Saint Joseph Health System
Mishawaka and Plymouth
Initial/Annual Credentialed Allied Health
Surgical Competency Policies

Surgical Staff Initial Appointment and Annual Competencies Include:

- Fire Safety Perioperative Services and Procedural Areas
- Code Blue Resuscitation Process
- Electrosurgical Safety, Malignant Hyperthermia Crisis
- Surgical Hand Scrub and Sterile Gowning and Gloving
- Universal Protocol for Wrong Site Surgery
- Violence and Threats in the Workplace
- Positioning of Surgical Patients
- Blood Borne Pathogen Exposure
- Surgery – Traffic Control

SAINT JOSEPH HEALTH SYSTEM

Version #: 4

Title: Fire Safety - Perioperative, Obstetric, & Procedural Areas

Document Owner: Stephanie Luther	PI Team:	Date Created: 12/06/2022
Approver(s): Carol Walker, Stephanie Luther, Suzanne Risner		Date Approved: 07/03/2025
Location: Saint Joseph Health System (SJHS)		Department: Cardiac Cath lab-angioplasti (14030_13230), Cardiac Cath lab-angioplasti (14035_13230), Interventional Radiology (14030_21350), Labor and Delivery Services (14030_10650), Obstetrics (14035_10635), Operating Room (14030_37020), Operating Room (14035_37020)

POLICY:

1. Fire Safety depends upon each individual taking an active part in fire prevention. In order to provide a safe environment for our staff, patients, and visitors, SJRMC will strive to maintain an environment free from the hazard of fire. Should a fire emergency take place, the intent is to take advantage of the fire response procedures in addition to fire safety features constructed into our facilities
2. To provide an organized response in the event of a fire, staff is trained upon hire in the fire plan procedures and to further enhance these efforts, staff participates in fire drills throughout the year. Hospital fires are a serious hazard. The loss of life and property is minimized when well organized procedures have been established, and when all persons involved have carried out their instructions in a systematic organized and effective manner.
3. In order to provide a safe working environment for our associates and a safe haven for our patients and visitors, Saint Joseph Regional Medical Center will strive to maintain an environment free from the hazard of fire.
4. Should a fire occur, the main hospital is supplied with automatic sprinkler and smoke detection devices. All hallway doors are fire resistant and close automatically to contain a fire.
5. To provide an organized response in the event of a fire, all associates are fully trained upon hire in the fire plan procedures and use of a fire extinguisher and again through annual education training. To further enhance these efforts, associates participate in fire drills one per shift per quarter throughout the year.
6. Hospital fires are a serious hazard. The loss of life and property is minimized when well-organized procedures have been established, and when all persons involved has carried out their instructions in a systematic organized and effective manner. For this reason, associates are educated to fully acquaint themselves with this plan.

PROCEDURE:

SJRMC Holy Cross Pkwy/Plymouth location:

A. **STAFF MEMBER DISCOVERING A FIRE OR SMOKE**

1) Do not panic

2) Remember RACE

R - Rescue persons in immediate danger

A - Alarm/Alert by sounding the closest fire alarm or notify the operator by dialing "55555"

C - Contain the fire by closing door

E - Extinguish fire (attempt) with closest fire extinguisher or evacuate area, (do not put yourself at risk)

3) To use a fire extinguisher, remember PASS

P - Pull the safety pin

A - Aim at the base of the fire

S - Squeeze the handle

S - Sweep from side to side until the fire is out or extinguisher has been exhausted

4) Dry Chemical ABC extinguishers are used for Class A, B, or C fires and is an all-purpose extinguisher.

5) CO2 fire extinguishers are used for Class B (oil, grease or gasoline) or C (electrical) fires.

B. **REPORTING A FIRE ALARM**

1) Using the nearest fire alarm pull station and pull the lever down and release.

2) Remain at the fire alarm pull station to give exact location of the fire. If a telephone is within easy access dial "55555" [Plymouth 8-8888] and give the exact location and nature of the fire. DO NOT hang up the telephone; stay on the line until the "all clear" is given.

3) In the event you are not able to access a fire alarm pull station, dial "55555" [Plymouth 8-8888] and give the exact location and nature of the fire. DO NOT hang up the telephone.

4) Audible fire alarm sounds and strobes flash throughout the facility once the pull station is activated.

5) Alarm signal appears on the Switchboard and Fire Command Center alarm screen detailing the location in which the alarm was triggered.

C. **ARRIVAL OF FIRE DEPARTMENT**

1) Once Fire Alarm is announced, Security will meet the Mishawaka Fire Department at the Fire Command Center (Level 1, far South side of ED) to direct them to the location of the fire [Plymouth-Main Entrance]

2) The Fire Department will assume command of the scene upon arrival.

STAFF RESPONSE TO FIRE ALARM

A. **SWITCHBOARD OPERATOR RESPONSIBILITIES -** When notified of a fire by phone or fire alarm, the switchboard operator will:

1) Over the public address system, announce the Code F and its location as indicated on the Edwards Fire System and/or as called on extension "55555" [Plymouth 8-8888] . Switchboard Operator will announce **"Attention please, Code F, (location given on screen or by caller)** and then repeat this phrase three times.

2) Notify security

3) Contact the Mishawaka/Plymouth Fire Department using the Red phone or 911. Give the location of the fire and any additional information if known.
4) Notify the Administrator on-call, Administrative Supervisor, Safety Officer, Manager of Plant Operations, and/or designees.
5) Keep one outside line free for emergency use.
6) Once the fire has been extinguished, under the advisement of the Mishawaka/Plymouth Fire Department the Administrator On-Call, Administrative Supervisor, Safety Officer or their designee will direct the switchboard operator to announce "All Clear" over the in-house public address system. The switchboard operator may not accept the "All Clear" direction from any other staff member.
7) Reset the Fire system when instructed to do so by the authorized person.

B. **ADMINISTRATOR ON-CALL, ADMINISTRATIVE SUPERVISOR, SAFETY OFFICER RESPONSIBILITIES**

1) Report to the scene of the fire.
2) Directs all SJRMC fire emergency activities in conjunction with the Mishawaka Fire Department.
3) In the event that medical gasses must be shut off, ONLY THE CHARGE NURSE/PERSON or RESPIRATORY THERAPY can authorize the shutoff of medical gasses. Anyone can be directed to turn the shutoff valve, but ONLY THE CHARGE NURSE/PERSON or RESPIRATORY THERAPY can authorize it.
4) May initiate Incident Command System (refer to Incident Command System Procedures).
5) Under the advisement of the Mishawaka/Plymouth Fire Department, notify the switchboard operator to give the "all clear" announcement.

C. **SECURITY RESPONSIBILITIES**

1) Meet the Mishawaka Fire Department at the Fire Command Center (Level 1, far South side of ED) Plymouth Main Entrance
2) Provide backup support to the Administrator On-Call.
3) Complete a fire alarm evaluation.
4) Ensure all used fire extinguishers are picked up and scheduled for recharging.

D. **EMERGENCY RESPONSE GROUP RESPONSIBILITIES**

1) The following staff will **report immediately** to the announced area:
   a) All designated Plant Operations associates
   b) All designated Environmental Services associates
   c) All Security associates
2) Respond to all fire alarms with extinguishers.
3) Contain fire by assuring all corridor fire doors, doors, and windows in the immediate area are closed.
4) Assist the fire department and nursing unit as needed.
5) Protect equipment from unnecessary water damage.

6) Once the "all clear" is given, ensure all extinguishers with intact seals are returned to the point from which they were obtained.

7) Plant Operations, shut off air supply and air exhaust/return unit to area affected by the fire.

E. STAFF RESPONSE TO FIRE ALARM – AT FIRE POINT OF ORIGIN

1) In the event the fire or smoke is present in your work area, the following steps should be taken during a Fire Alarm:

   a) Practice **RACE**

      (1) **R**escue persons in immediate danger (room evacuation).

      (2) **A**larm by pulling the closest fire alarm pull station or directing a co-worker to dial "55555". [Plymouth 8-8888]

      (3) **C**ontain the fire by closing the door to the room or area.

      (4) **E**xtinguish the fire by using a portable fire extinguisher and the PASS acronym if you are able; do not put yourself at risk.

   b) In the event the fire is in a patient care area, and can be contained to a room or area without causing harm to other patients, visitors, or staff, associates should begin closing doors and windows to other patient rooms.

   c) In the event the fire is in a patient care area, and cannot be contained to a room or area without causing harm to other patients, visitors, or staff, associates should immediately begin moving patients and visitors through egress routes past smoke/fire doors (horizontal or vertical evacuation).

   d) When evacuating an area, you need to move patients and visitors through one set of fire doors before evacuating vertically.

   e) Take a count of patients (use patient census report if able) and visitors in your department.

   f) Supply medical gas masks via portable tanks to those in need.

   g) Portable medical gas tanks should be moved away from fire area to a place of safety.

   h) Wall medical gas system will be shut off as directed: **ONLY THE CHARGE NURSE/PERSON or RESPIRATORY THERAPY** can authorize the shutoff of medical gasses. Anyone can be directed to turn the shutoff valve, but **ONLY** the Charge Nurse/Person or Respiratory Therapy can authorize it.

F. STAFF RESPONSE TO FIRE ALARM – AWAY FROM FIRE POINT OF ORIGIN

1) In the event the fire or smoke is **not** present in your work area, the following steps should be taken during a Fire Alarm:

   a) Comply with specific duties assigned by this plan and your department director/supervisor.

   b) Close all doors and windows in your area.

   c) Contain patients and visitors to an area of safety within your department.

   d) Take a count of patients (use patient census report if able) and visitors in your department.

e) Begin taking steps to prepare/talk through evacuation. If the fire alarm is in an adjacent area, prepare to evacuate.

f) When evacuating an area, you need to move patients and visitors through one set of fire doors before evacuating vertically.

