Sierra Center for Foot Surgery

Patient Safety Plan

Patient Safety Committee

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

Patient Safety Plan

Patient Safety Check List and Patient Safety Policies

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

Program for The Prevention and Control of Infections and Communicable Diseases

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

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

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

Patient Safety Committee:

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

The committee shall consist of: the patient safety officer, at least two providers of health care who treat patients at the medical facility, including, one member of the medical staff and one member of the nursing staff and the chief financial officer. A patient safety committee established pursuant to this section must meet at least once every calendar quarter.

The members are as follows:

Patient Safety Officer: DON .

Medical: CRNA and DPM

Nursing: RN

CFO/Administrator

Facility-acquired infection defined. "Facility-acquired infection" means a localized or systemic condition which results from an adverse reaction to the presence of an infectious agent or its toxins and which was not detected as present or incubating at the time a patient was admitted to a medical facility, including, without limitation: Surgical site infections; Ventilator-associated pneumonia; Central line-related bloodstream infections; Urinary tract infections; and Other categories of infections as may be established by the State Board of Health.

Sentinel event

- An event included in Appendix A of "Serious Reportable Events in Healthcare--2011 Update: A Consensus Report," published by the National Quality Forum; or
- Any death that occurs in a health facility.

Mandatory reporting of sentinel events.

- A person who is employed by SCFS, **within 24 hours** after becoming aware of a sentinel event that occurred at the health facility, notify the patient safety officer of the facility of the sentinel event; and
- The patient safety officer shall, **within 13 days** after receiving notification report the date, the time and a brief description of the sentinel event to:
  (1) The Division of Public and Behavioral Health of the Department of Health and Human Services.
  (2) QUAD A (within 5 days if a death, 30 days for all other adverse events See QUAD A standards for more details.)

If the patient safety officer of SCFS personally discovers or becomes aware, in the absence of notification by another employee, of a sentinel event that occurred at the health facility, the patient safety officer shall, **within 14 days af**ter discovering or becoming aware of the sentinel event, report the date, time and brief description of the sentinel event to:

(1) The Division of Public and Behavioral Health of the Department of Health and Human Services.
(2) QUAD A (See QUAD A standards for more details)

The report must contain:

- The unique identification code assigned to SCFS
- The name of the person who is making the report;
- The date on which the sentinel event occurred;
- The date that the facility was notified of the occurrence of the sentinel event;
- If the patient resides in NV, the county in which the patient resides;
- If the patient does not reside in NV, the state or country in which the patient resides;
- The date of birth of the patient;
- The sex of the patient;
- A description of the sentinel event; and
- The department of the facility at which the sentinel event occurred.

Mandatory investigation of sentinel event by health facility.

SCFS shall, upon reporting a sentinel event, conduct an investigation or cause an investigation to be conducted concerning the causes or contributing factors, or both, of the sentinel event and implement a plan to remedy the causes or contributing factors, or both, of the sentinel event.

SCFS is not required to take the actions described concerning a death confirmed to have resulted from natural causes.

<u>Within 45 days</u> after receiving notification or becoming aware of the occurrence of a sentinel event, the patient safety officer of SCFS must submit a second report to the Division. A report must be submitted.

(a) The factors that contributed to the sentinel event, including, without limitation:

- Any medical or other condition of the patient;
- Any policy, procedure or process of the medical facility;
- Any environmental condition of the medical facility;
- Any behavior of a member of the staff of the medical facility;
- Any situation present at the medical facility; and
- Any problem involving communication or documentation at the medical facility.

(b) The corrective actions, if any, that will be taken by SCFS to address the factors that contributed to the sentinel event, including, without limitation:

- A review of the policies, procedures or processes of the medical facility;
- Any change or development of the policies, procedures or processes of the medical facility;
- Any disciplinary actions taken against a member of the staff of the medical facility by the medical facility;
- Any environmental or equipment changes made in the medical facility;
- Any education or retraining provided to the staff of the medical facility;
- The date by which each corrective action will be completed; and
- The title of the person who is responsible for overseeing each corrective action.

