Physicians' Surgery Center of Nevada

POLICIES & PROCEDURES
Facilities and Environment
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SUBJECT: GENERAL	REFERENCE #8001
DEPARTMENT: FACILITIES AND ENVIRONMENT	PAGE: 1 OF: 1
	EFFECTIVE: 5/11/2016
APPROVED BY:	REVISED:

POLICY:

The ASC will be properly equipped, and the appropriate staff will correctly maintain and test the equipment on a regular basis. Both equipment and supplies will be adequate in quantity and properly located throughout the ASC to be readily available for patients' needs. The building and/or staff will provide for the issues described in procedures below.

PROCEDURE:

1. All patient areas (Bathrooms, patient bays, operating/procedure rooms, and reception area) will be constructed and maintained to promote the highest level of privacy possible for patients.
2. Staff will make reasonable provisions to accommodate disabled individuals.
3. The ASC Director will ensure appropriate staff and the Biomedical Technician will properly test and maintain the center's equipment.
4. All appropriate staff members will be in-service trained in the use of the emergency response equipment. This equipment is readily available to the staff.
5. The ASC Director or designee will maintain stock levels of supplies and, where appropriate, set reorder points. He/she will reorder replacement stock in sufficient time to replenish depleted on-hand provisions. Supplies will be pre-positioned to provide convenience when needed.
6. Parking is marked and adequate with Handicap access as required.
7. Temperature and Humidity will be monitored in each Operating Room, PACU/Admit/ Medication storage area daily.
8. All staff will assume responsibility to preserve a clean facility and keep all equipment and systems properly maintained and serviceable. Facility construction will provide adequate lighting and ventilation throughout the entire center.
9. The infection control program will address issues minimizing sources and transmission of infection.
10. Nourishment, when provided to meet the clinical needs of patients, will be stored, prepared, served and disposed of in compliance with local health department requirements.
11. The Center will keep a maintenance contract with a local pest control company and provide all reasonable measures to avoid the incursion of pests.
    A. Self-closing doors, closed windows, screens, controlled air currents or other effective means will protect all openings to the outside air against an invasion of insects, rodents, or any other unwanted vermin.
    B. The contracted Pest Control company will arrange to have the facility inspected monthly.

SUBJECT: EMERGENCY POWER	REFERENCE #8002
DEPARTMENT: FACILITIES AND ENVIRONMENT	PAGE: 1 OF: 1
	EFFECTIVE: 5/11/2016
APPROVED BY:	REVISED:

POLICY:

The ASC will provide an emergency power generating system for use when the public power system fails.

PROCEDURE:

1. A licensed inspector will test and inspect the generator and automatic transfer switching system regularly.
2. All faceplates of electrical outlets on the emergency power system will be appropriately marked for ease of identification.
3. ASC personnel will maintain and periodically test an emergency lighting grid in the facility. This lighting system will permit the staff to function in emergencies and enable safe building evacuation by patients and staff should the need arise. The light will illuminate the procedure rooms, hallway, nurses' station, and PACU.
4. The generator set(s) shall have sufficient capacity to pick up the load and meet the minimum frequency and voltage stability requirements of the emergency system within 10 seconds after the loss of power.
5. Facility managers will maintain the generator set(s) and associated equipment, including all appurtenant parts, to be capable of supplying services within the 10-second interval. Maintenance shall be performed in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Chapter 6.
   A. Appropriate staff shall test the generator set(s) 12 times a year, with testing intervals not less than 20 days or exceeding 40 days.
   B. The scheduled test under load conditions shall include a complete simulated cold start and appropriate automatic and manual transfer of all essential electrical system loads.
   C. Competent personnel shall conduct the scheduled tests. The needed tests keep the machines ready to function, serve to detect causes of malfunction, and provide training for staff in operating procedures.
   D. ASC staff will keep a written record of all inspections, generator set(s), performance, exercising period, and repairs.

PHYSICIANS' SURGERY CENTER OF NEVADA

SUBJECT: LOCAL, STATE, FEDERAL & LIFE SAFETY CODE OF 2000, BUILDING CODES & REGULATIONS	REFERENCE #8003
	PAGE: 1 OF: 2
DEPARTMENT: FACILITIES AND ENVIRONMENT	EFFECTIVE: 5/16/2018
APPROVED BY:	REVISED: 1/27/2021

POLICY:

The Board of Directors of Physicians' Surgery Center of Nevada has contracted and built a structure to house the ASC, which complies with all applicable requirements enumerated in the subject above. Furthermore, it is the Board's policy to provide oversight, which assures ongoing compliance with these requirements.

PROCEDURE:

1. The terms of the architectural development and construction contracts require both design and construction to meet all local, state, federal, and life safety codes and regulations.
2. Both occupancy and state licensure inspections have validated compliance with items listed above.
3. Center management will invite the local Fire Marshal to make annual inspections to assure a fire safe facility.
4. Competent personnel will inspect all facility firefighting equipment and systems routinely. He/she will certify these as current with applicable local and state requirements.
5. The Center management has established a service contract to maintain the fire alarm system and illuminated fire exit signs in good working order. (Agreements Binder)
6. Appropriate staff will inspect, test and certify the facility sprinkler system is in working order.
7. Competent personnel will inspect, exercise, and certify the emergency power generator on a regularly scheduled basis. This task ensures the emergency lighting, is appropriate to the facility, and provides enough illumination for adequate evacuation of patients and staff if needed.
8. All staff will participate in regular fire drills. Management will evaluate and document both staff and facility systems' performance of these drills. Managers will conduct special training to address any identified deficiencies.
9. Automatic fire doors protect all stairwells and code required hallways.
10. Annually competent personal will test all magnetic door- releasing devices on the surgical doors and will document when and whom conducted the test. (NFPA 72-2010: Table 14.4.5)
11. Annual testing of the automatic smoke-detection shutdown for the air-handling equipment will be conducted by appropriate vendor/agency.

Interim Life Safety Measure (ILSM)

1. An Interim Life Safety Measure will be implemented when Life Safety Code deficiencies cannot be immediately corrected. An Interim Life Safety Measure may also be implemented during times of Construction. An ILSM is necessary any time the requirements of the Life Safety Code cannot be met by the ASC.

2. The ASC will utilize a Construction Risk Assessment as an aid in determining when an ILSM is warranted.
3. When the ASC identifies a Life Safety Code deficiency that cannot be immediately corrected or when construction activities could lead to a severe safety issue, action will be taken. The actions may include
   A. Initialing a Fire Watch—when the fire alarm system is out of service for more than four out of 24 hours, a sprinkler system is out of service for more than 10 hours is a 24-hour period. Fire watch times will be documented.
   B. Posting Signage and/or an ILSM Memo—to inform staff and public of an alternative exit or to warn of a minor Life Safety deficiency such as a sprinkler head that needs repair.
   C. Daily Inspections of Affected Areas—such as exits that could be blocked by construction workers, construction supplies, or rehab building materials
   D. Providing a temporary fire alarm system when a fire system is impaired—In this case the ASC would most likely shut down operations. If the fire system is impaired, a Life Safety expert would be contacted for possible solutions.
   E. Providing additional Firefighting Equipment—additional fire extinguishers may be provided when construction materials pose a fire risk
   F. Provide smoke-tight temporary construction partitions made of noncombustible or limited-combustible material—to use during construction if a fire wall is compromised by the construction.
   G. Increased surveillance of the building—Construction areas will be checked for proper storage of materials and visible safety concerns; storage, housekeeping and debris-removal will be inspected to reduce building's flammable and combustible fire load.
   H. Additional Fire Response Training—Staff are trained annually on the use of fire extinguishers but will have refresher training during periods of construction. An additional quarterly fire drill will be conducted. Special education will be given to the staff concerning possible construction items that could lead to a fire
   I. Inspects and tests temporary systems monthly
   J. Additional training on building deficiencies, construction hazards, temp measures
   K. Training for impaired structural or compartment fire safety features

12. Although many of the above strategies may be used during small construction projects or minor Life Safety Deficiencies, any large-scale construction project or serious Life Safety deficiency will be evaluated carefully by the Governing Board as to whether the ASC should remain open. With the limited resources of the ASC, the Governing Board will most likely choose to close the center until the construction is completed or the Life Safety Deficiency is repaired.

PHYSICIANS' SURGERY CENTER OF NEVADA

SUBJECT: HANDICAPPED PERSONNEL	REFERENCE #8004
DEPARTMENT: FACILITIES AND ENVIRONMENT	PAGE: 1 OF: 1
	EFFECTIVE: 5/11/2016
APPROVED BY:	REVISED:

POLICY:

The Center will take all reasonable steps to accommodate disabled/handicapped personnel.