G. **TERMINATION – "ALL CLEAR" ANNOUNCEMENT**

1) Once the fire has been extinguished and/or the alarm assessed, under the advisement of the Mishawaka/Plymouth Fire Department, the Administrator On-Call, Administrative Supervisor, Safety Officer or their designee will direct the telephone operator to announce "all clear".

2) Operator will announce, "Attention Please, Fire Alarm All Clear", (repeat phrase three times)

H. **STAFF EDUCATION**

1) During the new hire orientation process each new associate will receive education on the Fire Plan.

2) Staff receives annual Environment of Care education through HealthStream.

3) Staff receives annual fire extinguisher training through HealthStream.

4) In addition, staff also receives education by participating in fire drills held throughout the year.

SPECIFIC DEPARTMENTAL DUTIES - Operating Room, Labor and Delivery, Anesthesia

POLICY:

A. To identify key concepts for fire prevention and define the response to surgical/procedural fires.

B. These guidelines apply to all procedural areas where there is a potential fire risk. Including but not limited to the operating rooms (OR's), labor and delivery, interventional radiology and catheterization lab.

C. Medical, nursing and ancillary colleagues working in the perioperative/ procedural environment will adhere to these guidelines.

D. Preventing fires and associated risks to the patient and colleagues is the responsibility of all perioperative colleagues. All colleagues have the responsibility to be aware of prevention strategies.

E. All OR fires will be fully investigated by conducting a complete root cause analysis (RCA).

F. Colleagues will complete mandatory annual fire safety education/competency and will also receive fire education/competency as part of orientation.

1) Colleagues will be aware of the risks and components of the fire triangle:

a) Heat: (electrocautery, laser, light sources, electrical equipment).

b) Fuel: (drapes, clothing, linens, alcohol based skin preps, collodion, tinctures, patient hair and GI gases, shoe covers etc.).

c) Oxidizer: (oxygen, nitrous oxide).

2) Colleagues will be knowledgeable of, and implement interventions for:

a) Controlling ignition sources

b) Managing fuel sources

c) Minimizing oxidizers

d) Be aware of RACE and responses for each.

(1) Rescue

(2) Alarm

(3) Confine

(4) Extinguish

e) Location and proper use of fire extinguishers (PASS).

(1) Pull pin

(2) Aim at base of flame

(3) Squeeze handle

(4) Sweep

f) Location of medical gas shut off valve.

g) Egress locations.

h) Evacuation procedures.

Note: Respond to fire- follow your emergency preparedness policy.

G. Fire Risk Assessment

1) Perioperative / procedural colleagues and anesthesia will conduct a fire risk assessment at the beginning of each procedure.

2) Appropriate fire safety prevention strategies will be utilized to ensure patient and colleague safety.

3) Active communication among all colleagues and physicians will occur regarding the potential use of an ignition source in an oxygen enriched environment and where alcohol based skin preps are used.

H. All OR colleagues, physicians and anesthesia will utilize the following operating/procedural fire prevention strategies.

1) Heat- Ignition source

a) Electrocautery Unit (ESU)

(1) Place the patient return electrode on a large muscle mass close to the surgical site.

(2) Store the ESU pencil in a plastic holder when not use.

(3) Keep surgical drapes or linens away from an activated ESU.

(4) Moisten drapes if absorbent towels and sponges will be used in close proximity to the ESU active electrode.

(5) Do not use an ignition source to enter the bowel when distended with gas.

(6) Keep ESU active electrode away from oxygen or nitrous oxide.

(7) Keep the ESU tip clean.

(8) Use active electrodes or return electrodes that are manufacturer approved for the ESU being used.

(9) Use approved protective covers as insulator on the active electrode tip. Not red rubber catheter or packing material.

(10) Activate ESU only in close proximity to target tissue and away from other metal objects.

(11) Inspect minimally invasive electrosurgical electrodes for impaired insulation; remove electrode from service if not intact.

(12) Use cut or blend settings instead of coagulation.

(13) Use lowest power setting for the ESU.

(14) Only the person controlling the active electrode activates the ESU.

(15) Remove active electrode from electrosurgical or electrocautery unit before discarding.

b) Laser:

(1) Use a laser-resistant endotracheal tube when using laser during upper airway procedures.

(2) Consider placing wet sponges around the tube cuff if operating in close proximity to the ET tube.

(3) Use wet sponges or towels around the surgical site

(4) Only the person controlling the laser beam activates the laser.

(5) Have water and the appropriate type fire extinguisher available.

c) Light sources and other electrical equipment.

(1) Place the light source in standby mode or turn off when not in use.

(2) Inspect light cables before use and remove from service if broken light bundles are visible.

(3) Select defibrillator paddles that are correct size

(4) Use only manufacturer recommended defibrillator paddle lubricant.

(5) Place defibrillator paddle appropriately.

(6) Inspect electrical cords and plugs for integrity and remove from service if broken.

(7) Check biomedical inspection stickers on equipment for a current inspection date and remove from service if not current.

(8) Do not bypass or disable equipment safety features.

(9) Follow manufacturer's recommendations for use.

(10) Keep fluids off electrical equipment.

2) Fuel Source:

a) Safe use of alcohol based (flammable) skin preparation agents

(1) Alcohol skin preps are to be used with extreme caution on head and neck procedures. Adequate time must be allotted to allow all liquids and fumes to dry and dissipate. Extended dry times may be needed.

(2) Conduct a skin prep "time out" to ensure the prep is completely dry.

(3) Allow skin-prep agents to dry completely according to manufacturer's recommendations- extend dry times to areas with skin folds and hair.

(4) Use appropriate size prep for surgical area.

(5) Prevent pooling of skin prep solutions.

(6) Remove prep-soaked linen and disposable prepping drapes.

(7) Allow fumes to dissipate before draping.

(8) Allow chemicals (e.g., alcohol, collodion, tinctures) to dry completely.

(9) Use moist towels around the surgical site when using a laser.

(10) Consider using moist sponges to pack the throat during throat procedures.

(11) Use water based ointment (i.e. KY) and not oil based ointment in facial hair and other hair near the surgical site.

b) Caution is to be used for all materials described as non-flammable (all non-flammable material will burn under the right conditions).

I. Oxidizers- Oxygen (air), Nitrogen, Oxygen Enriched Atmosphere (OEA).

1) Stop supplemental 02 or nitrous oxide 1 minute before using ignition source.

2) If >30% concentration required, intubate or use laryngeal mask airway.
3) Tent drapes to allow for free air flow.
4) Keep oxygen percentage as low as possible.
5) Use an adhesive incise drape.
6) Inflate endotracheal tube cuff with tinted saline for oropharynx or airway type procedures.
7) Evacuate surgical smoke from small or enclosed spaces.
8) Consider packing wet sponges around the back of the throat for oropharynx or airway type procedures.
9) If supplemental O2 is used -suction the oropharynx deeply before using ignition source for oropharynx procedures.
10) Check anesthesia circuits for possible leaks.
11) Turn off O2 at end of each procedure.

REFERENCES/STANDARDS:

- AORN (2013). Fire prevention in the perioperative setting. *Association of periOperative Registered Nurses*. Retrieved from http://www.aorn.org/PracticeResources/ToolKits/FireSafetyToolKit/
- CMS (2013), State Operations Manual , Appendix A - Survey Protocol, Regulations and Interpretive Guidelines for Hospitals http://cms.gov/manuals/Downloads/som107ap_a_hospitals.pdf
- FDA (2011). Recommendations for healthcare professionals on preventing surgical fires. FDA US Food and Drug Administration. Retrieved from http://www.fda.gov/MedicalDevices/Safety/AlertsandNotices/ucm275189.

SAINT JOSEPH
Regional Medical Center

Version #: 1

Title: Code Blue Resuscitation Process

Document Owner: Michelle Suetkamp	PI Team: Provision of Care	Date Created: 07/01/1992
Approver(s): Michelle Suetkamp	Date Approved with no changes: 01/30/2023	Date Approved: 01/30/2023
Location: Saint Joseph Regional Medical Center (SJRMC)		Department: Nursing Administration (14030_10005) (14035_10005) Nursing, Nursing Floats, Surgical Intensive Care Unit

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POLICY:

POLICY STATEMENT

1. Basic resuscitative and life support services will be immediately initiated for any person who experiences a medical emergency, unless otherwise directed by a valid advance directive statement from the person.
2. Determines, whenever possible, whether the individual has a resuscitative order or a do-not-resuscitate order
    - Then review the chart for corresponding documentation.
    - Follows established hospital policies and procedures related to advance directives.
    - If evidence of relevant advance directives cannot be provided or confirmed, assumes none exists and provides appropriate resuscitative services.

PURPOSE

To establish procedures for providing appropriate resuscitative and life support services to persons experiencing a medical emergency to save or sustain life as part of the hospital's commitment to patient health and safety.

SCOPE: Applies to medical emergencies experienced by all persons at the hospital, including patients, staff, family members, visitors, and others.

1. Applies to the acute care hospitals, the MRI centers, and some Medical Office Building (MOB) Suites. All entities within the MOB (SJHS owned and non-owned) should notify 911 as well as activate the Code team. SJHS code team will handoff appropriately to the EMS. EMS will assume management of the code upon arrival. If the patient requires ED intervention, EMS will transport the patient to the ED.
2. Code Blues in procedural areas (OR, IR, Cath Lab, Endo Lab) will be managed by the department. Code Blue Team will be called if more assistance is required.
3. At Plymouth Campus, for code blues in the MOB/ONC areas the Med Surg Step Down Unit will take the adult crash carts. The ER staff or security will bring the Ferno Cart. If pediatric code, the pediatric crash cart will be taken by an RN from the ER Department. The ER nurse will bring the I/O drill and needles.

RESPONSIBILITIES

The Provision of Care Committee is responsible for overseeing, reviewing, revising, maintaining, and implementing this policy.