(c) A copy of the plan to remedy the causes or contributing factors, or both, of the sentinel event developed or the statement prepared.

(d) A report submitted must indicate the date that the report was submitted to the Division. Proof satisfactory to the Division of the date that a report was submitted includes:

- The postmark on the package in which the report was submitted to the Division;
- The date stamp created by a facsimile machine used to transmit the report to the Division;
- The electronic date stamp created by a program of electronic mail used to transmit the report to the Division; and
- Any other evidence acceptable to the Division

If SCFS receives a patient who was transferred or discharged from another medical facility believes that a sentinel event affecting the patient occurred at the other medical facility SCFS shall report the sentinel event to the facility from which the patient was transferred or discharged. A medical facility that is informed of a sentinel event shall report the sentinel event.

Within 45 days after reporting a sentinel event SCFS **shall conduct an investigation** of the causes or contributing factors, or both, of the sentinel event.

Determine whether changes in the policies, procedures or processes of SCFS are necessary to prevent a subsequent sentinel event under similar circumstances.

Follow a nationally recognized methodology for conducting an analysis of the root cause of the sentinel event.

SCFS shall, after conducting an investigation pursuant to this section, develop and implement a plan to remedy the causes or contributing factors, or both, of the sentinel event.

- State how each finding of the investigation will be addressed and, if necessary, corrected by the medical facility;
- Identify the changes and corrective actions that will be implemented by the medical facility to reduce risk to patients or provide an explanation for not implementing any changes or corrective actions;
- Provide the title of the person responsible for implementing each change and corrective action identified in the plan;
- Provide a timeline for implementing the plan, including, without limitation, when each change or corrective action will be implemented by the medical facility;
- Provide for an evaluation of the effectiveness of the plan and a method for making revisions to the plan based on the evaluation;
- Establish a schedule for monitoring and assessing the continued effectiveness of the plan; and
- Provide the title of the person who is responsible for monitoring the overall plan.

If, after conducting an investigation pursuant to this section, SCFS determines that a plan to remedy the causes or contributing factors, or both, of the sentinel event is not necessary, SCFS shall prepare a written statement documenting the reasons for making such a determination.

Annual summaries of reports of sentinel events

On or before March 1 of each year, SCFS shall provide to the Division a summary of the reports submitted by SCFS during the immediately preceding calendar year. The summary must include, without limitation:

(a) The total number and types of sentinel events reported by the health facility, if any;

(b) For a medical facility:

- A copy of the most current patient safety plan established and
- A summary of the membership and activities of the patient safety committee and

(c) Any other information required by the State Board of Health concerning the reports submitted by the health facility.

Notification of patients involved in sentinel events.

- SCFS shall designate a representative for the notification of patients who have been involved in sentinel events at that health facility.
- A representative shall, not later than **7 days after discovering** or becoming aware of a sentinel event that occurred at SCFS, provide notice of that fact to each patient who was involved in that sentinel event.
- The provision of notice to a patient must not, in any action or proceeding, be considered an acknowledgment or admission of liability.

Provision of certain information relating to facility-acquired infections to patients.

1. SCFS shall:
   - Provide to each patient, upon admission of the patient, the general and facility-specific information relating to facility-acquired infections
   - Post in publicly accessible areas of SCFS information on reporting facility-acquired infections, including, without limitation, the contact information for making reports to the Division. Such information may be added to other required notices concerning the making of reports to the Division.
2. The information provided to each patient must include, without limitation:
   - The measures used by SCFS for preventing infections, including facility-acquired infections;
   - Information on determining whether a patient had an infection upon admission toSCFS, risk factors for acquiring infections and determining whether an infection has been acquired;
   - Information on preventing facility-acquired infections;
   - Instructions for reporting facility-acquired infections, including, without limitation, the contact information for making reports to the Division; and
   - Any other information that SCFS deems necessary.

