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SECURITY

POLICY

The Governing Body is responsible for creating a suite that can be secured. The Clinical Supervisor is responsible for ensuring that the suite is secure throughout the day and after each surgical day.

PROCEDURE

1. The number of people with access shall be kept to a minimum. Only those employees *requiring* access will be issued keys. The Clinical Supervisor and/or Administrator is responsible for all keys/authorization.
2. Emergency assistance can be summoned by calling the front desk from any phone, or dialing 911 for fire or police assistance. In addition, direct emergency numbers are included on the Emergency Phone List.
3. Signs will be posted “Authorized Personnel Only” leading into the recovery and reception area.
4. All visitors shall check in the reception area. The receptionist will notify the appropriate personnel.
5. The Center will control and identify security sensitive areas to prevent all unauthorized entries.
6. During hours of non-operation, security is provided by a monitored security system.
7. A keypad will be utilized to arm and dis-arm the security system. The Clinical Supervisor and/or Administrator is responsible for ensuring that the system is armed at the end of each day and dis-armed at the beginning of each day. The Clinical Supervisor and/or Administrator is also responsible for ensuring that appropriate staff know how to arm and dis-arm the security system.

Fort Apache Surgery Center

SMOKING

POLICY:

The Center is a smoke-free facility and does not permit smoking or vape smoking inside the facility or near any entrances to the facility. There shall be signs posted throughout the center to inform the staff, patients and visitors of our “NO SMOKING” policy.

PROCEDURE:

Management personnel are responsible for enforcing the no smoking policy of the Center.
Employees are informed of the Center’s policy at time of hire.
Management personnel are responsible for ensuring that the No Smoking signage remains posted and visible to staff, patients and visitors.

Fort Apache Surgery Center

RECALL- EQUIPMENT, SUPPLIES AND FOOD

OVERVIEW

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 is a voluntary action that takes place because manufacturers and distributors carry out their responsibility to protect the public health and well-being from products that present a risk of injury or gross deception or are otherwise defective.

POLICY

There shall be a policy and procedure in place to ensure that the Center does not utilize any recalled or discontinued, medical devices, equipment and supplies or food products. In addition, there shall be a mechanism whereby the Center locates recalled or discontinued equipment, supplies and food products. When the Center is notified (e.g., by the manufacturer or FDA) of such a recall for an item it is not to be utilized for safety reasons and the Center is to notify the appropriate individuals and organizations regarding the notification, if appropriate (ie, the item has been used beyond the date of the recall).

PROCEDURE

1. The Clinical Supervisor will register with FDA Recalls & Alerts website to monitor any notifications.
2. When a notice is received from the FDA or the manufacturer that, for safety reasons, the specific item should be not utilized:
    a. Immediately notify all nursing, clinical and medical staff members regarding the recall.
    b. The Clinical Supervisor will check to see if the equipment or supplied was utilized at the Center.
    c. If the equipment or supply listed is/was used, the Clinical Supervisor shall refer to the inventory list to determine if the recalled/discontinued item matches the recall listed in the notification. If it does not match, no action need be taken.
    d. If there is a match, the Clinical Supervisor shall notify the Medical Director and applicable staff members. The following action will be completed:
        i. If there is any existing stock of the recalled/discontinued item, the Clinical Supervisor shall follow the directions of the notification.
        ii. If the recalled/discontinued item was utilized, the Clinical Supervisor will notify members of the medical staff regarding the recall.
        iii. If the notification instructs that patients are to be notified, the Clinical Supervisor is responsible for ensuring that medical records are reviewed and patients notified in the manner prescribed.

Fort Apache Surgery Center

HAZARDOUS MATERIALS AND WASTE-
INVENTORY OF HAZARDOUS SUBSTANCES

POLICY:

An inventory of all known hazardous substances used in this Center shall be kept in a location known to all employees. All hazardous materials shall be identified and labeled with hazard warnings according to the Centers Hazard Communication Program. (Please refer to Hazard Communication Program/OSHA Manual)

Specific information on each noted hazardous substance can be obtained by reviewing the Safety Data Sheet for that substance.

NOTE: The Center shall have all the required permits, licenses, manifests, and safety data sheets required by law and regulation for managing hazardous materials and waste.

Fort Apache Surgery Center

HAZARDOUS MATERIALS AND WASTE BIOHAZARDOUS WASTE HANDLING OF

BACKGROUND AND DEFINITIONS

This Center must comply with all state and federal regulations regarding handling and disposal of waste. Depending on the classification of the Center ("large volume" or "small generator"), there will be different regulations and reporting requirements.

Biohazardous waste, also called infectious waste or biomedical waste, is any waste containing infectious materials or potentially infectious substances such as blood. Of special concern are sharp wastes such as needles, blades, glass pipettes, and other wastes that can cause injury during handling.

Biohazardous waste includes the following materials:

1. **Human blood and blood products:** All human blood, blood products (such as serum, plasma, and other blood components) in liquid or semi-liquid form. Items contaminated with blood that, if compressed, would release blood in a liquid or semi-liquid form, or items caked with dried blood capable of being released during handling. Other body fluids or tissues containing visible blood.
2. **Human Body Fluids:** Human body fluids in a liquid or semi-liquid state, including: semen, vaginal secretions, cerebral spinal fluid, synovial fluid, pleural fluid, pericardial fluid, peritoneal fluid and saliva from dental procedures. Also includes any other human body fluids visibly contaminated with blood, and all body fluids in situations where it is difficult or impossible to differentiate between body fluids.
3. **Pathological waste:** All human tissues, organs, and body parts, including waste biopsy materials, tissues, and anatomical parts from surgery, procedures. Any unfixed human tissue, except skin.
4. **Sharps waste:** Sharps waste must be packaged as described in Sharps policy.