Every staff member is responsible for the following:

Title: Code Blue Resuscitation Process

- Identifying persons experiencing a medical emergency that requires resuscitative or life support services
- Responding to those incidents according to established hospital policy

The Code Team is responsible for responding to codes. The Code Team consists of the following roles:

- Code team leader – A physician or nurse with advanced training who directs the overall resuscitative effort and issues all medical and resuscitative orders and medications
- A charge nurse or other nursing supervisor who coordinates the response, communicates with family, manages crowd control (with security team), and coordinates patient transfer
- A bedside nurse or any other individual who finds the patient unresponsive or in cardiac or respiratory arrest who calls for help and starts CPR
- Recorder – A nurse with code experience who maintains accurate documentation of the event and all interventions. Documents all patient care activities associated with the code, including all resuscitative and life support services provided. Documentation will be entered into the EMR.
- Respiratory leader – A respiratory therapist or physician who manages the airway including performing bag mask ventilation and/or intubation
- Compressor – An individual with CPR training who performs chest compressions
- A nurse who manages the patient's IVs and medications
- Code cart nurse – A nurse who manages the crash cart and its contents
- Pharmacist – A pharmacist responds to all code blues that are called overhead at the Mishawaka campus and during the day at the Plymouth campus and House Supervisor after-hours at Plymouth.
- Multi-Specialty Technician-a MST from critical care or designated by the house supervisor will respond to provide laboratory draws and processing support at Mishawaka Campus.
- Phlebotomist or designee will respond at the Plymouth Campus.

Individuals may perform more than one role on the Code Team, if necessary.

A pediatric/neonatal RN will respond to pediatric/neonatal code blues. The pediatric/neonatal RN will bring the pediatric code cart to pediatric codes occurring in units outside of PACU, Post Op, ED, and Pediatrics.

If Pediatric code is called outside of ED or PACU, the ED will bring the Pediatric code cart and IO kit at the Plymouth Campus.

PROCEDURES

1. Any staff member that needs to activate the code blue while the patient is in their room should pull the code blue lever in the room. Any staff member calls the hospital operator at 5-5555 in Mishawaka and 8-8888 in Plymouth to activate the hospital's Code Team and provides the operator with the precise code location when a code occurs outside of the patient room. Additionally, the caller should inform the operator if the patient is pediatric. NICU codes are not called overhead.
2. The hospital operator does the following:
   - Records information from the caller.
   - Records the date and time of the call.
   - Announces the code and designates the exact location.

Title: Code Blue Resuscitation Process

3. The charge nurse on the unit where the code occurred or designee does the following:
   Maintains and manages code carts, including the following:
   - Cleans back board, monitor and external surfaces of the code cart.
   - Take medication drawer to Pharmacy for a replacement.
   - Notify Distribution that code cart was used so that supplies can be replaced for Mishawaka Campus
   - House Supervisor will ensure code cart is replenished and ready for us at the Plymouth Campus.
4. Code Blue Team
   - Responds immediately to all codes and calls for assistance.
   - Provides appropriate resuscitative and/or life support measures.
   - Provides family members the option of being present during resuscitation procedures, if appropriate, according to established hospital policy.
5. An ED staff member will bring a stretcher to all codes in non-clinical areas to transport the patient.

REFERENCE
Joint Commission Standard PC.02.01.11, EP 1. Resuscitation services are provided to the patient according to the [hospital]'s policies, procedures, or protocols.

Reference Policies:
Advance Directive Policy

SAINT JOSEPH
Regional Medical Center

Version #: 6

Title: ELECTROSURGICAL SAFETY

Document Owner: Stephanie Luther	PI Team: Environment of Care, Provision of Care	Date Created: 08/01/92
Approver(s): Jeannie Bowlin, Loretta Schmidt, Suzanne Risner		Date Approved: 10/04/2023
Location: Saint Joseph Regional Medical Center (SJRMC)		Department: Operating Room (14030_37020)

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POLICY:

1. To provide guidelines to perioperative staff in the use and care of the electrosurgical equipment.
   A. Personnel working with electrosurgery equipment shall be knowledgeable about the principles of electrosurgery, risks to patients and measures to minimize these risks and corrective actions to employ in the event of a fire or injury.
   B. In all procedures involving the use of electrosurgical equipment, patients and personnel must be protected from hazards associated with electrosurgery.

PROCEDURE:

A. Personnel selecting new and refurbished electrosurgical units (ESU) and accessories for purchase or use shall make decisions based on safety features to minimize risks to patients and personnel.

B. The ESU shall be used in a manner that minimized the potential for injuries.
   1) Instructions for ESU use, warranties and a manual for maintenance and inspections shall be obtained from the manufacturer and be readily available to users.
      a) Operating instructions specific for the device shall be on or attached to each ESU.
   2) The ESU shall be securely mounted on a tip-resistant cart or shelf and shall not be used as a shelf or table.
   3) The ESU shall be protected from liquids.
      a) Liquids shall not be place on top of the ESU.
      b) Foot pedal accessories shall be encased in a clean, impervious cover when there is potential for fluid spills on the floor.
   4) Safety and warning alarms and activation indicators shall be operational, audible, and visible at all times.
   5) The ESU shall be visually inspected and the return electrode monitor tested according to manufacturer's instructions before use.
   6) Settings should be based on the operator's preference consistent with the intended application and the manufacturer's written instructions for patient size, active electrode type, and return electrode placement.
   7) The circulating nurse shall confirm the power settings with the operator before activation of the ESU.
   8) The ESU shall be operated at the lowest effective power setting needed to achieve the desired tissue effect.
   9) If the operator requests a continual increase in power, personnel shall check the entire ESU and accessories circuit for adequate placement of the dispersive electrode and cord connections.

10) The electrode tip shall be visually inspected before each use and replaced if damaged.
11) Perioperative registered nurses shall be aware of potential patient safety hazards associated with specific internal implanted electronic devices (IED) and the appropriate patient care interventions required to protect the patient from injury. These devices may include cardiac pacemakers, implanted cardioverter defibrillators (ICD), neurostimulators, implantable hearing devices, implantable infusion pumps, and osteogenic stimulators.
12) After use, personnel shall
    a) Turn off the ESU;
    b) Dispose of single use items;
    c) Clean all reusable parts and accessories according to the manufacturer's directions
    d) Inspect accessories and parts for damage, function, and cleanliness.
13) An ESU that is not working properly or is damaged shall be removed from service immediately and reported to Biomed.

C. The electrical cords and plugs of the ESU shall be handled in a manner that minimizes the potential for damage and subsequent patient and user injuries.
    1) The ESU electric cord shall be adequate in length and flexibility to reach the electrical outlet without stress or the use of an extension cord.
    2) The ESU shall be placed near the sterile field, and the cord shall reach the wall or column outlet without stress on the cord and without blocking a traffic path.
    3) The electrical cord shall be free of kinks, knots, and bends.
    4) The ESU plug, not the cord, shall be held when it is removed from the outlet.
    5) The ESU's cord should be kept dry.
    6) The ESU's cord shall be inspected or electrically tested for outer insulation damage.
        a) The ESU shall be removed from use if there is any evidence of breaks, nicks, or cracks in the outer insulation coating of the electrical cord.

D. The active electrode shall be used in a manner that minimizes the potential for injuries.
    1) The active electrode shall be visually inspected at the surgical field before use. Inspection shall include but not limited to
        a) Identifying any apparent damage to the cord or hand piece; and
        b) Ensuring compatibility of the active electrode, accessories, the ESU, and the procedure.
    2) A damaged and/or incompatible active electrode, accessory, or ESU shall be immediately removed from use.
    3) When not in use, the active electrode should be placed in a clean, dry, non-conductive safety holster. A plastic or other non-conductive device should be used to secure the active electrode cord to the sterile drapes.
        a) The protective cap of a battery-powered cautery should be in place when the cautery is not in use.
    4) The electrode cord should be kept free of kinks and coils during use.
    5) The active electrode should be connected directly into a designated receptacle on the ESU.
        a) When needed, only adaptors approved by the manufacturers of both the ESU and the accessory shall be used.

6) Only the user of the active electrode should activate the device whether it is hand or foot controlled.
7) Active electrode tips shall be used according to the manufacturer's instructions. The active electrode tip:
    a) Should be compatible with the ESU.
    b) Should be securely seated into the hand piece, and
    c) Should not be altered.
8) The active electrode tip should be cleaned away from the incision whenever there is visible eschar.
9) Methods to remove debris from the active electrode tip should include but not limited to;
    a) A moistened sponge or instrument wipe to clean non-stick electrosurgical tips on the sterile field, and
    b) Abrasive electrode cleaning pads to remove eschar from non-coated electrodes on the sterile field.
    c) The active electrode tip should not be cleaned with a scalpel blade.
10) If the active electrode becomes contaminated, it should be disconnected from the ESU and removed from the sterile field.
11) If an active monopolar electrode is being used in a fluid-filled cavity, the fluid used should be an electrically inert, near isotonic solution (e.g., dextra 10, dextran 70, glycine 1.5%, sorbitol, mannitol) unless the equipment manufacturer's written directions for use instruct otherwise.
12) The active electrode shall be placed on the mayo stand at the delivery time of the baby in the cesarean section operating room.
13) Fire safety measures shall be followed when electrosurgery is in use according to local, state, and federal regulations.
    a) Active electrodes shall not be activated in the presence of flammable agents (e.g. antimicrobial skin prep, de-fatting agents, uncured methyl methacrylate) until the agents are dry and vapors have dissipated.
    b) Caution shall be used during surgery on the head and neck when using active electrode in the presence of combustible anesthetic gases.
    c) Open suture packets containing alcohol shall be removed from the sterile field as soon as possible.
    d) Sponges used near the active electrode tip should be moist to prevent unintentional ignition.
    e) When battery-powered, hand-held cautery units are used, the batteries should be removed before disposal of the cautery unit
    f) Electrosurgery should not be used in the presence of gastrointestinal gases.
    g) Electrosurgery should not be used in an oxygen-enriched environment.
        (1) The lowest possible oxygen concentration that provides adequate patient oxygen saturation should be used.
        (2) Surgical drapes should be arranged to minimize the buildup of oxidizers (eg oxygen and nitrous oxide) under the drapes, to allow air circulation, and to dilute the additional oxygen.