Procedure for informing patient, legal guardian or other person that patient at medical facility has infection;

1. When a provider of health care confirms that a patient at the medical facility has an infection, the provider of health care or the designee of the provider of health care shall, as soon as practicable but not later than **5 days** after the diagnosis is confirmed, inform the patient or the legal guardian or other person authorized by the patient to receive such information that the patient has an infection.
2. A person or governmental entity who, with reasonable care, informs a patient or the legal guardian or other person authorized by the patient to receive such information that an infection was not acquired at the medical facility and of the apparent source of the infection is immune from any criminal or civil liability for providing that information.

Patient safety plan:

1. SCFS shall develop an internal patient safety plan to improve the health and safety of patients who are treated at that medical facility.
2. The patient safety plan must include, without limitation:
   - The patient safety checklists and patient safety policies most recently adopted.
   - An infection control program to prevent and control infections within SCFS.
3. To carry out the program, SCFS shall adopt an infection control policy.
   The policy must consist of:
   - The current guidelines appropriate for the facility's scope of service developed by a nationally recognized infection control organization as approved by the State Board of Health which may include, without limitation, the Association for Professionals in Infection Control and Epidemiology, Inc., the Centers for Disease Control and Prevention of the United States Department of Health and Human Services, the World Health Organization and the Society for Healthcare Epidemiology of America; and
   - Facility-specific infection control developed under the supervision of a certified infection preventionist.

- The program to prevent and control infections within SCFS must provide for the designation of a person who is responsible for infection control when the infection control officer is absent to ensure that someone is responsible for infection control at all times.
- SCFS shall submit its patient safety plan to the governing board for approval in accordance with the requirements of this section.
- After SCFS patient safety plan is approved, all providers of health care who provide treatment to patients will be notified of the existence of the plan and of the requirements of the plan. SCFS shall require compliance with its patient safety plan.
- The patient safety plan must be reviewed and updated annually in accordance with the requirements for approval set forth in this section.

Patient Safety Officer:

1. SCFS shall designate an officer or employee to serve as the patient safety officer.
2. The person who is designated as the patient safety officer shall:
   - Supervise the reporting of all sentinel events alleged to have occurred,
   - Take such action as he or she determines to be necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred.
   - Serve on the patient safety committee
   - Report to the patient safety committee regarding any action taken.

Infection Control Officer

1. SCFS shall designate an officer or employee of the facility to serve as the infection control officer.
2. The person who is designated as the infection control officer:
   - Shall serve on the patient safety committee.
   - Shall monitor the occurrences of infections at SCFS to determine the number and severity of infections.
   - Shall report to the patient safety committee concerning the number and severity of infections.
   - Shall take such action as he or she determines is necessary to prevent and control infections alleged to have occurred.
   - Shall carry out the provisions of the infection control program and ensure compliance with the program.
3. SCFS shall designate an infection control officer who *has successfully completed a nationally recognized basic training program in infection control, which may include, without limitation, the program offered by the Association for Professionals in Infection Control and Epidemiology, Inc., or a successor organization.* SCFS shall ensure that an infection control officer completes *at least 4 hours of continuing education each year* on topics relating to current practices in infection control and prevention.
4. SCFS shall maintain records concerning the certification and training required by this section.

Patient safety committee:

1. SCFS shall establish a patient safety committee composed of:
   - The patient safety officer.
   - At least two providers of health care who treat patients at SCFS, including, without limitation, one member of the medical staff and one member of the nursing staff of SCFS and
   - The chief financial officer.
2. A patient safety committee must meet at least once every calendar quarter.
3. A patient safety committee shall:
   - Receive reports from the patient safety officer
   - Evaluate actions of the patient safety officer in connection with all reports of sentinel events alleged to have occurred.
   - Review and evaluate the quality of measures carried out to improve the safety of patients who receive treatment.
   - Review and evaluate the quality of measures carried out to prevent and control infections at the facility.
   - Make recommendations to the or governing body to reduce the number and severity of sentinel events and infections that occur.