Responsibilities of Biohazardous Waste Generators

Surgery centers that generate biohazardous waste are responsible for:

1. Ensuring that the waste is properly packaged and transferred to the contracted hazardous waste hauler;
2. Packaging the waste as directed to prevent exposure or injury (needlesticks, cuts) to anyone handling the waste; and
3. Packaging the waste in the appropriate packaging (sharps in sharps containers, other waste in red bags).

Biohazard Waste Minimization

Although biohazard waste bags are often conveniently placed throughout the Center, it is important to remember that these bags are for ***biohazard and contaminated wastes only,*** and are not to be used for regular trash. Disposal of non-biohazard waste in a biohazard waste container adds significant costs to waste management.

The following are examples of items that do **not** need to be disposed as biohazard waste:

1. Gloves used to handle containers of blood or body fluids;
2. Paper towels or bench paper on which containers of blood or body fluids may have been placed but did not spill; and
3. Any other material used to handle blood indirectly but that did not come into direct contact with the blood.

Continued Biohazardous Wastes - Handling Of

POLICY:

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1. There is to be a standardized, safe and effective method for disposing of bio-hazardous waste.
2. All bio-hazardous waste shall be handled and packaged appropriately while ensuring that proper labeling is present for the containers or bags and the areas that house these wastes.
3. All personnel shall be informed of the proper methods for handling bio-hazardous waste through periodic inservices.
4. Universal/Standard precautions must be adhered to at all times which includes the required use of eye protection, barrier materials and gloves when handling bio-hazardous materials, including bags and tubs

PROCEDURE:

1. Wastes are accumulated in those containers with a red bag insert. Only those waste materials deemed appropriate shall be placed in the red bags (see Sharps policy for sharps handling and disposal).
2. Red bags and their contents are then transferred to the biohazardous waste storage area in the designated containers (that are labeled).
3. The biohazardous wastes pick-up company will then pick up these wastes regularly (as frequently as required, see agreement).

Fort Apache Surgery Center

BIOHAZARDOUS WASTES - RED BAG CONTENTS
(WHAT MUST I PUT INTO THE RED BAG?)

The following materials are to be placed in the Red Bags for pick-up by the biohazardous waste company.

I. INFECTIOUS WASTE: This includes any disposable item that has been soiled by any bodily fluid of the patient and would include such items as:

Surgical Gloves

Dressings and Packings
Swabs
Specula
Soiled Gowns
Drapes

Catheters & Canulae

Waste from Isolation Rooms
Suction Tubing
Laboratory Wastes:
-Culture Dishes
-Pasteur Pipettes*
-Vacutainers & other vials contaminated by specimens*
-Slides*
-Lancets*
-Capillary Tubes*
-Discarded live & attenuated vaccines
-Any residual specimen from medical or pathological laboratories

II. SHARPS:

Used hypodermic equipment (including syringes)
Scalpel blades
Lancets
Suture needles
Broken glass
Pipettes
Any item in other category marked with *

Sharps MAY NOT be placed directly into a Red Bag. They must be deposited into leakproof, rigid, puncture resistant containers that are secured from tampering, tightly lidded or taped closed prior to being put into Red Bag containers.

They must be deposited into leak proof, rigid, puncture resistant containers that are tightly lidded or taped closed prior to being put into Red Bag containers.

Universal precautions must be adhered to at all times which includes the required use of eye protection, barrier materials and gloves when handling bio-hazardous materials, including bags and tubs.

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BLADES, GLASS, NEEDLES, SHARPS, AND SYRINGES – HANDLING AND DISPOSAL OF

This policy is designed to meet all state, city and county regulations and to protect all staff who are at risk in the handling of waste sharps. Procedures for non-sharp waste (e.g., non-sharp infectious, chemical, radioactive, unbroken glassware, and non-hazardous waste) are not affected by this policy.

DEFINITION:

Sharps include:

1. Needles (whether or not attached to a syringe or covered by a plastic guard);
2. IV tubing with needle attached;
3. Glass slides and cover slips;
4. Scalpels, razor blades, and lancets; and
5. Broken glass and splintered plastic, *when contaminated with blood or other potentially infectious material.*

Non-contaminated broken glass and plastic are NOT considered sharps for disposal purposes.

SHARPS WASTE MINIMIZATION:

Although sharps containers are often conveniently placed throughout the Center, it is important to remember these containers are for ***sharps waste only***, and are not to be used for non-sharp biohazard waste or regular trash. Disposal of non-sharp biohazard waste in a sharps container adds significant costs to waste management.

The following are examples of items that should **not** be disposed of as sharps waste:

1. Gloves;
2. Paper towels;
3. Plastic vials and conical tubes;
4. Pillow covers, paper sheets

SHARPS WASTE DISPOSAL PROCEDURES:

Sharps are collected in standard sharps containers. These sharps containers are available in multiple sizes.

The **standard (non-chemical) sharps waste** pickup procedure is as follows:

1. When sharps container is 2/3 to 3/4 full, secure the lid. At no time shall containers be filled past the "fill line".
2. Place the sharps container in the appropriate location (with the biohazard label) for pickup by the contracted purveyor.

