPR

Performance Criteria

Performance Guidelines:

1. Establish unresponsiveness. One rescuer activates the emergency response system.

Rescuer 1

2. Open the airway (head tilt-chin lift or jaw thrust). Check breathing (look, listen, and feel). *

3. If breathing is absent or inadequate, give 2 slow breaths (1 to 11/2 seconds per breath), ensure adequate chest rise, and allow for exhalation between breaths.

4. Check for pulse (brachial in infants, carotid in children) and other signs of circulation (breathing, coughing, or movement in response to 2 rescue breaths). If signs of circulation are present but breathing is absent or inadequate, provide rescue breathing (l breath every 3 seconds, about 20 breaths per minute).

Rescuer 2

5. If no signs of circulation are present, or heart rate is less than 60 bpm with signs of poor perfusion, begin cycles of 5 chest compressions and 1 breath. Pause to allow Rescuer 1 to provide 1 slow breath after 5 compressions. * Start compression at end of chest rise from rescue breath.
   a. *Infants: use 2 thumb-encircling hands compression technique, compression rate of at least 100 per minute.*
   b. *Child: typically use 1 -hand compression technique, compression rate of about 100 compressions perminute.*

6. After 20 cycles of 5:1 (about 1 minute), Rescuer 1 provides 1 breath and rechecks for signs of circulation (pulse, breathing, cough, movement, response to stimulation). * If no signs of circulation are present, continue cycles of compressions and ventilations (5:1 ratio), beginning with chest compressions.

* If the victim is breathing or resumes adequate breathing and no trauma is suspected, place in the recovery position.

Child 1-Rescuer CPR Performance Criteria

Performance Guidelines:

1. Establish unresponsiveness. If a bystander is available, send that person to activate the emergency response system.

2. Open the airway (head tilt-chin lift or jaw thrust). Check breathing (look, listen, and feel). *

3. If breathing is absent or inadequate, give 2 slow breaths (1 to 1 ½ seconds per breath), ensure adequate chest rise, and allow for exhalation between breaths.

4. Check for carotid pulse and other signs of circulation (breathing, coughing, or movement in response to initial 2 rescue breaths). If signs of circulation are present but breathing is absent or inadequate, provide rescue breathing (1 breath every 3 seconds, about 20 breaths per minute). *

5. If no signs of circulation are present, or heart rate is less than 60 bpm. with signs of poor perfusion, begin cycles of 15 chest compressions (typically 1-hand compression technique, rate of about 100 compressions per minute) and 1 slow breath.

6. After about 1 minute of rescue support, check for signs of circulation. * If rescuer is alone, activate the emergency response system. If no signs of circulation are present, continue 15:1 cycles of compressions and ventilations. If signs ofcirculation are present but breathing is absent or inadequate, continue rescue breathing (1 breath every 3 seconds, about 29 breaths per minute).

* If the victim. is breathing or resumes adequate breathing and no trauma issuspected, place in the recovery position.

Child Bag-Mask Ventilation
Performance Criteria

Performance Guidelines:

1. Establish unresponsiveness. If a second rescuer is available, send that person to activate the emergency response system.

2. Open the airway (head tilt-chin lift or jaw thrust). Check breathing (look, listen, and feel). *

3. If breathing is absent or inadequate, properly position the mask to achieve an effective seal while holding the airway open.

4. Give 2 slow effective breaths (1 to 1½ seconds per breath), ensure adequate chest rise, and allow for exhalation between breaths.

5. Check for carotid pulse and other signs of circulation (breathing, coughing, or movement in response to 2 breaths). If signs of circulation are present but breathing is absent or inadequate, provide rescue breathing (1 breath every 3 seconds, about 20 breaths per minute).

6. If no signs of circulation are absent, or heart rate is less than 60 bpm with signs of poor perfusion, begin 5:1cycles of compressions and ventilations. If the rescuer is alone, activate the emergency response system after approximately 1 minute.

* If the victim is breathing or resumes adequate breathing and no trauma is suspected, place in the recovery position.

Child FBAO in Responsive Victim

(and Responsive Victim Who Becomes Unresponsive)

Performance Criteria

Performance Guidelines:

1. Ask "Are you choking?" If yes, ask "Can you speak?" If no, tell child you are going to help

2. Give abdominal thrusts using proper hand position *avoid xiphoid).

3. Repeat thrusts until object is expelled (obstruction removed) or victim becomes unresponsive.

Child Foreign-Body Airway Obstruction-Victim Becomes Unresponsive

4. If a second rescuer is available, send that rescuer to activate the emergency response system while you remain with the victim.