- At least once each calendar quarter, report to the governing body regarding:
    - The number of sentinel events that occurred during the preceding calendar quarter;
    - The number and severity of infections that occurred during the preceding calendar quarter; and
    - Any recommendations to reduce the number and severity of sentinel events and infections that occur.
- Adopt patient safety checklists and patient safety policies, review the checklists and policies annually and revise the checklists and policies as the patient safety committee determines necessary.

Patient safety checklists and patient safety policies:

1. The patient safety committee shall adopt patient safety checklists and patient safety policies for use by:
    - Providers of health care who provide treatment to patients at SCFS facility;
    - Other personnel of the medical facility who provide treatment or assistance to patients;
    - Employees who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the facility, including, without limitation, a janitor.
    - Persons with whom SCFS enters into a contract to provide treatment to patients or to provide services which may affect the health or welfare of patients.
2. The patient safety checklists must follow protocols to improve the health outcomes of patients and must include, without limitation:
    - Checklists related to specific types of treatment. Such checklists must include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of health care.
    - Checklists for ensuring that employees and contractors with SCFS who are not providers of health care follow protocols to ensure that the room and environment of the patient is sanitary.
    - A checklist to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received:
        - Proper instructions concerning prescription medications;
        - Instructions concerning aftercare; and
        - Any other instructions concerning his or her care upon discharge.
    - Any other checklists which may be appropriate to ensure the safety of patients at the medical facility.
3. The patient safety policies adopted pursuant to subsection 1 must include, without limitation:
    - A policy for appropriately identifying a patient before providing treatment. Such a policy must require the patient to be identified with at least two personal identifiers before each interaction with a provider of health care. The personal identifiers may include, without limitation, the name and date of birth of the patient.
    - A policy regarding the nationally recognized standard precautionary protocols to be observed by providers of health care including, without limitation, protocols relating to hand hygiene.
    - A policy to ensure compliance with the patient safety checklists and patient safety policies adopted pursuant to this section, which may include, without limitation, active surveillance. Active surveillance may include, without limitation, a system for reporting violations, peer-to-peer communication, video monitoring and audits of sanitation materials.
4. The patient safety committee shall:
    - Monitor and document the effectiveness of the patient identification policy
    - At least annually, review the patient safety checklists and patient safety policies and consider any additional patient safety checklists and patient safety policies that may be appropriate for adoption for use.
    - Revise a patient safety checklist and patient safety policy as necessary to ensure that the checklist or policy, as applicable, reflects the most current standards in patient safety protocols.

VTE Risk Assessment and Prophylaxis Orders

Each Risk Factor Represents 1 Point

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

Subtotal_____

Each Risk Factor Represents 2 Points

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

Subtotal_____

Each Risk Factor Represents 3 Points

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

Subtotal_____

Total Risk Factor Score_____

0 Points= Very Low Risk:

- Early ambulation

1- 2 Points= Low Risk: Consider

- Sequential compression devices
- TED Hose

3 - 4 Points= Moderate Risk: Choose One

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

_____**Ambulatory Surgery- No VTE Prophylaxis Required**

_____**VTE Prophylaxis Contraindicated. Reason:** _____

Physician Signature_____Date_____

Physician Name: Jeffrey K. Bean, D.P.M

Revised 2/7/2024 BAlton

Processed by (if other than physician)_____

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

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

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

Pre-Operative Orders

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

Signature _____ D.P.M

Post-Operative /Discharge

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

Signature _____ D.P.M Date _____

Post Op Instructions for Foot Surgery

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

What to do if:

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

PATIENT SIGNATURE: _____ **DATE:** _____

WITNESS: _____**DATE:** _____

Discharge Policy and Procedure

PURPOSE:

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

Patients not receiving sedation:

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

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

- Awake, alert and oriented.
- Vital signs are stable (see above)
- Color is pink and skin is warm and dry or within patient's own normal limits.
- Dressings are clean and dry.
- Patient is able to take fluids without nausea.
- Patient denies pain.
- Responsible party is here and able to understand discharge instructions.
- Patient has follow-up appointment for post-operative care.
- Patients shall be discharged only upon written orders of the attending physician.