(3) The active electrode should be used as far from the oxygen source as possible.

h) Personnel should be prepared to immediately extinguish flames should they occur.

(1) Nonflammable material (e.g., wet towel, sterile saline, water) should be available on the sterile field to extinguish the fire.

E. When monopolar electrosurgery is used, a dispersive electrode shall be used in a manner that minimizes the potential for injuries.

1) The patient's skin condition shall be assessed and documented before and after ESU use.
2) Return-electrode contact quality monitoring should be furnished on general-purpose electrosurgery units. Dual return electrodes should be used.
3) Return-electrode continuity monitoring should be used if return-electrode contact quality monitoring is not available. If using return-electrode continuity, a single-foil electrode should be used.
4) Dispersive electrodes shall be compatible with the ESU.
5) A single-use dispersive electrode shall be used once and discarded. If a single-use dispersive electrode must be repositioned, a new single-use electrode shall be used.
6) Dispersive electrodes shall be an appropriate size for the patient (e.g., neonate, infant, pediatric, adult) and not altered (e.g., cut, folded).
7) Before the application of a single –use dispersive electrode,
   a) The manufacturer's expiration date should be verified, and the dispersive electrode should not be used if it is past the manufacturer's date;
   b) The package containing the dispersive electrode should be opened immediately before use; and
   c) The integrity of the dispersive electrode should be checked for flaws, damage, discoloration, adhesiveness, and dryness.
8) The conductive and adhesive surfaces of the single-use dispersive electrodes should be placed on clean, dry skin over a large, well-perfused muscle mass on the surgical side and as close as possible to the surgical site according to the manufacturer's directions for use.
9) Single-use electrodes should not be placed over bony prominences, scar tissue, hair, weight-bearing surfaces, potential pressure points, or areas distal to tourniquets.
10) Hair should be removed following recommended practices (i.e., clipping) if it interferes with single-use electrode contact with the patient's skin.
11) The single-use electrode should not be placed over an implanted metal prosthesis including insulin pumps.
12) Placing the single-use electrode over a tattoo, many of which contain metallic dyes, should be avoided.
13) Following application of the single-use dispersive electrode, uniform contact with the skin should be verified.
14) Corrective measures for poor single-use dispersive electrode contact include, but not limited to
   a) Removing oil, lotion, moisture, or prep solution;
   b) Removing excessive hair; changing sites; and
   c) Applying a new pad.

15) The single-use dispersive electrode should be placed on the patient after final positioning.
    a) If tension is applied to the dispersive electrode cord, the perioperative registered nurse should reassess the integrity of the dispersive electrode, its contact with the patient's skin, and the connection to the ESU.
    b) If the patient is repositioned, the perioperative registered nurse should verify that the dispersive electrode is in full contact with the patient's skin.
16) The single-use dispersive electrode should be placed away from a warming device.
17) Dispersive electrodes should be kept dry and protected from fluids seeping or pooling under the electrode.
18) Contact between the patient and metal devices should be avoided.
    a) Patient's metal jewelry that is between the active and dispersive electrode should be removed.
    b) Patient's monitoring electrodes (e.g., electrocardiogram, oximetry, fetal) should be placed as far away from the surgical site as possible.
    c) Needle electrodes for monitoring or non-surgical functions should be avoided.
    d) When use of needle monitoring electrodes is medically necessary, alternate electrosurgery technologies (e.g., bipolar, laser) should be considered.
19) When multiple ESU are used simultaneously during a surgical procedure, the compatibility of equipment and proper functioning of corresponding electrode monitoring systems should be verified with the manufacturer.
    a) Separate single-use dispersive electrodes should be used for each ESU.
    b) The dispersive electrodes should be placed as close as possible to their respective surgical sites and the single-use dispersive electrodes should not overlap.
20) During high-current, long-activation-time, radio-frequency (RF) ablations and other electrosurgical procedures (e.g., tumor ablation, bulk tissue resection), considerations should include, but not limited to;
    a) Identifying surgical procedures that require the use of high-current, long-activation-time RF ablation and electrosurgical techniques;
    b) Taking inventory of RF generators that require special or multiple dispersive electrodes;
    c) Following the manufacturer's recommendations for use of large-size dispersive electrodes or multiple dispersive electrodes;
    d) Ensuring proper placement and full patient contact of the dispersive electrode;
    e) Reviewing the manufacturer's directions for use and requirements for accessories;
    f) Using and selecting the appropriate non-conductive, near-isotonic solutions (e.g., sorbitol, mannitol, dextran 10 or 70, glycine) for irrigation or distention unless contraindicated by manufacturer's directions; and
    g) Using the lowest possible power settings and minimum activation time for obtaining the desired tissue effect.
    h) When a single dispersive electrode does not adequately disperse high current and there are not specific manufacturer's directions, a second dispersive electrode with an adaptor or return electrode with a larger conductive surface may be considered for use.

21) When removing the single-use dispersive electrode, the adjacent skin should be held in place and the dispersive electrode peeled back slowly.

F. **Personnel shall take additional precautions when using electrosurgery during minimally invasive surgery**.

1) Personnel should verify that the insufflation gas is nonflammable.
2) Conductive trocar systems should be used.
3) Minimally invasive surgery electrodes shall be examined for impaired insulation before use.
   a) Active electrode insulation integrity testers that use high DC voltage to detect full thickness insulation breaks shall be used.
   b) The lowest power setting that achieves the desired result should be selected.
4) The active electrode should not be activated until it is in close proximity to the tissue.
5) Patients should be instructed to immediately report any postoperative signs or symptoms of electrosurgical injury. Patient postoperative care instructions should include symptoms to look for, including but not limited to
   a) Fever
   b) Inability to void
   c) Lower gastrointestinal bleeding
   d) Abdominal pain
   e) Abdominal distention
   f) Nausea
   g) Vomiting
   h) Diarrhea

G. Bipolar active electrodes, including vessel-occluding devices, shall be used in a manner that minimizes the potential for injuries.

1) Molded, fixed-position pin placement bipolar cord should be used. Bipolar and monopolar plugs should be differentiated to prevent misconnections of active and return electrodes.
2) Dispersive electrodes are not needed with bipolar active electrodes.

H. Ultrasonic electrosurgical devices shall be used in a manner that minimizes potential for injuries.

1) When using an ultrasonic electrosurgical device, a dispersive electrode should not be used.
2) Inhalation of aerosols generated by an ultrasonic electrosurgical hand piece should be minimized by implementing control measures, including but not limited to smoke evacuation systems and wall suction with an in-line ultra low penetration air (ULPA) filter.

I. Argon enhanced coagulation (AEC) technology poses unique risks to patient and personnel safety and shall be used in a manner that minimized the potential for injury.

1) All safety measures for monopolar electrosurgery should be used when using AEC technology.
2) Air should be purged from the argon gas line and electrode by activating the system before use, after moderate delays between activations, and between uses.
3) The argon gas flow should be limited to the lowest level possible that will provide the desired clinical effect. **WARNING**: The Argon gas flow must be turned down to 4L (or as low as possible for laparoscopy. **IT MUST NEVER BE USED IN THE UTERUS.**

4) The active electrode should not be placed in direct contact with tissue and should be moved away from the patient's tissue after each activation.
5) When using the AEC unit during minimally invasive surgical procedures, personnel should follow all safety measures identified for AEC technology.
    a) Endoscopic CO2 insufflators should be equipped with audible and visual over-pressurization alarms that cannot be deactivated.
    b) The active electrode and argon gas line should be purged according to the manufacturer's recommendations.
    c) The patient's intra-abdominal cavity should be flushed with several liters of CO2 between extended activation periods.
6) Personnel using the AEC technology should be knowledgeable about signs, symptoms, and treatment of venous emboli.
    a) Patient monitoring should include devices that are considered effective for early detection of gas emboli (e.g., end tidal CO2).

J. Potential hazards associated with surgical smoke generated in the practice setting shall be identified, and safe practices established.
1) Surgical smoke should be removed by use of a smoke evacuation system in both open and laparoscopic procedures.
    a) When large amounts of plume are generated, an individual smoke evacuation unit with a ULPA filter should be used to remove surgical smoke.
    b) The suction wand of the smoke evacuation system should be no greater than two inches from the source of the smoke generation.
    c) Smoke evacuation units and accessories should be used according to manufacturer's written instructions.
    d) When a minimal amount of plume is generated, a central suction system with an in-line ULPA filter may be used to evacuate the plume.
    e) When a centralized system dedicated for smoke evacuation is available, the smoke evacuator lines should be flushed according to the manufacturer's instructions to ensure particulate matter buildup does not occur.
    f) Used smoke evacuator filters, tubing, and wands should be disposed of as potentially infectious waste following standard precautions.
    g) Personnel should wear high-filtration surgical masks during procedures that generate surgical smoke.

K. Personnel shall receive initial education and competency validation on procedures and shall receive additional training when new equipment, instruments, supplies or procedures are introduced.

L. Documentation shall include, but not limited to:
1) Electrosurgical system identification serial number
2) Range of settings used
3) Dispersive electrode placement
4) Patient's skin condition before dispersive electrode placement
5) Patient's skin condition after removal of dispersive electrode

6) Adjunct electrosurgical devices used (e.g., ultrasonic scalpel, bipolar forceps)

References/Standards:

- 2016 Perioperative Standards and Recommended Practices, Association of PeriOperative Registered Nurses, Inc, Denver, CO.
- Rothrock, Jane C., Alexander's Care Of The Patient In Surgery, 16th ed., Mosby, St. Louis, Missouri, 2018.