PROCEDURE:

1. The facility will provide Handicapped parking, properly marked and consistent with local codes.
2. Building entrances and exits will be wheelchair accessible.
3. Handicapped designed and equipped restrooms will be conveniently accessible.

SUBJECT: HAZARDOUS WASTE	REFERENCE #8005
	PAGE: 1 OF: 1
DEPARTMENT: FACILITIES AND ENVIRONMENT	EFFECTIVE: 5/11/2016
APPROVED BY:	REVISED:

POLICY:

Center management will devise and conduct a hazardous waste program consistent with a documented plan prepared by the ASC Director and approved by the Board. This plan will address concerns associated with hazardous waste and materials, (solid, liquid, or gas), of all types normally found in an ASC, and will serve to protect both patients and staff.

PROCEDURE:

1. The ASC Director will prepare an ASC hazardous waste plan and submit it to the Board of Directors for approval prior to any procedures on patients conducted in the Center.
2. Documentation for this plan is in the ASC's OSHA manual.

SUBJECT: SAFETY	REFERENCE #8006
DEPARTMENT: FACILITIES AND ENVIRONMENT	PAGE: 1 OF: 5
	EFFECTIVE: 5/11/2016
APPROVED BY:	REVISED:

POLICY:

This plan is for patient safety, to outline the framework by which leadership and inter-disciplinary staff creates, implements, and monitors proactive efforts in improving patient care and reducing medical errors.

All staff shall participate in identifying risks involving patient safety and make suggestions to reduce medical/healthcare errors. The plan specifies processes by which operational responsibility for assuring activities related to patient safety performed within the center are coordinated, objective-oriented, and effective.

1. The ASC management has established a coordinated, organization-wide, and proactive patient safety program, which encompasses the patient, the environment, staff, physicians, visitors, and families. Leadership ensures the allocation of financial, informational, physical, and human resources to improvement activities. These activities are regularly evaluated to ensure the resources are adequate and meet the established goals.
2. This plan, its function, and communication structure are integrated into the Quality Management Plan and duties. The ASC leadership has taken the responsibility of building an environment dedicated to continually improving patient safety and reducing errors in a blame-free culture.
3. The functions within the structure cover all aspects of patient safety. Essential communication and collaboration occur on a daily, if not hourly, basis between the important functions of Quality Management and patient safety.
4. A report, generated quarterly, to the governing body on the occurrences of medical/healthcare errors and actions taken to improve patient safety, both in response to episodes and proactively.

DEFINITIONS:

A. Safety**:** Patient is free from accidental injury.

B. Error**:** Practitioner's failure to complete a planned action as intended. Additionally, staff use of a wrong plan to achieve a desired outcome.

C. Unanticipated Outcome**:** Results of a treatment or procedure differing significantly from those anticipated. Generally, this refers to a sentinel event.

PROCEDURE:

1. Authority, Responsibility and Accountability

A. The Board authorizes the implementation of a Patient Safety Program articulating patient safety as a specific intention and promotes an environment that moves beyond blame.

B. The Quality Management Committee will administer the plan. Additionally, the Quality Management Committee will provide the leadership, plan, goals and objectives as well as quarterly reports to the Board.

C. The Board supports and endorses patient safety as a top leadership priority and strategic goal, including the identification and management of sentinel events.

D. The Board will allocate resources for measuring, assessing, and improving performance and for patient safety initiatives. These resources include finance, education, the allocation of time, provision for information systems & data management processes informing ongoing Quality Management, and for improvement of patient safety.

2. <u>Blame-Free Environment</u>

A. We recognize human errors may be symptoms of underlying system flaws and do not necessarily represent personal failures.

B. Organizationally, we embrace the concepts of a blame-free environment, which includes, but is not limited to:

I. Recognizing employees practicing at our facility do not purposely seek to create errors.

II. Realizing often, errors occur because of ineffective, improperly designed, or flawed systems.

III. Reporting is the norm. Employees learn everyone is a valuable member of the team and are obligated to speak up for patient safety.

IV. There is no retribution for raising concerns or reporting errors in good faith.

V. A blame-free environment rewards rather than disciplines good faith reports of errors or variations.

VI. Successes are celebrated.

VII. Staff providing empathetic support for healthcare workers involved in unanticipated outcomes, including management support.

3. <u>Goals</u>

A. Keep overall patient satisfaction at 95% or better as measured by patient satisfaction surveys and or follow up phone calls.

B. Improve service/outcome in at least one clinical indicator.

C. Enhance patient safety and reduce adverse outcomes through education and further development of a blame-free culture. Practitioners and directors focus on processes and encourage the reporting of any errors or unanticipated outcomes.

D. Present educational programs on patient/staff safety.

E. Maintain continuous state, Medicare and accreditation readiness.

F. Continue to recognize opportunities to integrate and standardize processes and methodology to benefit all patients served.

G. Provide a mechanism for informing patients about unanticipated outcomes of their care.

4. Patient Safety Objectives

A. Reduce burden of illness, injury, and disability and improve health and functioning of our patients.

B. Make healthcare at our facility safe, effective, patient-centered, timely, efficient, and equitable.

C. Establish monitoring and tracking processes to evaluate the progress of the organization in pursuit of these goals.

D. Implement state-of-the-art approaches to redesign care processes based on best practices:

E. Use information technologies; promote knowledge & skills management; develop effective teams; coordinate care across conditions, services & settings over time; and incorporate performance & outcome measurement for improvement and accountability.

F. Make scientific evidence more useful and accessible to clinicians and individuals with journals and other current resource information.

G. Build an information infrastructure to support patient care delivery, consumer health, quality measurement and improvement, public accountability, clinical and health services research, and clinical education.

H. Include records of unanticipated adverse events in criteria to prioritize opportunities for improvement during planning processes.

I. Consider patient safety in all design and redesign initiatives.

5. Safe Medication Practice

A. Evaluating and taking action when appropriate to improve safety within the scope of medication usage has been added to the functions of the Quality Management Committee.

B. The organization's acting pharmacist is a standing member of the Quality Management Committee and safe medication practices is a standing agenda item.

C. The main responsibility is to continuously evaluate and re-engineer the medication use process retrospectively, concurrently, and prospectively. This continuous evaluation assures safety, accuracy, and prevention of medication mistakes, with a focus on risk assessment, efficient use of resources and information sharing.

6. Staff and Physicians

A. The center management has created a blame-free environment.

B. All personnel are encouraged to report, not just on defined incidents, but also on anything they believe is inappropriate or could be a risk to patient safety.

C. Management will take action and trends noted & documented for all occurrences.

D. The Center's New Employee Orientation will cover patient safety.

E. All topics are part of the curriculum for yearly, mandatory education. These topics include:

I. Medical error reduction.

II. Reporting of errors, incidents, or quality concerns.

III. Blame-free culture.

IV. Team dynamics.

7. Patients, Families and Visitors

A. Patients and families are a vital part of the safety program. We encourage patients to participate in their own care and the safe provision of that care in all aspects.

8. Management and Reporting of Errors

A. When staff members discover an error, patient safety comes first.

B. Practitioners should make every effort to correct the error.

C. Appropriate staff should assess and care for the patient immediately, then notify the physician, and complete an incident report for Risk Management.

Disclosure

1. Unanticipated Outcomes

A. Informing patients and/or families about outcomes of care including unexpected outcomes is an established process. We have formally added this to our patient rights.

B. The appropriate treating physician will disclose information about unanticipated outcomes, such as those reviewable under the Incident Report policy, to the patient and his/her family.

C. Due consideration is given to confidentiality guidelines and fulfillment of our ethical responsibility to cultivate and demonstrate organizational commitment to patient safety and to the community we serve.

D. For unanticipated outcomes related to non-physician care, the Medical Director/ASC Director will disclose information to the patient and/or family after discussion with the appropriate treating physician and Risk Management.

E. Administrative personnel are involved as needed and appropriate to ensure disclosure of information to the patient in a timely manner.

F. When the outcome involves a minor patient, or incompetent adult, the primary obligation of disclosure is to the legal guardian; however, the patient will be included in the

discussions of the event to the extent of his/her capacity as determined by the parent/guardian with the advice of the healthcare team.

2. **Confidentiality of Peer Review Process**

   A. Recognizing the discussion of complete, prompt, and truthful disclosure outlined in this policy and the benefits of such disclosure, we also recognize the benefits of maintaining the confidentiality of peer review documents and processes. This is necessary to encourage openness and participation in these processes to advance patient safety and quality of care. For this reason, we maintain the confidentiality of peer review documents and processes while providing complete, prompt, and truthful information to patients.

3. **Other Confidentiality Issues**

   A. To maintain the privacy of patients/families and staff members, those discovering, involved in investigations, or communicating with patients or parents, should treat information about occurrences as confidential.