Patients are transported from the facility, in a wheelchair pushed by ASC personnel, to a waiting vehicle driven by a responsible adult.

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

- Post-operative follow up phone call can be made by a physician's designated person or the physician.

10/10/2023 ab

Patient Identification

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

Policy Name: **Gauze Count**
Manual: **Patient Safety and Facility Safety**
Creation Date:**12/22/2022** Revision Date:**10/10/2023**
Governing Board Approval: Date:

Gauze Count

I. Gauze will be counted into pre-determined stacks (the number will be labeled on the pack), wrapped, and sterilized. The sterilization process will follow established sterilization policies and procedures.

II. Each pack of gauze will be counted by the surg tech or surg assist when pack is unwrapped in the OR. Count will be noted by circulating nurse.

III. After surgery is completed and before final closer another count of gauze will be conducted and number verified by surg tech/surg assist and circulating nurse.

Policy Name: **Surgical Timeout**
Manual: **Patient Safety and Facility Safety**
Creation Date:**10/1/2021** Revision Date:**6/27/2022**
Governing Board Approval: Date:**6/28/2022**

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

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

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

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

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

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

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

Surgical Time Out

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

Once completed, gauze and blades will be added to the surgical tray.
Update 10/17/22

Policy Name: **Surgical Site Marking**

Manual: **Patient Safety and Facility Safety**
Creation Date:**10/1/2008** Revision Date:**10/17/2022**
Governing Board Approval: Date:Click or tap to enter a date.

Surgical Site Marking

Each surgical site will be marked and initialed by the operating physician while the patient is in pre-op and still conscious. The patient will be involved in confirming the site by either writing yes or their initials on the surgical foot.

Refusal of Site Marking

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

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

Patient Positioning in Surgery

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

It must:

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

When in correct position:

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

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

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

- Mechanics of operating table.
- Correct body positions.

Anesthesia Policy and Procedure Statement

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

1) Pre-operative evaluation: all patients to receive any type of anesthetic will be interviewed by the anesthesia provider prior to induction. At a minimum this includes: basic H&P, NPO status, drug allergies, review of baseline vital signs. Provider is to ensure patient is safe to proceed with anesthetic.
2) Ensure that Anesthesia informed consent has been signed (can be included in surgical consent).
3) Patient monitoring: all patients will have continuous monitoring of respirations, 0_2 saturation, End Tidal C02 monitoring, BP and EKG throughout entire administration of propofol. At no time may the anesthesia provider leave the patient unattended during anesthesia delivery.
4) BP and HR must be taken and recorded at a minimum of every 5 minutes.
5) Anesthesia provider will adhere to strict standards regarding infection control. This will include all ASA guidelines, universal precautions, etc. and will include specifically:

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

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

I understand that I have been consulted to provide anesthesia services for Sierra Center for Foot Surgery and in so doing agree to follow basic standards of care as set out by the ASA. I have current knowledge and understanding of these guidelines and understand that any

failure on my part to follow these guidelines may result in harm to the patient. I will not hold Sierra Center for Foot Surgery or its employees responsible for any negligence on my part in providing anesthesia.

Signed:_____Date:_
_____

Hand Hygiene

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

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

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

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

Wearing gloves is not a substitute for hand hygiene

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

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

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

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

application.

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

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

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

Sentinel Event Policy

11/30/22

Sierra Center for Foot Surgery will follow all policies concerning Sentinel Events put forth by the State of Nevada

Surgical Closing Procedure

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

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

Electrosurgery Policy and Procedures

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

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

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

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

- On an area with well-perfused muscle.
- On skin that is clean, dry and intact.
- Ensure that return electrode has uniform contact with the patient's skin before the surgery begins. If there is poor contact remove oils, lotions, hair or moisture that is interfering with contact.
- Position the electrode to provide a direct current route between the surgical site and the return electrode. For unilateral cases place the electrode on the same side as the surgery, for

bilateral cases place the return electrode higher and make sure there are no skin-to-skin contact points.