SAINT JOSEPH
Regional Medical Center

Version #: 5

Title: MALIGNANT HYPERTHERMIA CRISIS

Document Owner: Stephanie Luther	PI Team: Provision of Care	Date Created: July 1, 1996
Approver(s): Bowlin, Jeannie; Risner, Suzanne		Date Approved: 08/02/2022 June 30, 2011
Location: Saint Joseph Regional Medical Center (SJRMC)		Department: Cardiac Cath lab-angioplasti (14030_13230), Cardiac Intervention Unit (14030_37070), Emergency Medical Service (14030_86230), Emergency Room Services (14030_36000), GI Lab (14030_37200), Operating Room (14030_37020), Post Op Phase II (14030_37040), Recovery Room (PACU) (14030_37500)

POLICY:

1. Registered nurses, and the surgical technologists in perioperative areas, critical care, emergency department, Family Birthplace and House Administrative Supervisors shall be knowledgeable about malignant hyperthermia. Anesthesiologists shall manage the patient in a malignant hyperthermia crisis and the perioperative nursing team shall assist the anesthesiologist during a malignant hyperthermia crisis.

PROCEDURE:

A. Suggested M.H.A.U.S. (Malignant Hyperthermia Association of the United States) protocol for malignant hyperthermia management shall be available in the perioperative department and on the malignant hyperthermia cart.
   1) This protocol may provide guidelines for patient management but may not apply to every patient and out of necessity must be altered according to specific patient needs.

B. The malignant hyperthermia hotline phone number shall be available on the malignant hyperthermia cart.

C. Malignant hyperthermia crisis cart with supplies shall be available in Surgical Services. Additional medication is located in Family Birthplace and in the Pharmacy.
   1) If a malignant hyperthermia event occurs outside Surgical Services staff should immediately call 5-5555 to initiate the emergency response "Malignant Hyperthermia Code" to their specific location.
      a) The operator will overhead "Malignant Hyperthermia Code" and the location.
      b) The operator will call the House Supervisor, Pharmacy, Surgery Charge at 5-2110 and OB Anesthesia.
      c) Plymouth Campus notify the Administrative Supervisor
   2) The house supervisor will retrieve the Malignant Hyperthermia Cart from PACU and cool fluids from the West Core in Surgery and deliver it to the location. As available, surgery staff will be sent to support the care and treatment of the patient. As available, an anesthesiologist will also be sent.
      a) Plymouth-MH cart located OR corridor and cool fluids in PACU refrigerator.

3) Supplies shall include but not limited to:
   a) Drugs: Dantrium (Dantrolene) x 36 vials and sterile water for mixing Dantrium
   b) Equipment: Syringes, needles, Foley catheter kit, urometer, nasogastric tubes (varied sizes, rectal tube, tubes and labels for blood studies.
4) An assigned person shall restock outdated medications and supplies on a routine basis.
5) The crash cart shall be used along with the Malignant Hyperthermia cart during a crisis.

D. Refrigerated supplies that may be needed to bring body temperature down will be kept in the department. These supplies include but not limited to:
   1) Humulin - regular
   2) Normal Saline solution for irrigation and infusion.
   3) Ice packs for application to the head, axilla, groin and underneath patient, if possible.

E. If a patient is known to be a susceptible malignant hyperthermia patient:
   1) Notify the surgeon and anesthesiologist of patient's history.
   2) Have malignant hyperthermia supplies readily available.
   3) Have the crash cart readily available.
   4) Using the patient's weight, calculate initial Dantrium dose to be used if crisis occurs.

F. Employee education:
   1) All staff in each department who care for post-surgical patients including registered nurses, licensed practical nurses, surgical technologists, specialist techs and assistive personnel shall read and know this policy with its associated procedure and complete annual education on malignant hyperthermia.
   2) The Director of Surgical Services and Medical Director of Anesthesia shall approve appropriate literature for review.
   3) Malignant hyperthermia literature for review shall include but not limited to:
      a) Pathophysiology
      b) Agents capable of triggering malignant hyperthermia
      c) Clinical signs of malignant hyperthermia
      d) Treatment
      e) Drug of choice
      f) Staff response to a malignant hyperthermia crisis

References/Standards:

- 2015 Perioperative Standards and Recommended Practices, Association of PeriOperative Registered Nurses, Inc., Denver, CO, 2015.
- "Emergency Therapy for Malignant Hyperthermia", Malignant Hyperthermia Association of the United States (mhaus), Sherburne, NY, February 2015.

SAINT JOSEPH
Regional Medical Center

Version #: 4

Title: SURGICAL HAND SCRUB AND STERILE GOWNING AND GLOVING

Document Owner: Stephanie Luther	PI Team: Infection Prevention, OR	Date Created: May 1, 1996
Approver(s): Jeannie Bowlin, Karen Kring, Suzanne Risner		Date Approved: 04/13/2017 June 30, 2011
Location: Saint Joseph Regional Medical Center		Department: Operating Room (14030_37020)

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POLICY:

1. A surgical hand scrub shall be done prior to sterile gowning and gloving for a surgical procedure.
2. Only sterile surgical gowns made from a material that has proven to be an effective barrier against the passage of microorganisms from nonsterile to sterile areas may be worn for surgical procedures.

PROCEDURE:

A. All personnel shall practice general hand hygiene.
   1) Hand hygiene shall be immediately before and after patient contact.
   2) Fingernails shall be kept short, clean and healthy.
      a) Nails shall not extend beyond the fingertips.
      b) Nail polish may be worn but must not be chipped or worn longer than 4 days.
   3) Clinical surgical services personnel shall not wear artificial nails.
   4) Cuticles, hands, and forearms should be free of open lesions and breaks in skin integrity.
   5) Rings, watches, and bracelets shall be removed before performing hand hygiene.
   6) Basic hand washing shall consist of washing with antimicrobial soap and water when hands are visibly soiled or using an alcohol based hand rub when hands are not visibly soiled.

B. An FDA-compliant surgical hand antiseptic agent (i.e., surgical hand scrub/rub) approved by the hospital infection control personnel shall be used for all surgical hand antisepsis/hand scrubs.
   1) Reusable containers shall be washed and dried thoroughly before refilling. Reusable containers shall not be topped off.
   2) All surgical hand scrubs/rubs shall be used according to the manufacturer's written instructions.
   3) Approved solutions to use for the surgical hand scrub/rub include but not limited to: Povidone-Iodine 7.5%, Chlorahexidine Gluconate 1% solution with Ethyl Alcohol 61% (Avaguard), 80% Ethyl Alcohol with emollients (Sterillium Rub), Chlorahexidine Gluconate Solution 2% (Endure 420).

C. Surgical hand asepsis/hand scrub shall be performed before donning sterile gloves for surgical or other invasive procedures.
   1) Rings, watches, and bracelets shall be removed before beginning the surgical hand scrub.
   2) Hands shall be washed with plain or antimicrobial soap and running water immediately before beginning the surgical hand antisepsis/scrub.

D. A traditional, standardized, anatomical, timed method or a counted stroke method may be used for surgical hand antisepsis/hand scrubs.

Title: SURGICAL HAND SCRUB AND STERILE GOWNING AND GLOVING

1) A traditional, standardized, surgical hand antisepsis scrub procedure shall include, but not limited to, the following:
   a) Wash hands and forearms with soap and running water immediately before beginning the surgical scrub.
   b) Clean the subungual areas of both hands under running water using a disposable nail cleaner.
   c) Rinse hands and forearms under running water.
   d) Dispense the approved antimicrobial scrub agent according to the manufacturers written instructions.
   e) Apply the antimicrobial agent to wet hands and forearms. Some manufacturers may recommend using a soft, nonabrasive sponge.
   f) Visualize each finger, hand, and arm as having four sides. Wash all four sides effectively. Repeat this process for opposite fingers, hand and arm.
   g) Repeat this process if directed to do so by the manufacturer's written directions for use.
   h) Avoid splashing surgical attire.
   i) For water conservation, turn water off when it is not directly in use, if possible.
   j) Hold hands higher that elbows and away from surgical attire.
   k) Discard sponges, if used, in appropriate containers.
   l) In the OR, dry hands and arms with a sterile towel before donning a sterile surgical gown and gloves.
   m) General hand hygiene shall be performed immediately after surgical gloves are removed and before any further activities are undertaken.
2) The use of a brush for surgical hand antisepsis/hand scrubs is not necessary for adequate reduction of bacterial counts.
3) A standardized alcohol-based surgical hand rub product (according to the manufacture's written directions) application shall include, but not limited to:
   a) Wash hands and forearms with soap and running water immediately before beginning the surgical hand antisepsis procedure.
   b) Clean the subungual areas of both hands under running water using a nail cleaner.
   c) Rinse hands and forearms under running water.
   d) Dry hands and forearms thoroughly with a paper towel.
   e) Dispense the manufacture-recommended amount of the surgical hand rub product.
   f) Apply the product to the hands and forearms, following the manufacturers written directions. Some manufacturers may require the use of water as part of the process.
   g) Rub thoroughly until dry.
   h) Repeat the product application process if indicated in the manufacturer's written directions.
   i) In the OR, don a sterile surgical gown and gloves.
   j) General hand hygiene shall be performed immediately after surgical gloves are removed and before any further activities are undertaken.

E. In cases of emergency, where time does not permit, the scrub procedure times may be modified.

F. Once a surgical gown is donned, it is considered sterile in front from the level of the axilla to table level and the sleeves from two inches above the elbow to gloves.

1) The back of the gown is not considered sterile.
2) Stockinet gown cuffs are not considered sterile once a hand has passed through them.