   B. After initial action to ensure the patient's safety, any involved party in any occurrence should discuss the incident with, or report to the ASC Director.

   C. Those not directly involved in the response to, investigation of, or communication with families about accidents, should NOT discuss identified details with anyone.

   D. De-identified reports or case studies which have been stripped of patient or staff identifiers can be discussed for educational purposes.

4. **Communication and Operational Plan**

   A. The Quality Management Committee, through the initiation of pro-active risk rounds works with clinical staff encouraging communication and cooperation to implement effective ways of improving patient safety.

   B. Information discussed during the rounds could include any item collected from Letter A (above), but always includes incidents, patient complaints, and quality referrals.

   C. The rounds will help the staff identify trends and develop action plans to improve patient safety.

   D. All staff members are encouraged to report any observed incidents.

   E. Quality Management and patient safety are standing agenda items for the Board.

PHYSICIANS' SURGERY CENTER OF NEVADA

SUBJECT: SMOKING	REFERENCE #8007
	PAGE: 1 OF: 1
DEPARTMENT: FACILITIES AND ENVIRONMENT	EFFECTIVE: 5/11/2016
APPROVED BY:	REVISED:

POLICY:

This ASC is a non-smoking facility.

All staff will have responsibility to help enforce the policy by courteously and diplomatically informing visitors of the Center's smoke-free policy. Compliance is expected and Center personnel will seek observance of the stated policy with compassion, and by using tact, diplomacy, and appropriate judgment. This includes all tobacco products, and E-Cigarettes as well.

PROCEDURE:

1. Director will place appropriate signage in public areas informing patients, family members, visitors, and staff of this policy.
2. The ASC is committed to the promotion of health. For this reason and for the comfort of people who are nonsmokers, **smoking is prohibited** on Center property, including the parking area.
3. All visitors, employees, volunteers, and physicians are required to refrain from smoking while on Center property. There will be no changes in "break time" to accommodate any employee's smoking habit.

SUBJECT: SAFETY INSPECTIONS	REFERENCE #8008
DEPARTMENT: FACILITIES AND ENVIRONMENT	PAGE: 1 OF: 1
	EFFECTIVE: 5/11/2016
APPROVED BY:	REVISED:

POLICY:

The ASC will have monthly Environment of Care inspections.

PROCEDURE:

1. Staff designated by the ASC Director will conduct safety inspections on a monthly basis.
2. The inspection will focus on compliance with regulatory requirements (i.e. fire, electrical, general safety, and cleanliness for infection control).
3. The inspection staff team will report their results to the Director.
4. The ASC Director or designee will evaluate staff knowledge of emergency procedures, universal precautions, OSHA regulations, and other pertinent issues on a random basis.
5. The Quality Management Committee and Governing board will receive the results of the safely inspections and random evaluations.
6. The ASC Director will be responsible for ensuring any affected staff will implement corrective action, or procedural changes take place when needed.

PHYSICIANS' SURGERY CENTER OF NEVADA

Infection Control/Environmental Rounds

AREA INSPECTED:	**DATE:**	**INSPECTOR:**

C = Compliant; NC = Not compliant; CAC = Corrective action completed; FU = Follow-up required; NA = Not applicable

Criteria	**C**	**NC**	**Finding or Comment**	**CAC**	**FU**	**NA**
Patient Bays:						
Floors & walls clean						
Walls are free of breaks and penetrations						
Bathroom clean						
Sink clean						
Furniture clean and in good condition						
Gloves, PPE, available as per policy						
Barriers used appropriately						
Cubicle curtains clean and free of tears, etc.						
Treatment/Laser/Examination Rooms:						
Floors & walls clean						
Countertops clean						
Furniture clean and in good condition						
Gloves, PPE, available as per policy						
Clean and Dirty Utility & Storage Rooms:						
Adequate separation of clean & soiled						
Floors and walls clean						
No supplies stored on the floor						
Supplies stored 6” from floor						
Supplies stored 18” from ceiling						
No supplies stored under sinks						
No supplies stored in bathrooms, soiled utility rooms						
Supplies stored away from windows, vents						
Shelving/drawers/cabinets clean						
Soiled linen is bagged & placed in transport truck						
Hallways:						

PHYSICIANS' SURGERY CENTER OF NEVADA

Infection Control/Environmental Rounds

Criteria	C	NC	Finding or Comment	CAC	FU	NA
Floors and walls clean						
Free of obstruction and equipment						
Equipment & Non-Critical Items:						
Equipment in patient use clean						
Equipment stored is clean						
Linen:						
Clean linen stored on shelves or carts						
Soiled linen not placed on floor, furniture, etc.						
Soiled linen contained in bags, not overfilled						
Linen hampers & carts covered						
Linen hampers & carts clean & in good condition						
Offices, Work Stations & Reception Areas:						
Carpeting clean						
Desks clean and free from unnecessary clutter & food items						
Office equipment clean & free from clutter						
Floors free of clutter & trash						
Food only in designated areas						
Kitchen/Lounge/Meeting Rooms:						
Floors clean						
Empty cups & food items placed in trash						
Furniture clean & in good condition						
Refrigerator clean						
Waste Management:						
Waste containers not overfilled						
Waste containers clean, operational, & in good condition						
Waste containers covered as required						
Sharps containers available						
Sharps containers not over 75% filled						
Sharps containers secured appropriately						
Other Housekeeping Issues:						
Hand-washing sink is available						
Hand towels are available						

PHYSICIANS' SURGERY CENTER OF NEVADA
Infection Control/Environmental Rounds

Criteria	C	NC	Finding or Comment	CAC	FU	NA
Hand towel dispenser available/operable						
Hand-washing solution is available						
Soap is appropriate for area/unit						
Hand-washing solution dispenser available/operable						
Waterless soap is available to the staff						
No bar soap						
Area free of roaches, flies, mice & other vermin						
Tubs/showers are clean						
Vent grills clean						
Janitor's closet clean, all off the floor, mops hanging over sink						
MSDS for all cleaning chemicals						
Patient Nourishment:						
Floors & walls clean						
No expired juice/milk, etc.						
Ice machine clean						
Refrigerators:						
Daily checklist completed for temperatures						
Correct temp observed: Food & drink, 36-45° F						
Correct temp observed: Medications, 36-46° F						
Correct temp observed: Freezers, ≥32° F						
Only medications in medication refrigerator						
Only food in food refrigerator						
Patient food & staff food not mixed						
Refrigerator clean						
Items labeled as per policy						
Medications:						
Medications and IV's are inventoried for expiration/ proper labeling						
Open vials dated and timed as per policy						
Medication carts clean and organized						
Miscellaneous:						
Hand-washing observed when appropriate						
Ceiling tiles are clean and in good condition						
Ceiling is free of holes and penetrations						
Disaster, evacuation, fire, infection control						

PHYSICIANS' SURGERY CENTER OF NEVADA

Infection Control/Environmental Rounds

Criteria	C	NC	Finding or Comment	CAC	FU	NA
Area free of water leaks or spills						
Specimens being bagged, handled, labeled as per policy						
PPE, Safety devices available						
Grounds:						
Clean & free of trash						
Building walls free of penetrations						
Disinfection/Sterilization:						
Appropriate solutions available for soaking						
Appropriate containers available						
Containers clean, covered, labeled as required						
Instruments/devices being processed correctly						
Sterilizers clean						
Sterilizers functioning properly						
Sterilizer preventive maintenance available						
Sterilization parameters maintained						
Chemical/Biological monitors used as per policy						
Sterilization records/documentation complete						
Date of last Fire Drill						
Date of last Disaster Drill			Type:			
Emergency Generator tested?						
Are evacuation routes posted?						
Are fire extinguishers tagged/charged/ checked monthly?						
Are Biomed checks done on time, equipment marked?						
Have all new equipment been checked prior to patient use?						
Are exit and parking lot lights working?						
Has any equipment been logged in/out for repairs?						
Any incident reports concerning physical plant, equipment, or safety maintenance?						
CORRECTIVE ACTIONS:						

PHYSICIANS' SURGERY CENTER OF NEVADA

Infection Control/Environmental Rounds

Criteria	C	NC	Finding or Comment	CAC	FU	NA

PHYSICIANS' SURGERY CENTER OF NEVADA

Drill Assignment

What Kind of Drill	When	Employee Responsible
Monthly EOC	January	
	February	
	March	
	April	
	May	
	June	
	July	
	August	
	September	
	October	
	November	
	December	
External Disaster (Semiannually)	#1	
	#2	
Mock Code (Semiannually)	#1	
	#2	
Fire Drill (Quarterly)	First Quarter	
	Second Quarter	
	Third Quarter	
	Fourth Quarter	
Internal Spill (Semiannually)	#1	
	#2	
Emergency Management		

PHYSICIANS' SURGERY CENTER OF NEVADA

SUBJECT: DAILY INSPECTION LOG POLICY	REFERENCE #8009
	PAGE: 1 OF: 1
DEPARTMENT: FACILITIES AND ENVIRONMENT	EFFECTIVE: 5/11/2016
APPROVED BY:	REVISED:

POLICY:

The ASC temperatures, humidity, and eye wash stations will be monitored and recorded in a log for safe levels every day.