POLICY:

One of the greatest causes of skin punctures in the Operating Room is careless handling of needles left on syringes and surgical blades left on handles.

1. Any syringe with a needle that is used by personnel should be properly placed in the designated receptacle for needles and syringes. Needle caps must never be re-placed on the needle on the syringe.
2. Any syringe with a needle that is used on the sterile field should be disposed of at the end of the surgical procedure.
3. All used needles, blades and syringes shall be placed in the designated containers throughout the Center.

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PROCEDURE:

1. When finished with syringes and needles, place them into the designated plastic container. ***Never re-cap any used needle or any syringe.***
2. Place closed needle and syringe containers in the appropriate, labeled receptacles.
3. Emptied glass bottles are to be discarded in regular trash containers if they do not contain chemicals.
4. All sharps are to be put into an appropriate, puncture-resistant, labeled container.
5. At end of the procedure, all blades, needles and sharps are disposed of in the manner described previously. Infectious waste will be stored in the infectious waste container and will be picked up regularly by the bio-hazardous wastes pick-up company. See "Red Bag Contents" policy for those items that should be placed in the red bags and in hazardous waste containers.

Fort Apache Surgery Center

SPILLS POLICY

PURPOSE:

1. To prevent spread of infection through the Center and to maintain an aseptic environment.
2. To provide a safe environment for both patients and staff members, and provide protection from possible injury or exposure to hazardous material.

POLICY:

Any staff member who spills fluid or witnesses a spill in the Operating Room or perioperative areas shall adhere to the following procedures.

PROCEDURE:

1. Any staff member who spills fluid or the first staff member to see a spill on any surface of the facility shall first notify all personnel in the immediate area of the spill and warn them of its location.
2. The staff member shall then notify the Clinical Supervisor of the spill. The Clinical Supervisor shall inspect the spill site and determine whether the spill should be considered toxic or hazardous according to OSHA SDS standards. Should the spill be determined to be hazardous or toxic according to SDS standards, the disposal and ventilation procedures contained in the SDS manual shall be followed. THE SDS MANUAL SHALL BE AVAILABLE AT ALL TIMES IN THE CENTER AS A REFERENCE. The spill shall be handled in accordance with the Material Safety Data Sheet. If the spill contains, or may contain, body fluids, the spill shall be cleaned with a germicide, observing Universal/Standard Precautions and donning personal protective clothing and disposing of the disposable cleaning materials in the red bags and re-useable materials in the soiled linen container.
3. If the spill is determined by the Clinical Supervisor to be environmentally hazardous or toxic to staff and/or patients in the immediate area, evacuation procedures shall be initiated as outlined in the Safety Section of the Policies & Procedures.
4. ALL SPILLS SHALL BE CONSIDERED POTENTIALLY INFECTIOUS AND UNIVERSAL PRECAUTIONS ADHERED TO AT ALL TIMES.

In the presence of large blood spills, an EPA-registered disinfectant or a 1:10 final dilution of EPA-registered hypochlorite (bleach) solution initially should be used to inactivate bloodborne viruses to minimize risk for infection to health-care personnel from percutaneous injury during cleanup.

Reference: CDC Environmental Cleaning Procedures Best Practices for Environmental Cleaning in Healthcare Facilities, April 21, 2020

5. The Clinical Supervisor shall assign an appropriately trained staff member to the clean-up of the spill. The Staff member shall first carefully observe the area for any sharps or broken glass material which may cause injury during clean-up. This material shall be disposed of according to the Red Bag Policy on sharps.
6. Any applicable SDS procedures shall be reviewed and followed. In the absence of applicable SDS procedures, the staff member shall proceed to clean the area with appropriate germicide and hot water as outlined under the Terminal Cleaning Policy.
7. If the spill contains bodily fluids, or *may contain* bodily fluids, the spill shall be cleaned with a mop and germicide. After the mop is used for this purpose, it shall be placed in a red bag for disposal with other hazardous waste.
8. If the spill area is a floor space where there is ongoing traffic and the area remains wet, the area will be cordoned off with “Wet Floor” warnings to other personnel. The area shall be checked regularly until it is dry and warnings can then be removed.
9. The Clinical Supervisor shall inform the janitorial service of the area of the spill, and ask that it receive added attention during regular cleaning service

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FIRE SAFETY-FIRE IN THE OPERATING ROOM

GENERAL INFORMATION
Because of the presence of oxygen in the operating room, the potential for a dangerous fire is constantly present. A fire may be started by a spark from a cautery, from a suddenly malfunctioning piece of equipment or another source. The presence of oxygen means that this spark may be instantly amplified to a fire which will endanger the patient, surgeon and all medical staff.

POLICY
1. All medical staff shall be aware of and trained in the dangers of operating room fires and how to reduce the potential of operating room fires.
2. Physicians shall be advised of the danger of operating room fires and aware of ways to reduce the potential of operating room fires.
3. Precautions shall be taken for every case, every day to reduce the potential of operating room fires.
4. Inservices shall be held to educate Medical staff on the preventive measures used to reduce the risk of oxygen-aided fires in the operating room.
5. As part of the orientation program, the Clinical Supervisor and/or the Medical Director shall educate new employees in the dangers of operating room fires and inform them of ways to reduce the risk of these oxygen-aided fires.
6. Because of the constantly changing and advancing field of operating room instrumentation and because of the importance of this issue, Inservices for the medical staff shall be held at regular intervals (at least annually) to re-educate staff on the constant danger of these fires, ways to reduce the risk and ways of fires occurring and how to recognize potential causes