G. Gowns that become contaminated are changed or reinforced with sterile drapes or sleeves.
H. Scrub persons use closed gloving technique for initial donning of sterile gloves.
I. Gloves that develop a hole or become contaminated are changed as soon as possible using open glove technique or a sterile glove is applied over the contaminated glove.
J. When both gloves of a scrubbed person become contaminated the contaminated person needs to either regown and glove or be regloved by a sterile scrub person.
K. After donning non-sterile gloves the circulating nurses should remove the contaminated gloves of scrubbed persons.

References/Standards:

- 2011 Perioperative Standards and Recommended Practices, Association of PeriOperative Registered Nurses, Inc, Denver, CO, 2011.

SAINT JOSEPH
Regional Medical Center

Version #: 6

Title: UNIVERSAL PROTOCOL FOR PREVENTING WRONG SITE, WRONG PROCEDURE, AND WRONG PERSON SURGERY

Document Owner: Stephanie Luther	PI Team: POC		Date Created: 08/01/2001
Approver(s): Scott Ellis, Suzanne Risner		Date Approved with no Changes: 03/28/2025	Date Approved: 03/28/2025 6/14/2011
Location: Saint Joseph Regional Medical Center (SJRMC)			Department: Operating Room (14030_37020)

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POLICY:

1. The Universal Protocol focuses on the safety for all procedures (that is, all surgical and nonsurgical invasive procedures that expose patients to more than minimal risk). Patient Safety can be enhanced by correctly identifying the patient, making a correct diagnosis, selecting the appropriate procedure, identifying the correct site of the procedure, positioning the patient properly before surgery, and providing all necessary equipment.
2. Saint Joseph Health System is committed to providing quality care to the patients of our community and strives to prevent undesired patient outcomes or occurrences. This commitment is reflected in the SJRMC patient care processes where the patient care team are committed to following the "universal protocol" for preventing wrong site, wrong procedure and wrong person surgery based on the following principles:
   A. A robust approach using multiple, complementary strategies is necessary to achieve the goal of eliminating all wrong-person, wrong-site, wrong-procedure events.
   B. Active involvement and use of effective methods to improve communication among all members of the procedure team are important for success.
   C. To the extent possible, the patient and as needed, the family, are involved in the process.
   D. Consistent implementation of a standardized protocol is most effective in achieving safety.
   E. The Universal Protocol applies to all procedures that expose patients to more than minimal risk, including procedures done in settings other than the operating room.
   F. Pre-procedure verification, site marking, and the time-out procedures should be as consistent as possible throughout the hospital, including the operating room and other locations where invasive procedures are performed. In the event of life threatening emergencies only, steps may be abbreviated or skipped.
   G. Saint Joseph Health System will have zero tolerance for not adhering to the site marking policy.

PROCEDURE:

Pre-Operative Verification Procedure:

The operative/procedural team ensures that all the relevant documents and studies are available prior to the start of the procedure and that they have been reviewed and are consistent with each other, with the patient's expectations and with the team's understanding of the intended patient, procedure, site and, as applicable any implants. The team must address missing information or discrepancies before starting any procedure.

A. Verification of the correct person, procedure and site will occur at the following times:
   1) at the time the surgery/procedure is scheduled by surgical scheduler

2) at the time of pre-admission screening
3) at the time of admission or entry into the facility for a procedure – elective or emergent
4) during the signing of consent and prior to taking patient into operating room or procedural area (or at bedside if bedside procedure)

B. Verification will be done by staff completing the following processes:
1) Patient's identification wristband is visually checked by staff member and verified verbally with patient or legal designee.
2) Patient or legal designate states patient's name, birth date, procedure, procedure site and physician performing procedure to staff member.
3) Site and procedure verification with the order for consent, the consent itself, the history and physical, the surgical or procedural schedule, pre-anesthesia assessment and ancillary/diagnostic tests for films. The site must be marked prior to the surgical incision or the initiation of any procedure. Relevant images and results are properly labeled and able to be appropriately displayed.
4) Any time the responsibility for care of the patient is transferred to another caregiver, including the anesthesia providers at the time of and during the procedure.
5) With the patient involved, awake and aware, if possible or with their legal designee.
6) If patient is unable to participate in this process (i.e., comatose, incompetent, etc.), the patient's legal guardian or healthcare representative should participate in the process.

C. Marking the operative site: The team, including the patient [if possible], identifies unambiguously the intended site of incision or insertion.
1) Site marking is required for surgical procedures involving right/left distinction, multiple structures (such as fingers, toes, and/or lesions) or levels in spinal surgery.
2) The mark must be made using a marker that is sufficiently permanent to remain visible after completion of the skin prep.
3) The mark must be positioned to be visible after the patient is skin is prepped, the patient is positioned, and sterile draping is completed. If the site marking is covered during the draping process, the site must be remarked by the LIP as outlined below in Item E.
4) Final verification of the site mark must take place during the "Time Out."

D. DO NOT MARK any non-operative site.

E. The procedure site must be marked with the initials of the licensed independent practitioner or other provider who is privileged or permitted by the hospital to perform the intended surgical or non-surgical invasive procedure. This individual will be involved directly in the procedure and will be present at the time the procedure is performed. This cannot be delegated to an RN.
1) Make the mark at or near the incision site.
a) Mark all cases involving incision, percutaneous instrumentation or placement of instruments through a natural orifice with specific attention to laterality, surface (flexor, extensor) level (spine) or specific digit or lesion to be treated.
b) For minimal access procedures that intend to treat a lateralized internal organ, whether percutaneous or through a natural orifice, the intended side is indicated by a mark at or

near the insertion site indicating laterality and remains visible after completion of the skin prep and sterile draping.

c) Mark the skin at or near the proposed incision/insertion site to indicate the correct side of the proposed procedure, even when the proposed incision insertion site is in the mid-line or through a natural body orifice.

d) The mark must be positioned to be visible after the patient is prepped and draped, unless it is technically or anatomically impossible or impractical to do so.

e) Any portions of the procedure listed on the consent as "possible" involving laterality will not be marked.

2) Spinal procedure marking is completed in two steps: a) Initial marking of the general spinal region and unilaterality if not stated bilateral, with surgeon initials prior to the patient going into the operating room. b) Intra-operative radiographic techniques must be used to mark the exact vertebral level(s)

3) Craniotomies will be site confirmed by intra-operative radiographic techniques to confirm the side and site. The surgeon will identify the site by clipping the hair or by parting the hair at the incision site.

4) For cystoscopy procedures, with laterality for stent placement or removal, the site will be determined using radiographic imaging.

5) An alternative process is in place for patients who cannot easily be marked under the following conditions:

a) Cases in which it is technically or anatomically impossible or impractical to mark the site, such as mucosal surfaces, perineum and premature infants (for whom marking may cause permanent tattooing), an alternative method for visually identifying the correct side and site is used. Possible alternatives include:

(1) Marking on intact skin adjacent to the mucosa to designate laterality.

(2) Use of armbands, stickers or temporary site marking tattoos.

b) For interventional procedure cases for which the catheter/instrument insertion site is not predetermined (for example, cardiac catheterization, pacemaker insertion).

c) For teeth, the operative tooth name(s) and number are indicated on documentation or the operative tooth (teeth) is marked on the dental radiographs or dental diagram. The documentation, images, and/or diagrams are available in the procedure room before the start of the procedure.

d) For premature infants, for whom the mark may cause a permanent tattoo.

e) Any radiological procedure due to prior imaging before a procedure is started, the breast will not be marked until the image is done. Then the radiologist performing the procedure will mark the breast with their initials and a timeout will occur prior to any invasive aspect of the procedure. The placement of the needle will suffice for the OR site marking.

6) Site marking is not required when the individual doing the procedure is continuously with the patient from the time of the decision to do the procedure through to the performance of the procedure. However, the requirement for final time-out verification still applies.

7) If patient refuses to allow site to be marked, staff member should document the refusal on the Surgical Safety Checklist (see attached) and complete a Refusal of Care or Treatment form

with reason for refusal and patient signature. Procedure may be cancelled after additional discussion if site marking refusal remains.

F. "Time Out" immediately before starting the surgical procedure

1) This final procedure verification step is conducted prior to starting the actual procedure but after draping is complete, in the location where the surgical procedure will be done, and with the patient properly positioned for the procedure.
2) It must involve the entire patient care team using active communication. During the "time out," other activities are suspended to the extent possible without compromising the safety of the patient, so that team members are focused on the active verification of the correct patient, procedure, site and other critical elements. No music will be playing in the procedural room until the time out is completed and the time out must be documented in the Surgical Safety Checklist.
3) In the event there is only one person performing the procedure, a brief pause to confirm the "Time Out" criterion is appropriate.
4) Immediately prior to the start of the surgery/procedure, a time out is performed as follows and the team verbally verifies:
   a) There is a pause in all activities in the room
   b) There is an introduction of team members
   c) The following is confirmed:
      (1) Patient identification
      (2) Procedure
      (3) Site
      (4) Consents
   d) Site marking is visible through draping
   e) There is a review of critical or unexpected steps and procedural duration
   f) Anticipated blood loss is reviewed
   g) The following is reviewed:
      (1) Sterility
      (2) Any implants
      (3) Any special equipment
   h) It is reviewed whether antibiotics were given in the past 60 minutes
   i) Administration of the antibiotics is confirmed and the potential need for re-dosing is addressed
   j) Essential imaging and lab data is available and displayed if necessary
   k) When flammable germicides or antiseptics are used during surgery utilizing electrosurgery, cautery, or lasers, the following are reviewed:
      (1) Application site is dry prior to draping and use of surgical equipment
      (2) Pooling of solution has not occurred or has been corrected

(3) Solution-soaked materials have been removed from the operating room prior to draping and use of surgical devices

l) When a regional block is indicated for the patient, the anesthesiologist shares the status of the block during timeout indicating if complete or if it will be completed post-op.

m) All assigned dosimeter monitors are confirmed to be in place prior to the start of the procedure.

5) If any member of the surgical/procedural team has any questions or concerns regarding the correct patient, side and site, surgery/procedure to be done, positioning, availability of correct implants, or special equipment or requirements the procedure is not started until all questions and concerns are resolved.