PROCEDURE:

1. An assigned staff member will fill out this form daily.
2. The monitoring staff member will report any abnormalities to the Center Director.
3. The Center Director will report results to the Quality Management Committee.

PHYSICIANS' SURGERY CENTER OF NEVADA

Date Beginning_____

Daily Inspection Log

	Saturday	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday
Refrigerator Temp	WNL 36-46 F/ 2-8 C						
Medication #1							
Medication #2							
Freezer (WNL -20°C or colder)							
Food							
Room Temperature	WNL 68-72 °F						
OR #1							
OR #2							
Supply Room							
Medication Room							
Humidity Levels	WNL 20-60 °F						
OR #1							
OR #2							
Supply Room							
Medication Room							
Blanket/Fluid Warmer	--Fluids are dated with an expiration date 14 days from placement in warmer						
Upper/Fluids Max 104°F							
Lower/Linen Max 130 °F							
Exit Signs							
OR Hallway							
Outside Manager Office							
Eye Wash Station Flush 3minute min							
RN INITIALS							

PHYSICIANS' SURGERY CENTER OF NEVADA

SUBJECT: BROKEN EQUIPMENT	REFERENCE #8010
DEPARTMENT: FACILITIES AND ENVIRONMENT	PAGE: 1 OF: 1
	EFFECTIVE: 5/11/2016
APPROVED BY:	REVISED:

POLICY:

Employees at the ASC will take responsibility to ensure all broken equipment is properly tagged for repair and/or removal from their area.

PROCEDURE:

1. Employees may obtain red repair tags from the sterile supply room.
2. The recording employee must completely fill out each repair tag, attach it to the broken equipment, and then make sure to place the malfunctioning apparatus in designated areas for pick-up.
3. Appropriate staff should tag equipment needing repairs immediately at the point of use;
4. Center personnel should promptly remove any equipment located in patient rooms from those rooms.
5. Any blood or bodily fluids contaminated equipment must be labeled using a "Biohazardous Contaminated Equipment" tag, which is available from the sterile supply room.
6. The noting staff member should attach this tag to the repair tag and fill it in to indicate where the equipment is contaminated (i.e.: internally, specific parts, etc.).
7. For additional information on handling equipment contaminated with blood or body fluids, refer to the Exposure Control Plan.

SUBJECT: PRODUCT RECALLS, ALERTS, & NOTIFICATIONS	REFERENCE #8011
DEPARTMENT: FACILITIES AND ENVIRONMENT	PAGE: 1 OF: 2
	EFFECTIVE: 5/11/2016
APPROVED BY:	REVISED: 11/02/2023

PURPOSE:

To provide a systematic method for handling recall notices, product alerts, and product notifications to ensure the safety of all patients, visitors, and staff.

POLICY:

Facility personnel will take appropriate action to protect the well-being and safety of patients, employees and visitors upon receipt of a product manufacturer recall notice, field correction or other safety alert information

DEFINITIONS:
Recall : A recall is a method of removing or correcting products that are in violation of laws administered by the Food and Drug Administration (FDA).
Recall Classifications are categorized into one of three classes, according to the level of hazard involved:

- Class I: Dangerous or defective products that predictably could cause serious health problems or death. Examples include: food found to contain botulinum toxin, food with undeclared allergens, a label mix-up on a lifesaving drug, or a defective artificial heart valve.
- Class II: Products that might cause a temporary health problem, or pose only a slight threat of a serious nature. Example: a drug that is under-strength but that is not used to treat life-threatening situations.
- Class III: Products that are unlikely to cause any adverse health reaction, but that violate FDA labeling or manufacturing laws. Examples include: a minor container defect and lack of English labeling in a retail food

Alert: Notification from the manufacturer, the FDA, or a reporting service that there is a potential or actual problem with a product or with its use under certain circumstances.

PROCEDURE:

1. Recall notifications and/or safety alert notices may be initiated by the manufacturer (voluntary recall), distributor, the Food and Drug Administration (FDA) (mandatory recall), or by any staff member identifying a product defect
2. ASC staff should send all notices of product recall, safety notices, product notifications, product alerts, or similar types of communications to the ASC Director upon receipt.
3. The ASC Director will review the notice received and notify all areas possibly using or storing the item(s) identified in the product notice. Each area identified will receive a copy of the product notice and necessary action will be taken.
4. It will be the responsibility of the ASC Director to coordinate and process product and equipment recalls upon receipt of a recall notification.

5. Any other department that receives notice(s) of a recall (e.g., administration, materials management, pharmacy, etc.) will forward the original immediately to the ASC Director with a copy to the involved department.
6. ASC Director will consult with the involved department (e.g. pharmacy, dietary, laboratory, etc.) and/or manufacturer to determine the urgency and what action needs to be taken, such as removal of the product or device from service or stock and hold for repair, return, or instruction for training depending on the classification and/or potential for harm.
7. Inspection will be made of facility inventory, including the using department(s) by the ASC Director (or designee) to determine how many, if any, of the recalled items are in the Facility.
8. If the item is not in stock or in the using department(s), the return-reply notification will be filled out by the ASC Director (or designee) and returned to the affected vendor. The manufacturer's recall notification letter and a copy of the related response/documentation will be retained in a "Product Recall & Safety Alert" file by the ASC Director.
9. If a recalled item is located in the Facility, the ASC Director (or designee) will promptly ship the item back to the manufacturer per the instructions in the recall notification letter and fill out the return-reply card and return to the affected vendor. Disposition of the item(s) will be noted on the manufacturer's recall notification letter and the letter will be retained in the "Product Recall & Safety Alert" file by the ASC Director.
10. Attending physicians of those patients exposed to the product(s)/equipment recalled will be notified by the manager of the department where the recalled items were found and documentation of that notification will be sent to the ASC Director.
11. If it is determined that replacement product(s)/equipment is needed, the ASC Director (or designee) will work with the Materials Manager to make arrangements to obtain the desired items.
12. ASC Director and Materials Manager will keep a record of how many items were taken from inventory or the using department and the same amounts are then replaced to the appropriate location from the replacement stock immediately upon its receipt.
13. All recalls and safety alert notifications will be tracked using the "Product Recalls & Safety Alerts Log" and reported to the Governing Body on at least a quarterly basis.
14. The Facility will retain the "Product Recall & Safety Alert" logs, files and all supporting documentation for a minimum of three (3) years from the date of the recall or safety alert notice.
15. ASC Director must document each incoming notice as received in a chronological logbook to track the progress and review the status of the distribution of the notice.
16. The logbook will document the transmittal of the notification, receipt of staff signatures, and follow-up with the manufacturer, repair of the device, and distribution of the completed Medical Device Alert form.

SUBJECT: SAFE MEDICAL DEVICE ACT	REFERENCE #8012
	PAGE: 1 OF: 4
DEPARTMENT: FACILITIES AND ENVIRONMENT	EFFECTIVE: 5/11/2016
APPROVED BY:	REVISED:

POLICY:

The ASC will comply with the Safe Medical Device Act of 1990 by promoting the protection and wellbeing of all patients, visitors, and staff.

PROCEDURE:

1. Appropriate corrective action will be taken to protect the safety of all patients, visitors, and staff of the ASC whenever information on a product-related hazard or potential hazard is brought to the attention of managers of this facility.
2. The ASC Director shall ensure only Food and Drug Administration (FDA) approved pharmaceuticals and health devices, certified manufactured equipment, and qualified hospital-prepared products will be used in the Center and the products and devices recalled by the manufacturer or the FDA are removed when found to be in use within the facility.
3. The Safe Medical Device Act of 1990 requires device-user facilities (including hospitals, outpatient diagnostic and treatment facilities, nursing homes, and ambulatory surgical facilities) report incidents to the device manufacturer when the facility determines a device has or may have caused or contributed to the death or serious injury of a patient.