PROCEDURE
During head and neck procedures particular attention must be given to prepping, draping and positioning the patient, as patients with their heads draped are more susceptible to fire because supplemental oxygen can accumulate under the drapes. To decrease the risk of fire, the prep solution must be given adequate time to dry (3 minutes) - especially if there is alcohol in the solution. Draping and positioning the patient should be performed in a manner that does not allow pooling of oxygen under the drapes. Every effort should be made to use no more oxygen than is necessary to maintain adequate oxygen levels. If possible, provide room air or less than or equal to 30% oxygen, depending on patient needs. Oxygen can also be combined with air to decrease the risk of fire. If facial hair is exposed, coat the hair with a water-soluble surgical lubricating jelly to make it nonflammable. Additionally, moisten sponges, gauze and pledgets (and their strings) to render them ignition resistant. This is also true for chest procedures, where oxygen may pool in the open body cavity.

During all procedures, as a proactive safety measure, sterile water or saline must be on the back table prior to ESU, argon beam coagulator (ABC) or lasers being used. Additional safety measures that should be taken when performing electrosurgery, electrocautery or laser surgery are as follows:

- Stop supplemental O2 at least one minute before and during use of the unit, if possible. (Surgical team communication is essential.)
- Activate the unit only when the active tip is in view, especially if looking through a microscope
- Deactivate the unit before the tip leaves the surgical site

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- Place electrosurgical electrodes in a holster or another location off the patient when not in active use (i.e., when not needed within the next few moments)
- Place lasers in standby mode when not in active use
- Do not place rubber catheter sleeves over electrosurgical electrodes

Fiberoptic Light Sources

Fiberoptic light sources can start fires. Complete all cable connections before activating the source. Place the light source in standby mode, or turn the unit off when disconnecting cables. Never leave a light cord that is still luminating on top of the patient drapes. Although surgical drapes are fire retardant, they are still flammable.

In Case of a Fire in operative or procedural areas the following steps should be taken in order initiate RACE:

1. Announce the fire.
2. Remove the burning material from contacting the patient (drapes, ETT, etc.)
3. Have the anesthesiologist stop the flow of gases (i.e., O2, N2O, Desflurane, etc.)
4. Immediately smother/put out the fire (when safe to do so).
    - Attempt to extinguish with water or saline aim at the base of the fire.
    - To smother a fire hold a towel between fire and the patients airway, drop one end of the towel toward the patients head, drop the other end of towel over the fire, sweep your hand over the towel and raise the towel and keep your body away from the fire. **DO NOT PAT** the fire.
    - Obtain fire extinguisher as last response and Extinguish on floor.
5. Set off the fire alarm (Code Red)
6. Evacuate the patient, if necessary
7. Save any material/devices for follow-up investigation

Fighting Fires Involving an Endotracheal Tube

1. Announce the fire.
2. Collaborate and assist the anesthesia professional with:
    - disconnecting and removing the breathing circuit
    - turning off the flow of oxygen
    - pouring saline or water into the airway
    - removing the endotracheal tube and any segments of the burned tube
    - examining the airway
    - re-establishing the airway

Fighting Fires On or In Equipment

1. Communicate the presence of the fire to team members.
2. Disconnect equipment from its electrical source.
3. Shut off electricity to the piece of equipment at the electrical panel.
4. Shut off gases to equipment, if applicable.
5. Assess fire size and determine if equipment can be removed safely or if evacuation is needed.
6. Extinguish fire with extinguisher, if appropriate
7. Activate alarms, if necessary.
8. Notify the appropriate personnel.

Reference: Fire Prevention in the Perioperative Practice Setting 2013

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FIRE PROTECTION IMPAIRMENT PROGRAM

PURPOSE:

To establish procedures to be followed for water-based fire protection system is taken out of

service due to construction, alteration, power outage, repair or an emergency condition. These procedures include measures taken during the impairment to ensure that increased risks are minimized and the duration of the impairment is limited. Procedures set forth in this policy do not apply to routine scheduled maintenance or testing.

OVERVIEW

The probability of a fire or explosion causing major damage is increased whenever a fire protection system is impaired. The longer the fire protection system is impaired, the greater the probability becomes. Therefore, it is necessary to minimize the duration and scope of any impairment or provide for an alternate protection system.

A Fire Protection Impairment Program is an effective management program used to:

- Supervise the safe shutdown of fire protection systems
- Control potential fire hazards during the impairments
- Restore the fire protection system to service as soon as possible

SCOPE

This policy applies to all of the Centers employees, outside contractors and their representatives, or any company representative hired by the Center to provide services.

DEFINITIONS

Fire Protection Systems: Sprinkler systems, standpipe systems, fire hose systems, underground fire service mains, fire pumps, water storage tanks, water spray fixed systems, foam-water systems, special extinguishing systems, fire service control valves, fire alarms systems, and

Firewatch*:* A person or persons designated to physically patrol the area where the fire protection system is impaired.

Impairment: a shutdown, in whole or part, of a fire protection system.

Emergency impairment: when a fire protection system is out of service due to an unexpected occurrence, such as a ruptured pipe or an unexpected power outage.

Planned impairment*:* when a fire protection system is out of service due to work that has been planned in advance, such as revisions to the water supply or sprinkler piping system.

Impairment Coordinator (IC*):* The person who manages the impairment while system work is being performed and has overall responsibility for proper implementation of the Fire Protection Impairment Program. If the building engineer is not present the Safety Office will be designated as the Impairment Coordinator.