6) If the physician leaves the room after the time out, but prior to the incision, another time out must occur prior to the initiation of the procedure.

7) In procedural sedation location the initial order for sedation may be obtained as part of the time out or immediately following.

G. The appropriate Director or administrative designee will be notified of any concerns or issues that were encountered and appropriate action taken.

H. When two or more procedures are being performed on the same patient, a "time out" is performed to verify each subsequent procedure before it is initiated.

1) When the second procedure is a distinct and separate procedure.

2) When a second surgeon is performing the second procedure.

3) An intra-operative consult involving a second surgeon does not require a timeout unless a separate procedure is started.

I. Procedures for non-operating room settings, including bedside procedure:

1) Site marking must be done for any procedure that involves laterality, multiple structures or levels, even if the procedure takes place outside the operating room.

2) Verification, site marking, and "time out" procedures will be consistent throughout the organization, including the Operating Room, Ambulatory Surgery, ADU, Emergency Room, Endoscopy, Cath Lab, IR, OB, and other locations where procedures are performed.

Management of Wrong Site Surgery/Procedure/Wrong Person:

If during the course of the surgery/procedure, or, after the surgery/procedure has been completed, it is determined that the surgery/procedure is being performed or has been performed on the wrong surgical site or person, the physician will:

A. Notify the appropriate department director when the event occurred and Risk Management.

B. Act in accord with the patient's best interests to promote the patient's well-being.

C. Take necessary/appropriate steps to return the patient, as nearly as possible, to the patient's preoperative condition.

D. Perform the planned surgery/procedure on the correct site, unless there are medical reasons not to proceed in this manner. For example, if proceeding with the planned surgery/procedure on the correct site would increase the risk associated with extending the length of the surgery/procedure or if the correct site surgery/procedure would likely result in an additional and unacceptable disability.

E. Advise the patient or the patient's legal representative, and the patient's family: (as outlined in the Responding Justly to Adverse Outcomes Policy)
   1) of what occurred and of the likely consequences, if any, of the wrong site surgery/procedure;
   2) of any recommendations to the patient/family of what, in the physician's best judgment, is the appropriate course for the patient to follow under the circumstances
   3) of the physician's judgments in response to questions posed by the patient/family. Such consultation will take place as soon as reasonably possible following the occurrence.

F. If appropriate/necessary, the physician will proceed with immediate patient care interventions as consented to by the patient/family.

G. Record the events in the patient's medical record.

H. Provide necessary/appropriate information to the RN, who, in turn, will immediately complete a Midas Occurrence Report for physician related occurrences and a Voice for staff related occurrences.

I. An investigation will take place per the Sentinel Event Policy & Procedure

SAINT JOSEPH
Regional Medical Center

Version #: 1

Title: Violence and Threats in the Workplace

Document Owner: Jim McClanahan	PI Team: PI Steering and Leadership	Date Created: 08/18/2021
Approver(s): Christopher Karam	Date Approved with no changes: 05/06/2022	Date Approved: 05/06/2022
Location: Saint Joseph Regional Medical Center (SJRMC)		Department: Human Resource

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE

The purpose of this Policy is for Trinity Health Corporation ("Trinity Health" or a Health Ministry or Subsidiary) to reinforce its zero tolerance for acts and/or threats of violence and to provide a safe work environment for all Employees.

Trinity Health is committed to administering this Policy in accordance with its Mission, Core Values and commitment to Diversity, Equity and Inclusion.

POLICY

Trinity Health will not tolerate threats, threatening behavior or acts of violence by or against its Employees. Trinity Health is committed to maintaining a workplace free from violent or threatening behavior by fostering a work environment of awareness, education and prevention.

Zero tolerance means that all Employees (including regular, contract or temporary), contractors, agents, and vendors are prohibited from making or implying threats of physical violence, engaging in threatening behavior or engaging in acts of violence during their employment or agency relationship, while on Trinity Health property, while acting as a representative of Trinity Health, or by directing any such behavior towards Trinity Health or its Employees, contractors or agents, regardless of where or how it occurs including, but not limited to, telephonic and electronic communications (such as e-mail, employer facilitated chats, social media, video conferencing) made on or off Trinity Health property.

PROHIBITED CONDUCT

A. A threat or threatening behavior may consist of words or actions that create a reasonable perception or belief that there may be intent to harm persons or property, or actions or words that actually bring about harm. The following are some examples of what behavior is prohibited and what may be construed to be threatening behavior in certain circumstances. This list is not meant to be all inclusive.

1. A threat can be explicit or implied.

2. A threat can be the result of verbal, written or non-verbal actions.

3. Statements implying a threat or act of violence and made in the guise of a joke will be considered threatening.

4. Examples of threats include, but are not limited to:

- Verbal or written statements that express intent to harm another person.
- Conduct or speech that threatens, intimidates, abuses, harms, or coerces another person.
- Comments such as "you'll get yours," "watch your back" or other statements that imply acts of violence are inappropriate whether it occurs at the workplace or outside of the workplace (if the latter involves Employees or visitors of Trinity Health).
- Gestures implying that physical contact will be used, such as gestures of punching, choking, stabbing or shooting.
- Stalking behavior.
- Possessing a weapon in the workplace or on Trinity Health property.
- Threats can also include angry outbursts, street talk, profanity and "shop talk."

B. Actual physical violence is the unwanted touching of a person or their possessions that creates the fear of harm, or which does create fear or harm. Examples of physical violence include: striking, pushing, grabbing, slapping and/or unwanted touching of another person.

1. An act may constitute physical violence even if no injury or harm occurs. For example, "horseplay," or physical pranks, may constitute physical violence.

2. The use of an object that causes unwanted touching may also constitute physical violence.

WEAPONS PROHIBITED

Trinity Health prohibits the presence of any weapons on its property, even if the carrier of the weapon has a permit to do so, or even if stored (except in States where it is required to permit weapons by law) and/or concealed. Likewise, Trinity Health Employees, contractors and vendors are prohibited from carrying weapons in the course of their employment. Trinity Health property in this Policy includes Trinity health work locations, surrounding parking area(s), locations of Trinity Health sponsored activities, job sites and methods of transportations between such locations while in the course and scope of employment for Trinity Health.

For purposes of this Policy, prohibited "weapons" include, but are not limited to: firearms (whether loaded or unloaded); pellet, flare, tranquilizer and stun guns; ammunition; explosives, any knives with a blade longer than three (3) inches; striking instruments, including clubs and metal knuckles; martial arts weapons; bow and arrow combinations; and any other weapons that might be dangerous or could cause physical harm.

Title: Violence and Threats in the Workplace

Note: Exceptions to this Policy may be allowed by senior management for authorized Security and Law Enforcement Officers only.

MANDATORY REPORTING AND PROCEDURES

All Trinity Health Employees are responsible for helping to maintain a safe working and patient environment. Therefore, every Employee must report incidents of violence in the workplace or other potentially dangerous situations.1 Specifically, all Employees must notify security or management of any threats or acts of violence that they have witnessed, received, or have been told that another person has witnessed or received. All suspicious individuals or activities should also be reported as soon as possible to management or security personnel, if available. Supervisors, managers or security personnel that are advised of an act of violence, a threat or threatening behavior must contact Human Resources.

1. In appropriate circumstances, as determined in the sole discretion of Human Resources, an Employee against whom a complaint is made may be suspended, with or without pay, pending the outcome of an investigation. Any Employee found to have engaged in conduct in violation of this Policy will be subject to disciplinary action up to and including termination at the sole discretion of Trinity Health. Any Employee who fails to cooperate in an investigation will be subject to disciplinary action up to and including termination at the sole discretion of Trinity Health.

2. Any Employee who has knowledge of threatening behavior but does not make the required reports will be subject to corrective action up to and including termination at the sole discretion of Trinity Health. No Employee that reports violent acts or threatening behavior will be subject to retaliation based on their report.

3. All investigations will be handled in a discreet and confidential manner within the framework of applicable state laws. All employment decisions will be made in accordance with Trinity Health mission and its core values.

4. Human resources will take appropriate action to protect all Employees, contractors, vendors, agents, clients, volunteers, patients and/or visitors including suspension of an Employee pending conclusion of an investigation. If an investigation determines that an Employee has engaged in violence or demonstrated threatening behavior, that Employee will be subject to corrective action, up to and including termination of employment.

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* Health Ministries and/or Subsidiaries may have variances in their reporting structure and availability of security personnel, and may further define specific reporting requirements; however, no Employee(s) will be relieved of their responsibility to report.

5. Whenever the safety of the workplace may be threatening, Trinity Health reserves the right, without prior notice, to search any and all Trinity Health property, work areas, and personal belongings on Trinity Health premises. Failure to cooperate in such a search is considered misconduct and may result in corrective action, up to and including termination of employment. Any unauthorized articles discovered may be taken into custody and may be

turned over to law enforcement representatives.

6. An Employee who expresses or articulates threatening behavior may be required to meet with an Employee Assistance Program counselor, or other counselor or physician chosen by Trinity Health, as a part of an investigation and/or condition of continued employment. Any information disclosed or shared with the counselor or physician will be shared with Trinity Health to the extent deemed necessary by the counselor or physician to express the Employee's ability to remain safely employed with Trinity Health.

DOMESTIC SITUATIONS

Any Employee who has obtained an Order of Protection or Temporary Order of Protection barring an individual from any Trinity Health facility must contact Human Resources and Security to provide them with a copy of the order to ensure that that the individual is prohibited from entering the affected Employee's workplace. All necessary actions including contact with local police agencies will be taken to prohibit the individual from entering the workplace.