   A. The facility must also send a copy of the report to the FDA in the case of a death.
4. Serious illness or injury as defined by the Act is an illness or injury either life threatening or resulting in permanent impairment of a bodily function or permanent damage to a bodily structure, or necessitating immediate medical or surgical intervention to preclude permanent impairment of a bodily function or permanent damage to a bodily structure.
5. The FDA defines a medical device as any instrument, apparatus, or other article used to prevent, diagnose, mitigate or treat a disease or to affect the structure or function of the body with the exception of drugs. A medical device includes, but is not limited to, ventilators, monitors, dialyzers, and any other electronic equipment; implants; thermometers; patient restraints; syringes; catheters; in vitro diagnostic test kits and reagents; disposables; components; parts; accessories; and related software.
6. In accordance with Safe Medical Device Act of 1990, the ASC will establish methods for reporting these events. The ASC shall notify the FDA and the manufacturer (if known) within 10 working days of becoming aware of all incidents reasonably suggesting there is a probability a medical device has caused or contributed to the death of a patient. In cases involving medical devices where patients are injured or become seriously ill, a report must be filed within 10 working days to the manufacturer or the FDA if the manufacturer is unknown.

7. For any device failure having an adverse outcome, the following procedure must be implemented:
   A. Retain all packaging materials and disposable supplies.
   B. To ensure proper follow-up and investigation of the incident the medical personnel who report the adverse medical incident shall complete a Center Incident report form.
   C. This report should be sent to the ASC Director.
   D. The report should contain, at a minimum, the following information:
      I. Patient's name
      II. Patient ID number
      III. Name of attending physician notified
      IV. Type of adverse event
      V. Relevant laboratory/test data and patient history
      VI. Initial reporter of the event
      VII. Product name
      VIII. Location of product
      IX. Equipment identification number
      X. Serial number of product
      XI. Model number
      XII. Name of manufacturer, if known
      XIII. User facility/distributor name, address, and contact
      XIV. Event problem codes for device and patient
      XV. Brief description of incident
      XVI. Date and time of incident
      XVII. Information from all packaging materials and disposable supplies
8. Initially, an official from the Center will request Biomedical Engineering to document the condition of the device upon inspection. Control settings and any observed physical damage would be noted.
9. A designated facility employee will impound, tag, bag, and sequester the device with an identifying number and date. Staff will log the device into an impound log with all pertinent data recorded to show a "chain of evidence."

10. A team consisting of representation from Biomedical Engineering and the ASC Director shall conduct an investigation of the incident to determine if the device failed, or if there was an error by the user.
11. The team carrying out the investigation of the device failure shall conclude their research as appropriate before repair work is conducted. I
12. Investigation may include the following:
    A. Team approach (ASC Director, Third Party Manufacturer, Biomedical Engineering, Testing)
    B. Visual Inspection
    C. Third Party Investigation (May be recommended by facility insurance carrier.)
13. The ASC Director will review all written communication submitted to the FDA or the manufacturer prior to submittal. The ASC Director will determine the appropriateness of the communication and confirm the submitted documentation meets the requirements of the Safe Medical Device Act of 1990.
14. Administrative staff shall document, carefully and completely, any additional communications with the manufacturer or vendor. Contacting staff will request written acknowledgments for all verbal responses given by the manufacturer.
15. Copies of all written communications will be forwarded to the ASC Director.

FDA AND MANUFACTURER HAZARD ALERT AND PRODUCT RECALLS

1. Hazard recalls and alert notifications are received by the administration, pharmacy, clinical departments, materials management and other support departments. These products hazard and recall notifications shall be forwarded immediately to the ASC Director, following Policy 1005.
2. The ASC Director will receive and review all incoming device hazard/recall alerts, warning letters from manufacturers, product information reports of potential hazards, and facility notification reports.
3. Each incoming notice will be documented as received in a chronological logbook to track the progress and review status of the distribution of the notice.
4. The logbook will document the transmittal of notification, receipt of staff signatures, and follow-up with the manufacturer, repair of the device, and transmittal of the completed Medical Device Alert form.
5. The ASC Director shall determine what action(s) are to be taken by reviewing the notifications.
6. The device or product will be removed from use until it has been determined adverse health consequences do not exist.

7. Equipment and other medical devices removed from use shall be delivered to Biomedical Engineering, unless indicated otherwise on the Medical Device Alert form.
8. Medical supply items will be returned to the ASC Director unless otherwise indicated on the form.
9. Products withdrawn from use shall be retrieved from all areas where normally stocked, (i.e., SPD, Pharmacy, etc.).

RECORDKEEPING:

1. The Safe Medical Device Act requires user facilities and manufacturers to establish and maintain records related to reportable events. These records must be easily identified, facilitate timely access and must include the following:
   A. Information regarding the event or where the information is located.
   B. Copies of all completed Medical Device Reporting Forms and all information submitted to the FDA, distributors, and/or manufacturers regarding the event.
2. Facilities shall keep records related to an event for three years.
3. Authorized FDA personnel may have access to all required records at all reasonable times to copy and verify the records.

SEMIANNUAL REPORTS:

1. Facilities shall submit to the FDA a semiannual summary of all reports sent to manufacturers and FDA in the applicable six (6) month reporting period. The six-month reporting periods are January 1 and July 1.
2. The following information is to be submitted on the semiannual report to the FDA (Form FDA 3419):
   A. HCFA provider number or FDA assigned reporting number
   B. Reporting year, reporting period, and report date
   C. Complete name and address of user facility
   D. Name, title, and address of the contact person
   E. Lowest and highest report numbers of the reports submitted to the FDA and/or manufacturer during the reporting period
   F. A summary of basic information about each reported event or a copy of FDA Form 3500A submitted for each event

SUBJECT: MAINTENANCE OF ELECTRICAL EQUIPMENT	REFERENCE #8013
DEPARTMENT: FACILITIES AND ENVIRONMENT	PAGE: 1 OF: 1
	EFFECTIVE: 5/11/2016
APPROVED BY:	REVISED: 8/22/2023

POLICY:

It is the ASC Directors responsibility to ensure all electrical/electronic equipment is properly maintained and inspected.

PROCEDURE:

1. A Biomedical engineer or equivalent will inspect every 12 months, all the electrical equipment. (Including electrical outlets, breaker/fuse boxes, emergency light and power supplies)
2. The inspector's written reports confirming the electrical equipment is safe and operating according to the manufacturer's specifications, will be kept together and organized within the facility.
3. Service is to include cleaning and calibration
4. Once inspected, the examiner will place a current inspection sticker on the item. Any questionable equipment should be reported to the ASC Director for investigation.
5. Only equipment meeting this standard will be used in the ASC.
6. Records of all inspections, maintenance and other historical documentation shall be readily available for 3 years.
7. *** Note ***any new equipment, or loaned equipment being returned to the facility, must be inspected before its return to use.

SUBJECT: COMPRESSED GAS CYLINDER SAFETY	REFERENCE #8014
	PAGE: 1 OF: 3
DEPARTMENT: FACILITIES AND ENVIRONMENT	EFFECTIVE: 5/11/2016
APPROVED BY:	REVISED:

POLICY:

Center personnel shall handle and store all compressed gas cylinders in the ASC as explained in this policy and procedure to safeguard employees, visitors, and patients.

PROCEDURE:

CYLINDER MARKINGS AND HANDLING

1. At all times all compressed gas cylinders must be firmly secured in racks, approved transport carts, or chained to the wall.
2. Cylinders or supply containers shall be constructed, tested, and maintained in accordance with the U.S. Department of Transportation specifications and regulations.
3. All oxygen cylinders must be clearly marked with a "No Smoking" sign.
4. The cylinder label and markings must be clearly visible.
   A. No compressed gas cylinder should be defaced to confuse or hide the required markings or identification numbers.
   B. Attached labels or stencils naming the components and giving their proportions shall identify cylinder contents.
   C. Labels and stencils shall be lettered in accordance with ANSI Z48.1 (CGA Pamphlet C-4 Standard Method of Marking Portable Compressed Gas Containers to Identify the Material Contained.)
5. Cylinders should be kept out of high traffic areas.
6. All personnel responsible for the operation of gas administering devices shall be familiar with the physical properties and characteristics of all medical gases.
7. The gas cylinder supplier should be responsible for all filling, painting, marking, and identification of contents.
8. Prior to use, the contents of the cylinder should be verified both as to type of gas and purity.
9. Center personnel should make every effort to prevent a cylinder from falling or being hit.
   A. However, if a cylinder should fall or a valve be hit, the main cylinder valve and regulator should be examined for damage and leaks.
   B. If damage has occurred, the tank should be taken out of service immediately, plainly marked as damaged, and returned to the supplier.
   C. An Incident report should be completed.

10. Before applying any regulating device to a cylinder, the tank valve should be slightly opened and closed to allow gas flow to clean the connection. Once the regulator is on the tank, the main valve should be opened slowly. This prevents rupturing the diaphragm in the regulator.
11. When changing cylinders, test all potential sources of leaks at the regulator and cylinder.
12. Never use broken or corroded regulators. Proper regulating devices should be used at all times for dispensing gases. Only properly trained service companies should repair regulating devices.
13. When not in use, the pressure should be relieved from the regulator and the main cylinder valve closed.
14. All medical compressed gas cylinders should be color-coded using the United States or International color coding system.