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Fire Protection Impairment Program Continued pg. 2

Responsibilities

Employees

- Any employee who impairs a fire protection system, in whole or part, must first notify the Impairment Coordinator at facilities. If an impairment permit is required, the employee will attach the Fire & Life Safety System Permit/Impairment Tag to the fire department connection for sprinkler system impairments or to the fire

alarm annunciator/control panel for fire alarm systems.

Contractors, Outside Workers, Outside Company Representatives

- Any Contractor/contractor's representative or outside worker who impairs a fire protection system, in whole or part, must first notify the Impairment Coordinator at facilities. If an impairment permit is required, the contractor, contractor's representative, or outside worker will attach the Fire & Life Safety System Permit/Impairment Tag to the fire department connection for sprinkler system impairments or to the fire alarm annunciator/control panel for fire alarm systems.

Impairment Coordinator (IC)

- The IC will determine the level of impairment due to a shutdown, in whole or part, of a fire protection system.
- The IC will be responsible for completion of the Impairment Worksheet when authorizing impairments.
- The IC will be responsible for issuing and verifying removal of fire & life safety system permit/impairment tags when authorizing impairments.
- The IC will be responsible for coordination of the firewatch, if it has been determined that a firewatch is necessary. The IC will document firewatch activities, the Firewatch Log Sheet.
- The IC will be responsible for providing training to the Center employees who will be utilized as firewatch personnel.

IMPAIRMENT COORDINATION PROCEDURES

- The Center will be notified of a preplanned impairment of a fire alarm system.
- The fire alarm monitoring company, if utilized to monitorthat particular fire alarm system, will be notified of a preplanned impairment of a fire alarm system.
- The maintenance supervisor for the affected building will be notified of the preplanned impairment.
- The impairment coordinator will complete the Impairment Worksheet.
- The impairment coordinator will complete the fire & life safety system permit/impairment tag. The IC will authorize the preplanned impairment and verify that the following procedures have been implemented:
    1. The extent and expected duration of the impairment have been determined.
    2. The areas or buildings involved have been considered and the increased risks determined.
    3. Recommendations have been submitted to management or the property owner or designated representative.
    4. When a required automatic sprinkler system is out of service for more than10 hours in an 24 hour period, the impairment coordinator will arrange for one of thefollowing:

Fire Protection Impairment Program Continued pg. 3

a) Evacuation of the building or portion of the building affected by the system out of service, or
b) A fire watch for all portions of the building left unprotected by the shutdown until the fire alarm or sprinkler system has been returned to service. A fire watch utilized for a fire alarm or automatic sprinkler system shutdown will be composed of individuals beyond normal staffing, assigned to walk the areas affected. The number of fire watch personnel utilized will be determined by the impairment coordinator. Firewatch personnel used for fire alarm shutdowns must be specially trained in fire prevention and in occupant and fire department notification

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techniques.

5. Fire department will be notified
6. The insurance carrier, the alarm company, property owner or designated representative, and other authorities having jurisdiction will be notified.
7. The supervisors in the area to be affected will be notified.
8. Ensure the tag impairment system has been implemented.
9. All necessary tools and materials have been assembled on the impairment site.

When the fire alarm is out of service for more than 4 hours in a 24 hour period, the impairment coordinator will arrange for the following:

- Contact the local fire authority will be notified and
- The building is either evacuated or
- Fire watch is provided for all occupants left unprotected by the shutdown until the system is returned to service.

:

Emergency Impairment Procedures

When an emergency impairment shall include, but are not limited t, system leakage, interruption of water supply, frozen or ruptured piping and equipment failure. Emergency action will be taken to minimize potential injury and damage.

- The impairment coordinator will implement items 1 through 9 of section *Preplanned Impairments.*

Restoring Systems to Service

When all impaired equipment is restored to normal working order, the impairment coordinator will verify that the following procedures have been implemented:

1. Any necessary inspections and tests have been conducted to verify that affected systems are operational.
2. Supervisors have been advised that protection is restored
3. Fire department has been advised that the protection is restored.
4. The property owner or designated representative, insurance carrier, alarm company, and other authorities having jurisdiction have been advised that protection is restored.
5. The Fire & Life Safety System Permit/Impairment Tag has been removed

Reference: NFPA 101: 9.6, NFPA 25: 15 , 2011

MEDICAL EQUIPMENT- ELECTRICAL EQUIPMENT - SAFE USE OF

POLICY:

All electrical equipment must be used in a safe and orderly fashion. All electrical wires on equipment must be in a good and proper order, have no frayed ends or uncovered wires, broken plugs, etc. Any observation of this should be reported to the physician immediately, and immediate repairs undertaken.

PROCEDURE:

1. Only standard and UL approved electrical plugs should be put in any electrical outlet.

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2. All electrical outlets in the operating room(s) must be hospital grade and be checked for proper polarity and adequate grounding. All equipment fittings shall be hospital grade.
3. Always grasp electrical wiring on the plug head itself when pulling a plug out of a receptacle to avoid breaking the wire. Never pull on the wire itself.
4. Any evidence of shorting of equipment should be reported immediately to the surgeon and Clinical Supervisor.
5. Flashlights will be available.

Fort Apache Surgery Center

MEDICAL EQUIPMENT - ELECTROSURGICAL UNIT (ESU) SAFETY

POLICY:

All personnel will follow safety guidelines in order to reduce the potential for injury to the patients, surgeons and employees who use cautery equipment.