5. Open the airway with a tongue-jaw lift. If you see the object, remove it *(no blind finger sweeps).*

6. Open the airway (head tilt-chin-lift or jaw thrust), attempt rescue breathing; if no chest rise, reopen the airway (reposition head and chin) and try to ventilate again.

7. If ventilation is unsuccessful, provide 5 abdominal thrusts with the victim supine (use proper hand position, avoiding the xiphoid).

8. Repeat steps 5 through 7 until effective, then provide additional steps of CPR as needed. *

9. If rescuer is alone and airway obstruction is not relieved after about 1 minute, activate the emergency response system.

* If the victim is breathing or resumes adequate breathing and no trauma is suspected, place in the recovery position.

Child FBAO in Unresponsive Victim Performance Criteria

Performance Guidelines:

1. Establish unresponsiveness. If a second rescuer is available, send that rescuer to activate the emergency response system while you remain with the victim.

2. Open the airway (head tilt-chin lift or jaw thrust). and check for breathing. If breathing is absent or inadequate, go to step 3.

3. Attempt to ventilate; if unsuccessful (chest does not rise), reopen the airway (reposition head and chin) and try to ventilate again.

4. If ventilation is unsuccessful, perform up to 5 abdominal thrusts with the victim supine (use proper hand position, avoid xiphoid).

5. Open the airway with a tongue-jaw lift. If you see the object, remove it *(no blind finger sweeps).*

6. Repeat steps 3 through 5 until ventilation is effective, then continue the steps of CPR as needed. *

7. If rescuer is alone and airway obstruction is not relieved after about 1 minute, activate the emergency response system.

* If the victim is breathing or resumes adequate breathing and no trauma is suspected, place in the recovery position.

RATIONALE AND USE OF CRITICAL INDICATORS

A critical indicator report should be used to alert appropriate staff that a patient, visitor or employee has been injured, or that a patient is dissatisfied with the service received and or perceives he or she has been injured. Neither fault nor the presence or extent of the injury need to be determined to institute a critical indicator report. The critical indicator report is simply a tool to gather all of the facts on any situation that may have potential for future action. Obtaining accurate facts is possible only when the incident is fresh in everyone's mind.

The critical indicator report has several positive uses. For the Doctor, the report is the first step in the identification process which allows intervention and correction of the event. The report allows him to evaluate the educational needs of the employee and to correct possible deficiencies in education and or orientation.

It is extremely important that no punitive action be taken as a result of a critical indicator report. Employees who are fearful of punitive actions will not report an incident unless circumstances force them to doso.

Perhaps the greatest value of the report is noting potential problems that didn't cause damage this time, but may have serious consequences the next time it happens. A good rule of thumb is anytime one feels that he was just "lucky" and something worse didn't happen, a critical report is probably needed.

In order to obtain maximum benefit from the reports, it is important for your office staff to understand:

1. What constitutes an incident.
2. Steps to be taken once an incident has occurred.
3. What hazards are present or inherent in the system.

Critical Indicator Report

Provide the following information regarding the patient or visitor involved.

Name: _____ Age: _____ Sex: _____

Address: _____ Phone No. _____ Date of incident: _____ Time of incident: _____ Exact Location of Incident: _____

Diagnosis: _____ Surgical Procedure: _____ List any pertinent medication(s)

Time administered: _____ Time patient states ingested: _____

Witness Name: _____ Address: _____

Witness Name: _____ Address: _____

Describe in sequence what happened:

List any equipment involved:

(Include mfg., serial no., and company representative notified)

List steps taken to assist person involved in incident:

Action taken to prevent recurrence:

Podiatrist's statement regarding condition of person involved after the incident:

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Person preparing report:

Name: _____ Position: _____

Home address: _____

DEATH

In case of death of a patient in Sierra Center for Foot Surgery.

Immediately:

- Notify medical director.
- Notify any referring physician.
- Notify family and DORS.
- Coroner
- Since any death outside of a family home is considered unnatural, except for case of suicide, it is the coroner's responsibility to decide if an autopsy is required.
- Continue to treat patient with respect and dignity.
- Valuables, if present, are secured by the director of surgical services for release to family members.
- The body will be released when permission is given by the coroner to either the family's choice of mortuary or coroner's mortuary of the month.
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All documentation provided by the coroner will be properly filled out by Sierra Center for Foot Surgery staff and medical director including:

- Certificate of death.
- Body release.
- Autopsy request or denial.