Gas	Supports Combustion	Tank Color	Physical State When Compressed	Odor
oxygen	yes	green	gaseous	none
carbon dioxide	no	white	liquid & gas	none
helium	no	gray	gaseous	none
air	yes	brown	gaseous	none
nitrogen	no	black	gaseous	none

* MIXTURES OF GASES WILL HAVE BOTH COLORS DISPLAYED ON THE TANK.

CYLINDER STORAGE AND TRANSPORT

1. Carts and hand trucks for cylinders and containers shall be constructed for the intended purpose and shall be self-supporting. They shall be provided with appropriate chains or stays to retain cylinders in place.
2. All compressed gas cylinders should have a designated area for storage free from combustible materials. The storage area should be clearly marked "Compressed Gas Storage - No Smoking - No Open Flames - Keep Door Closed."
3. Cylinder storage areas should be well ventilated, cool and dry with the inside temperature never greater than 125 degrees F.
4. When cylinder valve protection caps are supplied, they shall be secured tightly in place unless the cylinder is connected for use.
5. Flammable gases should never be stored with oxygen or other gases supporting combustion.
6. Never permit oil, grease, or other readily flammable materials to contact oxygen or combustible gas cylinders, valves, regulators, gauges, or fittings.

7. If tanks are transported in a vehicle, the tank must be firmly secured with safety caps in place. All vehicle transportation must meet DOT regulations.
8. Never drop, drag, slide or roll gas cylinders. Cylinders should be moved only in a cart designed for this use and should have the safety cap in place.
   A. Exceptions: Small E cylinders may be hand carried short distances. Cylinders in Surgery may be moved between OR suites with the regulator attached if properly secured in an approved cart.

References:

NFPA 99 - Standard for Healthcare Facilities

GAS CYLINDER USE AT Physicians' Surgery Center of Nevada

Department	Gas	Size Cylinder
*SGM = Specialty Gas Mixture		
Surgery	Oxygen	E, D
	Compressed Air	E

SUBJECT: FIRE SAFETY	REFERENCE #8015
DEPARTMENT: FACILITIES AND ENVIRONMENT	PAGE: 1 OF: 4
	EFFECTIVE: 5/16/2018
APPROVED BY:	REVISED:

POLICY:

The ASC will establish and maintain a Fire Plan listing actions to be taken in the event of a fire, or there is any need to evacuate the facility.

This policy is integrated into the ASC's Emergency Management Program

PROCEDURE:

Definitions:

1. Code Red – Actual Fire
2. Code Orange – Fire Drill

Fire Procedures:

1. Even the smallest fire is a problem in an ASC, and MUST therefore, be reported immediately. Center staff members are to utilize the R.A.C.E. method when a fire occurs.
2. When a person suspects a fire, he/she should immediately activate a pull station alarm and page "Code Red" and the area of the fire. Then, activate the R.A.C.E. protocol:
   A. **R**escue all patients from immediate danger.
   B. **A**ctivate nearest alarm; alert others in the center either verbally or through the intercom system.
   C. **C**ontain the fire by closing all doors and turning off medical gases. (Oxygen needed for patients will be evaluated and controlled by the ASC Director or designee.)
   D. **E**xtinguish the Fire
3. A simple fire extinguisher training technique is the PASS method:
   A. **P**ull- Pull the pin on the extinguisher. (It is there to prevent accidental discharge.)
   B. **A**im- Aim the hose nozzle low toward the base of the fire. (This is the where the fuel source is.)
   C. **S**queeze- Squeeze the lever above the handle to release the extinguishing agent. (Release to stop the flow.)
   D. **S**weep- Sweep the nozzle from side to side at the base of the flames until extinguished. (Move toward the fire, aiming low at its base. Sweep until all flames are extinguished. Watch for re-igniting. Repeat as necessary. Have site inspected by fire department.)
4. If the fire is small and contained (for example, in a trash can), attempt to extinguish the fire with portable extinguishers, aiming at the base of the fire.
5. Place any fire extinguisher that has been used on its side on the floor. It will be collected and recharged after the fire scene is secure.

ALWAYS LEAVE AN AVENUE FOR YOUR ESCAPE. IF THE FIRE GETS LARGER, GET OUT AND CLOSE ALL DOORS BEHIND YOU!

1. In the event available staff cannot extinguish a fire, there may be a need to evacuate the ambulatory surgery center.

Evacuation:

The Scene commander/manager will ensure the Fire Department has been notified. Do not rely simply on the fire alarm. Summon the fire department by calling 911.

Immediate goal will be to remove the patients and staff from the fire area. The most common areas of fires in a surgery center would be the oxygen-enriched areas of the Ors, Pre-OP and Post-Op. The following would be the immediate response to a fire located in any of those areas.

OR Fire

1. All patients and staff will be immediately removed from the OR into the sterile corridor. All doors leading from rooms in the sterile corridor will remain closed once patients have been moved to the sterile corridor.
2. Patients will be moved to the back, Emergency Exit Transfer point, at door between OR one and Exam Room 126. Patients and staff will then exit directly into the parking lot.
3. If the back is blocked by fire, the patients and staff will proceed to the front of the building and exit through the ASC discharge door and through the building's front door.

Pre-Op recovery beds and Step-Down Recovery beds

1. All patients and staff will be immediately removed from the OR into the sterile corridor. All doors leading from rooms in the sterile corridor will remain closed once patients have been moved to the sterile corridor.
2. Patients will be moved to the back, Emergency Exit Transfer point, at door between OR one and Exam Room 126. Patients and staff will then exit directly into the parking lot.
3. If the back is blocked by fire, patients and staff will proceed to the front of the building and exit through the ASC discharge door and through the building's front door.

The Scene commander/ manager will designate a person to exit the building and select an evacuation area where all staff, visitors, and patients in the Center will assemble.

1. The front office staff will retrieve a copy of the patient register and transfer it to the evacuation area.
2. Once in the evacuation area, the front office staff will develop a written list of all persons/patients in the evacuation area. The Scene manager or designee will commence personal interviews to account for all staff, visitors, and patients.
3. The Scene manager or designee will report any missing individuals immediately to the on-site Scene Commander, and fire/ emergency response personal.

4. Once everyone has evacuated the building, stay in the evacuation area. Do NOT attempt to fight the fire! The Fire Department will do this.
5. If an operation is in progress, the attending physician will make every effort to end his/her case and allow his/her team and the patient to evacuate the building. If this is not possible, a member of the clinical staff should move the patient to a fire/smoke resistant compartment as distant from the fire as possible and await assistance from the fire department.

Key Points:

1. Remain calm; reassure patients and visitors.
2. Evacuate patients nearest the fire area first.
3. If one suspects a fire is behind a closed door, feel the door opening. If warm, do not open unless a person is trapped inside.
4. Use the telephone for emergencies only.
5. Prepare for evacuation if necessary.
6. Evacuate in the opposite direction of the fire.
7. Stay low in smoke-filled area. Breathable air will be at floor level.
8. Await further instructions.
9. Place patients awaiting fire evacuation in a safe area close to a firewall as indicated on evacuation plans.

Fire Drills

1. A quarterly fire drill will be conducted for all shifts. This drill will be unannounced. All drills will be conducted at least an hour apart. All drills will be conducted at least one hour apart.
2. Each staff member will participate in a fire drill at least once per year.
3. A designated observer will document each drill indicating the date, time, shift, description and evaluation of the drill, and the names of staff members directly involved in responding to the drill. The fire drill report included with this policy will be used to document the drill.
4. Fire drills will be designed and conducted in consideration of and reflecting the content of the fire response training.
5. Every quarter, the organization tests fire alarm equipment for notifying off-site fire responders. The completion date of the tests is documented

Annual Fire Inspection

1. Annually, in January, the ASC Director will request in writing a fire safety evaluation of the surgery center from the county code enforcement office.

2. The director will submit a copy of the inspection report to the Quality Management committee.
3. The ASC Director will prepare an action plan for any deficiencies noted and ensure all are resolved. After all deficiencies are addressed and corrected, the Quality Management Committee will be notified.

Tests and Inspections

1. Fire protection and suppression systems shall be maintained and tested in accordance with NFPA 10, 13, 14, 15, 25, 70, 72, and 96.
2. Fire alarm systems will be maintained in a safe, operable condition in accordance with NFPA 70 and 99 and will be inspected bi-annually.
3. Portable fire extinguishers will be serviced annually and inspected monthly, checking for charge, evidence of tampering, and accessibility.