PROCEDURE:

A. The ESU, dispersive electrode and active electrode shall be used according to the manufacturer's written instruction.

B. Perioperative personnel will be instructed in the proper operation, care and handling of the ESU during their orientation period. Return demonstration after instruction must be documented for the perioperative employee.

C. The ESU must be inspected before each use and checked at least annually by the biomedical service.

D. Damaged or malfunctioning ESUs must be removed immediately and reported to the management.

E. The ESU shall be assigned an identification number. The identification/serial number of the ESU is to be documented on the OR record.

F. To prevent injury, patients will be instructed to remove as much jewelry as possible before their surgical procedure.

G. The ESU shall be used in a manner that reduces the potential for injuries.

1. Following use, the ESU shall be turned off and the unit and all its reusable parts cleaned according to the manufacturers written instructions. The surface of the ESU shall not be saturated with or have fluids poured over it.
2. The ESU shall not be used in the presence of flammable agents (e.g., alcohol, tincture-based fluids)
3. Safety features (e.g., lights, activation sound indicator) shall be present and tested before each ESU use.
4. Power settings shall be confirmed verbally between the operator and the user before activation and determined in conjunction with the manufacturers written recommendations and the patients' size.

   The ESU shall be operated at the lowest effective power setting to achieve the desired effect for coagulation and cutting. Personnel shall check the entire ESU circuit if the operator requests a continual increase in power because of ineffectual usage results.
5. The ESU shall be protected from spills. Fluids shall not be placed on top of the ESU.

H. The ESU active electrode shall be used in a manner that minimizes the potential for injuries.

1. The active electrode shall be connected directly into a labeled, stress-resistant receptacle of the ESU. If an adapter is used, it shall be one that is approved by the manufacturer and does not compromise the generator's safety features.

2. The active electrode shall be inspected for damage, including impaired insulation, at the operative field before use.

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3. The active electrode shall be placed in a clean, dry, well-insulated safety holster when it is not in use.
4. The active electrode shall be disconnected from the ESU and replaced if it drops below the sterile field.

The active electrode shall have a tip that is secure and easy to clean.

I. The dispersive electrode shall be used in a manner that minimized the potential for injuries.

1. The patient's skin integrity shall be evaluated and documented before and after ESU use.
2. The dispersive electrode shall not be placed over bony prominences, scar tissue, skin over an implanted metal prosthesis, hairy surfaces, or areas distal to tourniquets and pressure points.
3. The dispersive electrode shall be the appropriate size for a patient (i.e., neonate, infant, pediatric, adult) and never be cut to reduce its size.
4. After positioning the patient, the dispersive electrode shall be placed on a clean, dry skin surface over a large, well-perfused muscle mass and as close to the operative site as possible.
5. Patients' jewelry shall be removed.
6. Excessive hair shall be removed before applying the dispersive electrode.
7. The dispersive electrode shall connect directly into a labeled, stress-resistant receptacle of the ESU. If an adapter is used, it shall be approved by the manufacturer and not compromise the ESU generator's safety features.
8. The dispersive electrode shall maintain uniform body contact to avoid tenting, gaping, and moisture that interferes with complete adhesion with the patient's skin.
9. The dispersive electrode shall be removed carefully to avoid denuding the surface of the skin.
10. The dispersive electrode and its connection to the ESU shall be checked if any tension is applied to the dispersive electrode cord or if the surgical team repositions the patient.

J. Bipolar active electrodes function differently than monopolar active electrodes and shall be used according to the manufacturers written instruction.

1. In bipolar electrosurgery, a forceps is used for the coagulation of body tissue. One side of the bipolar forceps is the active electrode, and the other side is the return or ground electrode.
2. A dispersive electrode is not needed because current flows between the two tips of the bipolar forceps rather than through the patient.

Reference AORN Standards, Recommended Practices and Guidelines (1999, 2000)

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1 Use of the ESU with an operating laparoscope requires personnel to:

- Examine all electrodes for impaired insulation before use,
- Ensure proper connection of equipment,
- Ensure that the active electrode is not activated until it is in close proximity to the tissue,
- Use the low-voltage cutting wave form setting whenever possible,
- Avoid open-circuit activation of the active electrode,
- Use the lowest power setting that achieves the desired result, and
- Use all metal or all plastic cannulas and not a hybrid cannula system (i.e., a combination of plastic and metal cannulas).

L. If patient or personnel injuries or equipment failures occur, the ESU and the active and dispersive electrodes shall be handled in accordance with the Safe Medical Devices Act of 1990.

M. Personnel shall take special precautions when using the ESU with patients who have pacemakers and/or automatic defibrillators.

1. Patients with pacemakers shall have continuous ECG monitoring during ESU use.
2. Patients with an automatic implantable cardioverter/defibrillator (AICD) shall:
   - Have the AICD device deactivated before the ESU is activated
   - Have a defibrillator immediately available, and
   - Have continuous ECG monitoring.

N. Exposure to smoke plume generated during electrosurgery shall be reduced.

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MEDICAL EQUIPMENT MAINTENANCE & REPAIR

POLICY:

1. Each piece of operating room and recovery room equipment shall be checked prior to any procedures commencing. This it to ensure proper operation of the equipment and reduce the possibility of malfunction and/or injury to patients or staff during any procedure or the recovery period.
2. Equipment used by the Center for the provision of patient care shall be maintained and serviced only by a contracted bio-medical company approved by the Governing Body.
3. All equipment be properly maintained so that it functions as intended and that services for maintenance and repair be obtained in a cost effective and timely manner.
4. The Center shall have documentation of the pre-cleaning, transport, and handling of medical devices intended for external vendor reprocessing, inspection, or repair.