- Do NOT place over bony prominences, scar tissue, hair, weight-bearing surfaces, potential pressure points, tattoos or a metal prothesis, distal to a tourniquet or near a warming device.
- Make sure to use the correct size of return electrode for individual patients. One-time use pads should not be cut, folded or altered in any way.
- Tape should NOT be used to hold the return electrode in place.
- The return electrode should be placed after final positioning. If the patient is re- positioned during surgery, verify that the electrode is still in contact with the patient's skin.

- Avoid skin to skin contact points such as fingers touching leg, legs touching legs. Place 2-3 inches of dry gauze between contact points to ensure that contact doesn't occur.
- Make sure that the patients DOES NOT have any contact with metal devices such as the bed, positioning devices, safety strap buckles to prevent a possible burn from directed current.
- Patient jewelry that is between the active electrode and return electrode should be removed.
- Make sure all alcohol-based prep has been allowed to completely dry before using the unit.
- Make sure that the cautery is a safe distance from any concentrated oxygen sources.
- Electrosurgery should not be used in the presence of external or internal pacemakers or Implantable Cardioverter Defibrillators. Electrosurgical devices can cause these devices to malfunction.
- If there is a request by the surgeon to increase the power, or if the unit is not performing as expected, check the return electrode and all connections before continuing the case. There may be a malfunction causing the need for additional power.
- When activating the unit, do not allow direct skin contact between the patient and the physician or assistant.
- When not using active accessories place them in a holster or in a clean, dry, non-conductive and highly visible area not in contact with the patient. Inadvertent contact with the patient may cause burns.

- NEVER silence the alarms.

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

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

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

Revised 9/18/2023 AB

Electrosurgery Safety Checklist

Patients Name: _____ Date: _____

Pre-operative check:

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

  Location: _____
  Is the site clean, intact and free of tattoos, scars? _____
  Is the site an area with well perfused muscle? _____
  Is the pad or plate in uniform contact with the skin? _____
  Is the site on the same side as the surgical site (unilateral)?
- ☐ If alcohol prep was used, is it completely dry? _____
- ☐ Are there any points of skin-to-skin contact? _____
  - If yes place a towel or gauze between these points.
- ☐ Is the patient touching any metal? _____
  - If yes, re-position the patient or place a barrier between the patient and the metal.
- ☐ Surgical smoke evacuator in place with single use tubing

Revised 2/7/2024 BAlton

Post-operative check:

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

Signature, Title _____ Date _____

RP: Safe Environment of Care

Recommendation II

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

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

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

[2: Moderate Evidence]

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

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

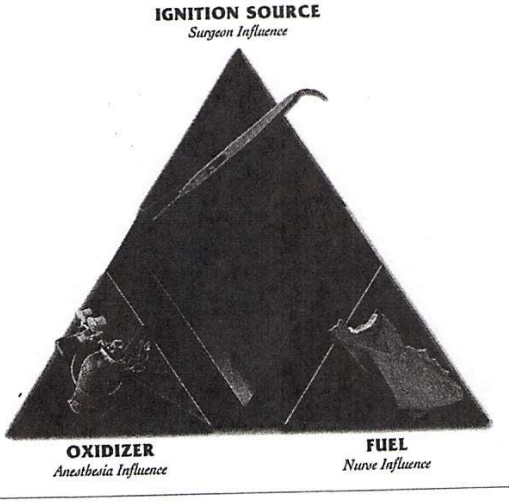
Fire prevention experts and professional associations support the importance of completing the risk assessment.[35,42] In one case report that involved a fire caused by the electrosurgical electrode igniting a sponge during open heart surgery, a lack of communication may have contributed to the fire.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

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

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

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

FIGURE 1. AORN FIRE TRIANGLE



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

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

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

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

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

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

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

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

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

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

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

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

FIGURE 2. AORN FIRE RISK ASSESSMENT TOOL

AORN

Fire Risk Assessment Tool

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

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

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

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

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

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

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

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

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

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

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