Fire Response Training

1. Each staff member will receive fire response training within 24 hours of his/her first day of employment in the facility, and at least annually thereafter, addressing at a minimum, the following:
   A. Fire Plan
   B. Reporting a Fire
   C. Use of the Fire Alarm System
   D. Location of Fire Extinguishers
   E. Location of Smoke Compartments
   F. Methods of Fire Containment
   G. Specific duties, responsibilities, tasks, or duties of each staff member.

PHYSICIANS' SURGERY CENTER OF NEVADA

FIRE ALARM CHECKLIST

Alarm Date: _____ Alarm Time: _____ Alarm Location: _____

Was the monitoring station notified, and ASC taken off line for the drill?	Yes	No	N/A
Was "Code-Red" heard in your area? (via phone, paging, or fire alarm)	Yes	No	N/A
Did employees react immediately in removing any endangered patients, visitors, or staff from the fire area?	Yes	No	N/A
Do your employees know how to report a fire?	Yes	No	N/A
Do your employees know the location of the nearest fire alarm pull station?	Yes	No	N/A
Do your employees know the location of the nearest fire extinguisher and how to operate it?	Yes	No	N/A
Do your employees know the proper evacuation route?	Yes	No	N/A
Were all doors closed in your area?	Yes	No	N/A
Was it necessary to shut off any gas, oxygen, or electrical appliances?	Yes	No	N/A
Were patients reassured that all necessary measures were being taken?	Yes	No	N/A
Were visitors reassured and asked to exit by the proper evacuation route?	Yes	No	N/A
Was someone stationed by the telephone for emergency calls?	Yes	No	N/A
Were all patients, visitors, and staff in your area accounted for?	Yes	No	N/A
Was the "All Clear" signal heard in your area? (via telephone or paging)	Yes	No	N/A
Do your employees understand the R.A.C.E. procedures?	Yes	No	N/A

Prepared By: _____ Department/Unit # _____

PHYSICIANS' SURGERY CENTER OF NEVADA

SUBJECT: CONTINUITY OF ESSENTIAL SERVICES	REFERENCE #8016
	PAGE: 1 OF: 1
DEPARTMENT: FACILITIES AND ENVIROMENT	EFFECTIVE: 5/11/2016
APPROVED BY:	REVISED:

POLICY:

The purpose of this policy is to define the action needing to occur prior to the failure of essential services, and to define the procedures to be followed when there is an outage or loss of power and/or water.

PROCEDURE:

1. **Actions Prior to Loss of Water**

   The ASC will acquire ten (10) gallons of potable non-sterile water and store the water in the "Bulk" storage room. The water will be labeled "Emergency Use Only" and, also will be marked "For use in the event of a loss of water." This water will be used only in the event of an emergency and will then be used only for hand washing.

2. **Actions Following a Loss of Water**

   No further surgical cases will be performed, and the case or cases in progress will be terminated as soon as possible.

   No further cases will be scheduled until the water supply is restored.

3. **Actions following Loss of Power**

   No new procedures shall commence, and procedures in progress shall be concluded as soon as possible.

****In the event the facility loses power, water, or fire alarms for more than four hours, all procedures will be cancelled and rescheduled. The facility will close.**

PHYSICIANS' SURGERY CENTER OF NEVADA

SUBJECT: FIRE EXTINGUISHERS	REFERENCE # 8017
	PAGE: 1 OF: 1
DEPARTMENT: FACILITES AND ENVIRONMENT	EFFECTIVE: 5/11/2016
APPROVED BY:	REVISED:

POLICY:

The ASC officials will provide an adequate number and variety of fire extinguishers, as required by the local code.

PROCEDURE:

1. Fire extinguishers are for use in the unlikely event a fire occurs at the ASC.
2. Fire extinguishers are inspected annually to ensure they are properly charged and in good working condition. They are checked monthly to ensure they are charged.
3. All staff members are expected to know the locations of the fire extinguishers.
4. Any fire extinguishers not properly charged or missing from their designated place must be reported to the ASC Director for charging or replacement.
5. All staff members, regardless of employment status, are required to attend an annual Fire Safety Training session including instructions for the proper use of fire extinguishers.
6. Each Fire Extinguisher will have a label attached or directly accessible to it:
7. In the unlikely event of a fire, use the R.A.C.E. procedure:
   A. **R**escue all patients from immediate danger.
      I. Protect patients, visitors, and personnel from smoke and flames.
   B. **A**ctivate nearest alarm; alert others in the center either verbally or through the intercom system.
   C. **C**ontain the fire by closing all doors and turning off medical gases. (Oxygen needed for patients will be evaluated and controlled by the ASC Director or designee.)
   D. **E**xtinguish the Fire

SUBJECT: SPILLS	REFERENCE # 8018
	PAGE: 1 OF: 2
DEPARTMENT: FACILITES AND ENVIRONMENT	EFFECTIVE: 5/11/2016
APPROVED BY:	REVISED:

POLICY:

The ASC management will provide a strategy for containing and cleaning up spills and using the spill kit.

PROCEDURE:

Definitions

1. **Bloodborne Pathogens** means pathogenic microorganisms present in the human blood and able to cause disease in humans. These pathogens include, but are not limited to, HBN and HIV.
2. **Contaminated** means the presence or the reasonable anticipated presence of blood or other potentially infectious materials on an item or surface. A spill is any contaminated liquid in excess of five (5) ml.
3. **Decontamination** means the use of physical or chemical means to remove, inactivate, or destroy bloodborne pathogens or chemicals on a surface or item to the point where they are no longer capable of transmitting infectious or hazardous particles, and the surface or item is rendered safe for handling, use, or disposal.

General Procedures

1. Always practice universal precautions by using proper protective equipment: mask, gloves, goggles, shoe covers, and gown. If any cuts or open areas on hands exist, it is better to double glove hands.
2. Spills must be contained immediately, and cleaned up by appropriate professional staff members or others properly trained and equipped to work with potentially hazardous materials.
3. Chemical Spills- see the MSDS located in the OSHA Manual or read the product label for the proper cleaning solution to use for decontamination of the area.

Spill Kit:

1. The Spill Kit is located in PACU/Soiled Utility, Decontamination room.
2. Read and follow the instructions listed on the kit for clean up and disposal in the hazard red plastic bag provided with the kit.

Follow Up

1. Immediately or as soon as possible following clean up with the Spill Kit, decontaminate with the appropriate disinfectant and properly dispose of any soiled items in the leak proof red bag.
2. Notify ASC Director of spill incident. The ASC Director will prepare the necessary Incident Report and will inform the Quality Management committee.

Eye Splash

1. If an eye splash occurs, flush/irrigate the affected area immediately at the Eye wash station.
2. Notify the ASC Director of eye splash incident.
3. The ASC Director will prepare the Incident Report and inform the Quality Management Committee.

PHYSICIANS' SURGERY CENTER OF NEVADA

SUBJECT: ALARMS	REFERENCE # 8019
DEPARTMENT: FACILITES AND ENVIRONMENT	PAGE: 1 OF: 1
	EFFECTIVE: 5/11/2016
APPROVED BY:	REVISED:

POLICY:

To ensure alarms for clinical monitoring and intervention systems are sufficiently audible to the health care workers so timely intervention can occur.

1. The facility will assure activation of alarms with appropriate settings and are sufficiently audible with respect to distances and competing noise.

Alarms systems will undergo scheduled preventive maintenance and testing as described in Policy 8013.

PROCEDURE:

1. Alarms
   A. Alarms on clinical monitoring and intervention systems will be maintained in the “on” position and will be sufficiently audible to staff.
   B. Alarm volumes will be set at a level so staff can hear them.
   C. Alarm parameters will not be set in such a manner that it prevents the equipment from sounding. Alarm parameters should be set consistent with a patient’s clinical condition and in conjunction with procedures or tests being performed on a patient. Each setting is individual to the patient.
2. Preventive maintenance
   A. The clinical monitoring and intervention alarm systems will undergo preventive maintenance by the Biomedical Engineer annually.
   B. A preventive maintenance tag will be placed on each piece of equipment to indicate the last date of maintenance.

SUBJECT: ALCOHOL SKIN PREPARATIONS	REFERENCE # 8020
DEPARTMENT: FACILITES AND ENVIRONMENT	PAGE: 1 OF: 2
	EFFECTIVE: 5/11/2016
APPROVED BY:	REVISED:

POLICY:

In light of alcohol's effectiveness as a skin antiseptic, there is a need to balance the risks of fire related to use of alcohol-based skin preparations with the risk of surgical site infection.

PROCEDURE:

Skin Preparations:

1. Using skin prep solutions that are:
   I. packaged to ensure controlled delivery to the patient in unit dose applicators, swabs, or other similar applicators;
   II. provide clear and explicit manufacturer/supplier instructions and warnings;
2. Ensure that the alcohol-based skin prep solution does not soak into the patient's hair or linens.
3. Sterile towels should be placed to absorb drips and runs during application and should then be removed
4. Ensure that the alcohol-based skin prep solution is completely dry prior to draping.