PROCEDURE:

1. The designated operating room staff member will check each piece of equipment to be used during the day by turning on the apparatus and checking to see that the functions of the unit work properly. With some machinery, it may not be possible for the equipment to run through all of its functions, but the safety of the machinery should be able to be determined by this exercise.
2. A bio-medical person will check each piece of equipment and perform electrical safety checks (preventive maintenance or PM) at least annually and attach labels to the equipment to verify these checks.
3. Documentation of bio-medical/safety checks shall be kept for at least three years.
4. Obvious hazards are reported. Any suspect equipment is immediately pulled from service until cleared. Should there be a suspect piece of equipment, the following procedures shall take place:
    - The Clinical Supervisor or designee shall be notified of the potential equipment malfunction.
    - The Clinical Supervisor shall make the decision to pull the equipment from service. Each staff member has the authority to refrain from using any equipment if they have a valid basis for the belief that the equipment is not functioning properly and/or may cause a hazard for the patient and/or a staff member.
    - The Governing Body-approved bio-medical engineer will be contacted to come out and inspect the equipment. If appropriate, the manufacturer may also be contacted.
    - The suspect equipment shall remain out of service until the bio-medical engineer has inspected, tested and approved the equipment. If the manufacturer inspected the equipment first, the bio-medical engineer must inspect, test and approve the equipment and deemed the equipment functioning properly and safe before it is returned to service.
    - The Clinical Supervisor is responsible for ensuring that written documentation is provided by the bio-medical engineer and that the documentation is filed appropriately and retained according to #3 above.

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MEDICAL EQUIPMENT MALFUNCTION

POLICY:

In any situation involving a medical device failure or malfunction, immediate steps shall be taken to ensure the health and safety of the patient. Immediate action shall also be taken to preserve the medical device as it was at the time of the occurrence to document the condition/status of the device and to immediately remove the device from service.

PROCEDURE:

At the moment of a medical device failure or malfunction:

1. Attend to the medical needs of the patient or the injured parties, removing them from the area if necessary.

2. The malfunctioning equipment is immediately pulled from service and labeled as NOT IN USE. Do not change any settings or disconnect any attachments.

3. The Clinical Supervisor or Medical Director is to be notified immediately.

4. The bio-med company is to be notified to perform an inspection and diagnosis on the equipment.

5. An incident report is to be filled out. If it is determined that the medical device caused or contributed to a patient or healthcare worker's death or resulted in serious injury or illness, a report will be submitted to the FDA and/or product manufacturer.
   (See Incident Report Policy)

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MEDICAL EQUIPMENT – USE OF DIRTY EQUIPMENT

POLICY

Equipment that is stored outside the surgical suite (Operating room, Recovery area) shall be considered dirty and shall be cleaned prior to use in the Operating room.

PROCEDURE

1. When it is determined that a piece of equipment stored outside of the surgical suite is to be used in a procedure, the Clinical Supervisor or designee and the Scrub Technician involved in the case shall be notified.
2. The Scrub Technician working in the Operating room on the case utilizing the "dirty" equipment shall ensure that the equipment is wiped down with an anti-bacterial solution prior to the equipment being moved into the Operating room.
3. The Scrub Technician shall also check the equipment to ensure that the equipment has a current preventive maintenance ("PM") sticker on the equipment. All equipment used in the Operating room and Recovery Room or having patient contact shall be checked by a bio-medical technician at least twice per year (every six months).

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MEDICAL EQUIPMENT - SUCTIONING EQUIPMENT

POLICY:

The Nurse Manager is responsible for the correct functioning of the suction system. The Nurse Manager shall familiarize himself/herself with the suction system and be aware of how it performs.

PROCEDURE:

A. Every case is to be treated as a “dirty” case, using Universal Precautions, including the proper use of protective barrier apparatus.

B. Following a dirty case, the suction bottles containing aspirate (plus and/or germicide) should be emptied.

C. A disinfecting agent shall then be used to clean the suction bottle followed by thorough washing with a germicide, rinsing and sterilization.

D. The disposable suction unit shall be placed in the red bags for infectious waste.

E. The suction racks and regulator shall be wiped down with a germicidal solution.

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PIPED MED GAS SYSTEM

POLICY

It is the policy of the Center that all "piped medical gas systems" shall be tested upon installation, modification, or repairs requiring opening of system prior to being placed into service.

PURPOSE

All piped medical gas systems shall be tested when installed, modified, or repaired prior to being placed into service to protect patient, staff, and visitors. The data will be documented. The following will be checked at a minimum:

- Cross Connection
- Piping Purity
- Proper pressures

All medical gas systems installed, repaired, or modified, shall be tested per NFPA® 99, Chapter 4 prior to being placed into service.

PROCEDURE

No scheduled repair, modification, or installation work shall be allowed to begin on any piped medical gas system without the written permission of the Clinical Supervisor or his/her designee.

No medical gas system shall be placed into service without the permission of the Clinical Director. This permission shall not be granted until all testing documentation, indicating that the system(s) are compliant, has been delivered to the Clinical Supervisor.

The following activities will be followed:

1. All piped medical gas systems shall be installed, modified, or repaired by qualified personnel as defined by NFPA® 99, Chapter 4.

2. All piped medical gas systems shall be tested, per NFPA® 99, Chapter 4, prior to being placed into service. These tests shall include cross connection testing, piping purity testing and pressure testing.

3. All medical gas systems shall be labeled per NFPA® 99, Chapter 4. Zone valve labeling shall include the exact rooms or areas which are served by the load side of the zone valve(s).

4. The testing documentation shall be maintained in the <<Applicable Department>>. Documentation may also be kept in the construction file for the project.

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MEDICAL GAS, VACUUM, WAG SYSTEM FAILURE

POLICY:

There shall be a policy in place should the vacuum pump and/or waste anesthesia gas (WAG) system should become inoperable. Clinical management shall be aware of the procedure.

BACKGROUND

The National Fire Protection Agency (NFPA) publishes regulations for many areas of construction, including medical gas systems. The Centers for Medicare and Medicaid Services (CMS) has adopted portions of the NFPA guidelines to be enforced for Medicare-certified ambulatory surgery centers.

Included in the NFPA guidelines is a requirement for a dual pump medical vacuum system. Should one of the pumps malfunction, the other pump will kick in until the first pump can be repaired. An alarm will notify Center staff regarding the condition of the pump. The second pump should not be used alone for more than five days of surgery.

The dual motor vacuum pump is also the mechanical source of the WAG system. Therefore the procedure is the same for both surgical suction and the WAG system.

PROCEDURE:

Should one of the dual pumps of the vacuum pump become inoperable, the second pump will take over and an alarm will sound notifying staff of the situation. The Clinical Supervisor is responsible for contacting the appropriate service provider to repair the system. Procedures may continue as scheduled for the remainder of the day. Procedures may continue to be scheduled while the second pump is being repaired up to five (5) days. If the second pump has not been repaired within five days, no additional procedures shall be performed until the pump has been repaired.

Should both motors of the vacuum pump become inoperable, the current procedure may be completed, but no additional procedures will commence until at least of the motors of the vacuum pump have been made completely operable.

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STORAGE AND HANDLING OF MEDICAL GASES POLICY

POLICY

All medical gases shall be stored in a designated area and handled in a safe manner as described below.

PROCEDURE:

Delivery

1. Contracted medical gas distributor will deliver medical gases.
2. Upon delivery gases should be placed in designated holders.
3. Cylinders shall be examined upon delivery to determine that tanks are labeled correctly, and to inspect for signs of damage.
4. Return any defective cylinders to distributor immediately if necessary.
5. Delivery schedule should be made in accordance with the needs of the facility.

Storage

1. Cylinders shall be stored upright and secured.
2. All cylinders should be labeled with contents, dangers, and also have a tag to designate whether the tanks are full or empty at all times.
3. When in storage protective steel cap shall remain on the tank.
4. Compressed gas should be in a well ventilated, dry area away from exits and stairways.
5. Group the cylinders by types of gas. Mark empty cylinders and group them together in storage.
6. Oxygen cylinders should be stored at least 20 feet from flammables or combustibles.
   .

Handling

1. Specifically designed regulators, pressure release valves, hoses and other auxiliary equipment for each gas should be used.
2. Do not drop, bang, slide. Clank, or roll cylinders.
3. Cylinders should be kept in appropriate holder at all times. Holders should be in proper working order.
4. Valves should be closed when not in use.
5. Cylinders should be kept upright.

Usage

1. Leaking containers shall be removed to a well ventilated area. Shut the leaking valve and retighten the valve gland or not.
2. Labels should be legible before cylinders is used, otherwise return cylinder to distributor.
3. Tanks should be kept away from fire, sparks and electricity.

When empty, close and return cylinders to designated area. Empty cylinders shall be tagged as **"EMPTY."**

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EMERGENCY POWER- UPS

Policy

The Administrator or designee is responsible for assuring that there is adequate emergency power for the facility.

Procedure

1. The Administrator or designee is responsible for providing emergency power for the facility.
    A. The UPS back up battery system must be inspected weekly and exercised under load for 30 min. each month.

2. The facility has a reliable, properly sized emergency power system.
    A. The power system is powered by a UPA that will provide power during an interruption of normal electrical service for circuits essential to life safety and critical patient care.
    B. The UPS is tested 12 times a year with testing intervals not less than 20 days and not more than 40 days apart. These tests shall be conducted for at least 30 continuous minutes under a dynamic load..
    C. Receptacles and switches powered by the UPS are IDENTIFIED.
    D. The organization tests all automatic transfer switches 12 times a year with testing intervals not less than 20 days and not more than 40 days apart. The automatic transfer switch should switch the facility from local electrical power to generator power in no more than 8 sec.
    E. The emergency power system provides selected power and lighting throughout the facility so that essential nursing, medical and environment of care services can continue.
    F. All documentation will be maintained by the Administrator or designee.

3. In service Training shall address equipment and/or operating procedures that are new or have changed during the year or have had a significant number of failures or user errors associated with them.
4. Orientation must include general education on the importance and requirements of generator power, how to activate the automatic transfer switch if only a partial conversion from local power to generator power occurs, and should also include the location of “red” emergency generator power outlets, and keys to unlock the generator or doors to the generator room, etc.
5. Once every 36 months the UPS will undergo a test for the full duration or 4 hours, whichever is less.
6. Annual testing of the UPS system will undergo a 90 minute test under a dynamic load.
7. UPS failures and other issues should be documented on an incident report.

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