*** This may take a few minutes or more, depending on the amount and location of the solution. The prepped area should be inspected to confirm it is dry prior to draping

Verify that all of the above has occurred prior to initiating the surgical procedure. Example: performed as part of a standardized preoperative "time out" to minimize the risk of medical errors during the procedure such as verifying that the patient is receiving the correct surgery.

Alcohol Hand Disinfectants:

1. Use of alcohol-based hand rub dispensers does not conflict with any State or local codes.
2. The dispensers are installed in a manner that minimizes leaks and spills that could lead to falls;
3. The dispensers are installed in a manner that adequately protects against inappropriate access
4. The dispensers are installed in accordance with the following provisions:
   A. Where dispensers are installed in a corridor, the corridor shall have a minimum width of 6 ft (1.8m);
   B. The maximum individual dispenser fluid capacity shall be:

I. 0.3 gallons (1.2 liters) for dispensers in rooms, corridors, and areas open to corridors.

II. 0.5 gallons (2.0 liters) for dispensers in suites of rooms;

C. The dispensers shall have a minimum horizontal spacing of 4 feet (1.2m) from each other;

D. Not more than an aggregate of 10 gallons (37.8 liters) of ABHR solution shall be in use in a single smoke compartment outside of a storage cabinet;

E. Storage of quantities greater than 5 gallons (18.9 liters) in a single smoke compartment shall meet the requirements of NFPA 30, Flammable and Combustible Liquids Code;

F. The dispensers shall not be installed over or directly adjacent to an ignition source;

G. In locations with carpeted floor coverings, dispensers installed directly over carpeted surfaces shall be permitted only in sprinkled smoke compartments

SUBJECT: TWENTY FOUR HOUR CLOCK	REFERENCE # 8021
DEPARTMENT: FACILITES AND ENVIRONMENT	PAGE: 1 OF: 1
	EFFECTIVE: 5/11/2016
APPROVED BY:	REVISED:

POLICY:

The twenty-four (24) hour clock shall be used to avoid confusion about AM and PM designation when charting.

The words AM or PM are not used when the twenty-four (24) hour clock is used.

1:00 AM	- 0100	1:00 PM	- 1300
2:00 AM	- 0200	2:00 PM	- 1400
3:00 AM	- 0300	3:00 PM	- 1500
4:00 AM	- 0400	4:00 PM	- 1600
5:00 AM	- 0500	5:00 PM	- 1700
6:00 AM	- 0600	6:00 PM	- 1800
7:00 AM	- 0700	7:00 PM	- 1900
8:00 AM	- 0800	8:00 PM	- 2000
9:00 AM	- 0900	9:00 PM	- 2100
10:00 AM	- 1000	10:00 PM	- 2200
11:00 AM	- 1100	11:00 PM	- 2300
12:00 noon	- 1200	12:00 midnight	- 2400
		12:01 AM	- 0001

SUBJECT: SECURITY	REFERENCE # 8022
	PAGE: 1 OF: 2
DEPARTMENT: FACILITES AND ENVIRONMENT	EFFECTIVE: 5/11/2016
APPROVED BY:	REVISED: 8/22/2023

POLICY:

Physicians Surgery Center of Nevada strives to provide a safe and secure environment for all its patients and staff. The ASC is responsible for managing the physical and personal security of patients and staff.

PROCEDURE:

1. Security of patients and staff will be included in the annual risk assessment performed by staff and provided to the center's Quality Committee. At a minimum, the following security areas will be discussed during this risk assessment:
   A. Pediatric Abductions
   B. Work Place Violence
   C. Weapons brought onto the property
   D. Loss of employee keys
   E. IT Information loss
   F. Distinguishing staff versus visitor or patient
   G. Control of access to the center
   H. Other items as identified by staff.

   If any of these elements, in the opinion of the Quality Committee, falls into the high-risk category, a study of the element will be conducted as a part of the annual Quality/Risk plan.
2. At least annual training will be provided to staff in the following areas that are related to the security and safety of staff and patients:
   A. Patient Safety
   B. Fire Safety
   C. Workplace Violence
   D. Emergency Preparedness
   E. Other items as identified by staff during annual risk assessment
3. Security of the ASC will be maintained by the following:
   A. The ASC has only one unlocked entrance door. All other exit/entrance doors are locked and require a key.

B. When visitors enter the reception area of the ASC, they are asked to identify themselves. No one is allowed out of the reception area and into the patient care area of the ASC without an escort. The door between the reception area and patient care area will remain locked while patients are in the center.

C. Should an individual appear threatening, the front office staff will call 911 and alert the staff by speakerphone in the back area for additional assistance.

D. As the staff is limited in number, it would be difficult to confuse an outsider as a staff member, but all ASC staff must wear identification badge at all times.

The ASC Director is responsible for reporting any suspicious activity to the Medical Director/ or the local police if she feels the situation is serious. For less serious concerns, she will report concerns to the Administrator. All concerns will be reviewed by the ASC's Quality Committee and Governing Body Board.

PHYSICIANS' SURGERY CENTER OF NEVADA

SUBJECT: IMMOBILIZER USE	REFERENCE # 8023
	PAGE: 1 OF: 1
DEPARTMENT: FACILITES AND ENVIRONMENT	EFFECTIVE: 5/11/2016
APPROVED BY:	REVISED:

POLICY:

Immobilizer use for the surgical patient will be applied to restrict movement of the patient arms during the procedure. The immobilizer is designed to protect the patient from interfering with medical treatment or risk of physical harm.

Procedure

1. Staff educates patients and their families/significant others about the use of the immobilizer as appropriate for patient safety and restriction of movement during the procedure.
2. Once the patient has been positioned on the stretcher in the operating room and the provider has performed the 'immediate assessment' by the MD or MDA, the patient will be requested to lay their arms alongside their bodies.
3. The immobilizer will then be wrapped around the upper torso- tight enough to restrict arm movement, but loose enough to not inhibit breathing/ comfort.
4. Staff will always confirm the comfort of the patient prior to beginning the procedure, readjusting as needed.
5. The immobilizer will be removed when the case is completed.

Cleaning

1. After patient use, the immobilizer will be wiped down with antiseptic wipe and allowed to air dry.

POLICY:
Any fire protection system (fire alarm, sprinkler, fire pump, etc.) that is out of service due to unforeseen circumstances or is shut down for maintenance or repair for more than 4 hours in a 24hour period is required to establish a fire watch if the space is occupied. This out of service situation is known as Fire Protection System Impairment. The precautionary program taken to monitor for a fire is called a **Fire Watch**.

For the person assigned to the fire watch, this must be he/her only job duty during that time period. The person must have at least one method of contacting the Fire Department in an emergency (land line phone or cell phone).
If the Center is located in an office building, the building owner is required to have an impairment coordinator.

The out of service equipment must be tagged with an "Out of Service" notice and an "Out of Service" notice must be placed at the fire alarm panel and the fire department connection indicator.

PROCEDURE:

1. Steps to take in Fire Protection System Impairment occurs:
    a. Attempt to determine the extent and expected duration of the impairment.
    b. If the system is to be shut down for maintenance or upon notification or discovery of a system impairment that is anticipated to last more than 4 hours, the **Fire Watch** Procedures will be initiated.
    c. Notify fire department, alarm monitoring company, building maintenance/owner/manager and other authorities having jurisdiction.
    d. Notify staff of the impairment and implementation of a Fire Watch.
2. Patrol of areas:
    a. The ASC Director or designee will conduct the Fire Watch. That person must have no other duties assigned during the Fire Watch period.
    b. In addition to patrolling the area, the Fire Watch includes making sure that other fire protection features of the building such as egress routes and any other fire protection systems are available and functioning properly.
    c. Fire watch inspection tour will be performed periodically throughout the affected areas, at random times as determined by the fire marshal for that outage.
    d. The person conducting the Fire Watch will go on a specific/consistent path throughout the Center, making sure all areas are covered at least hourly.
    e. Areas covered include all closets, storage areas, janitor closets, utility rooms and other normally unoccupied areas.
    f. Fire Watch person will periodically remind staff that the facility is on Fire Watch.

3. Fire Watch/ Fire or smoke identified:
    a. If a fire or smoke condition is identified, RACE will be initiated, and the Fire Watch person will contact the fire department immediately.
    b. A Fire Watch documentation form will be completed and daily sent to the Fire Marshal's Office at least once every 24 hours.
    c. When the systems are working again, and the Fire Watch is terminated, send a statement to the Fire Marshal's office stating the Fire Protection System is restored to normal operation and the Fire Watch cleared.
    d. A statement of repairs or other documentation of system maintenance will accompany statement of Fire Protection System restoration.