SCOPE/APPLICABILITY

This Policy is intended to be a system-wide policy that applies to all Employees of Trinity Health, its Health Ministries and Subsidiaries, subject to any modifications necessary to comply with applicable state and local laws and regulations, collective bargaining agreements, written employment agreements, accreditation requirements or otherwise and that are approved by the Trinity Health EVP, Chief Human Resources Officer or an appropriate designee, in consultation with the Trinity Health Legal Department as necessary. For purposes of this Policy, the Trinity Health SVP, System Office Chief Human Resources Officer is an authorized designee to approve such modifications.

DEFINITIONS

Employee means an employee of Trinity Health or one of its Health Ministries or Subsidiaries, whether that individual's status is permanent or temporary, contingent, part- or full-time. Trinity Health often uses the term "colleague" to refer to its Employees. In HR policies, "Employee" is used instead of "colleague" to be clear that HR policies apply to individuals in an employment relationship with Trinity Health or one of its Health Ministries or Subsidiaries. The form of the Policy does not change an Employee's Primary Employer, defined as the payroll company of record, and does not create a joint employment relationship with any entity.

Health Ministry (sometimes referred to as Ministry) means a first tier (direct) subsidiary, affiliate, or operating division of Trinity Health that maintains a governing body that has day-to-day management oversight of a designated portion of Trinity Health System operations. A Health Ministry may be based on a geographic market or dedication to a service line or business. Health Ministries include Mission Health Ministries, National Health Ministries, and Regional Health Ministries.

Policy means a statement of high-level direction on matters of importance to Trinity Health, its Health Ministries and Subsidiaries or a statement that further interprets Trinity Health's, its Health

Ministries' and Subsidiaries' governing documents. Policies may be either stand alone, Systemwide or Mirror Policies designated by the approving body.

Primary Employer means the entity for which the Employee provides more than 50% of services and is the payroll company of record.

Procedure means a document designed to implement a Policy or a description of specific required actions or processes.

Standards or Guidelines mean additional guidance which assists an Employee in understanding the employer's rule, policies and/or procedures, including those developed by accreditation or professional organizations.

Subsidiary means a legal entity in which a Trinity Health Ministry is the sole corporate member or sole shareholder.

Workplace Violence is defined as any behavior or statements (verbal, written or electronic) which creates a work environment that a reasonable person would find intimidating, threatening, violent or abusive. Workplace violence may also include the destruction or abuse of property through vandalism, arson, sabotage or other means. Workplace violence can occur at or outside the workplace (if it impacts work related activities). The defined conduct may be intentional or unintentional.

RESPONSIBLE DEPARTMENT

Further guidance concerning this Policy may be obtained from the Colleague and Labor Relations Center of Expertise.

APPROVALS

Initial Approval: August 18, 2021

Human Resources Policy No. 1012

SAINT JOSEPH HEALTH SYSTEM

Mirrored Trinity Wide Policy

Violence and Threats in the Workplace

PURPOSE/PROCEDURE

The purpose of this document is to provide Health Ministries with a standard method of access to ministry-wide Human Resource policies.

Health Ministries will post the ministry-wide Human Resource Policy Redirection document to its local policy repository for each ministry-wide HR policy. Each document will be named the title of the policy for which it is redirecting, as to allow users to easily search/locate the policy from their local resource. Any locally related addendums, procedures, and/or policies are to be listed under the below "Ministry Specific Related Addendums, Procedures, and/or Policies" section.

Policy Location:

To locate the policy for which this document is named, please visit the below link where all ministry-wide Human Resource policies are posted. Policies are listed in alphabetical order.

Ministry-wide HR Policies https://mytrinityhealth.sharepoint.com/sites/SO-ONEHR-TrinityWide/SitePages/Ministry-Wide-HR-Policies.aspx

MINISTRY SPECIFIC RELATED ADDENDUMS, PROCEDURES, AND/OR POLICIES

Not Applicable

Please note: when local HR policy conflicts with ministry-wide HR policy, ministry-wide HR policy supersedes local policy.

RESPONSIBLE DEPARTMENT

Further guidance concerning this document may be obtained from Human Resource Workforce Planning and HR Administration. Further guidance concerning the ministry specific related addendums, procedures, and/or policies may be obtained from your local Human Resources team.

SAINT JOSEPH
Regional Medical Center

Version #: 5

Title: POSITIONING OF SURGICAL PATIENTS

Document Owner: Stephanie Luther	PI Team: Provision of Care, OR	Date Created: 12/22/2022
Approver(s): Loretta Schmidt, Suzanne Risner		Date Approved: 02/21/2023
Location: Saint Joseph Regional Medical Center		Department: Operating Room (14030 37020)

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

POLICY:

1. All safety precautions shall be considered when positioning the patient on the operating room bed.
   A. To ensure safe positioning of the surgical patient to reduce risk for impaired skin and peripheral neurovascular integrity.
2. The operative procedure to be performed, the anesthesia provider and the surgeon/physician shall determine the patient position.

PROCEDURE:

A. The perioperative RN should review the surgery schedule before the patient's arrival, preferably before the day of surgery, to identify potential conflicts in availability of positioning equipment. The surgeon should request special positioning equipment at the time the procedure is scheduled.
B. The perioperative RN should confirm the room is set up appropriately for the planned procedure before the patient arrives to the OR.
C. Positioning devices shall be readily available, clean and in working order before placing the patient on the operative bed.
   1) Positioning and transporting equipment shall be periodically inspected and maintained in proper functioning condition.
      a) Malfunctioning positioning equipment and transporting equipment shall be taken out of service until fixed or replaced.
   2) Equipment shall be used and maintained according to the manufacturer's written instructions.
   3) Personnel shall demonstrate knowledge and skill in selection and use of positioning devices which include, but are not limited to:
      a) Operative beds and equipment (i.e., headrests/holders, overhead arm supports, stirrups and foot boards).
      b) Padding for pressure points.
      c) Securing devices (i.e., safety belts, kidney rests, bean bags). Specialty operative beds (i.e. fracture table).
D. The circulating nurse shall do a preoperative assessment for positioning needs. Patient assessment should include, but is not limited to:
   1) Age
   2) Height
   3) Weight
   4) Body mass index (BMI)
   5) Skin condition
   6) Presence of jewelry
   7) Nutritional status
   8) Allergies (e.g. latex)

9) Preexisting conditions (e.g., vascular, respiratory, circulatory, neurological, immune system suppression)
10) Laboratory results
11) Physical or mobility limitation (e.g., range of motion)
12) Presence of prosthetics or corrective devices
13) Presence of implanted devices (e.g., pacemakers, orthopedic implants)
14) Presence of external devices (e.g., catheters, drains, orthopedic immobilizers)
15) Presence of peripheral pulses
16) Perception of pain
17) Level of consciousness, and
18) Psychosocial and cultural considerations.

E. Intraoperative assessment factors should include, but not limited to:
1) Anesthesia care provider's access to patient.
2) Estimated length of procedure; and
3) Desired procedural position.

F. The nurse shall communicate with anesthesia and surgical personnel as to any specific positioning needs of the patient.

G. Perioperative personnel should use proper body mechanics when transporting, moving, lifting, or positioning patients.
1) An adequate number of personnel shall be used when transferring and/or positioning the patient.
2) Perioperative RN shall identify high-risk tasks for patient positioning and should implement ergonomic solutions to eliminate or reduce occupational risks for injury. (i.e., transferring, lifting and handling patients)
3) The perioperative registered nurse shall actively participate in safely positioning the patient under the direction of and in collaboration with the surgeon and anesthesia provider.
4) The perioperative registered nurse shall provide for patient dignity and privacy during transport, transfer and positioning.
5) Positioning shall be achieved without prolonged or unnecessary exposure of the patient.
6) Patient jewelry and body piercing accessories should be removed before positioning or transferring to the procedure bed.
7) Movement or positioning of the patient shall be coordinated with the surgical team to minimize shearing injuries.
8) Specific patient needs shall be communicated to the perioperative team before initiating transfer or positioning the patient.
9) Attention shall be given to protecting the patient's airway at all times during patient transfer and positioning.
10) Before and during transfer or positioning, perioperative team members shall communicate with each other regarding securing tubes, drains, and catheters. Action shall be taken to support these devices to help prevent dislodging.
11) The perioperative registered nurse shall actively participate in monitoring the patient's body alignment and shall confirm that the patient's legs are not crossed during transfer and positioning.
12) When on the procedure bed, the patient shall be attended by surgical team members at all times.
13) Every effort shall be made to ensure the number of personnel and required equipment shall be adequate to safely position the patient.
14) The perioperative registered nurse shall actively participate in monitoring the patient's tissue integrity based on sound physiologic principles.

15) The perioperative registered nurse shall implement general positioning safety measures including, but not limited to, the following:
    a) Positioning equipment shall be used to protect, support, and maintain the patient's position.
    b) Padding shall be used to protect the patient's bony prominences.
    c) The location of the patient's fingers shall be confirmed to ensure they are in a position that is clear of procedure bed breaks or other hazards.
    d) Safety restraints shall be applied carefully to avoid nerve compression injury and compromised blood flow.
    e) Surgical Services Pressure Ulcer Prevention Guidelines shall be utilized. (See addendum)
        (1) RIK (redistribution) mattress shall be used for patients with surgeries 4 hours or longer and for patients with Braden score 18 or less and more or more of the following:
            (a) Greater than 55 years of age
            (b) Coronary artery disease
            (c) History of diabetes
            (d) History of peripheral vascular disease including deep vein thrombosis or other emboli
            (e) History of paraplegia. paralysis
            (f) History of amputations
            (g) Preexisting or current pressure ulcers
            (h) Overweight (greater than 100 kg)
            (i) Underweight (less than 50 kg)
            (j) Surgery planned for 4 hours or great
            (k) Malnutrition
16) The patient's body shall be protected from coming in contact with metal portions of the procedure bed.
17) The patient's heels shall be elevated off the underlying surface when possible.
18) The patient's head and upper body shall be in alignment with the hips. The patient's legs shall be parallel and the ankles uncrossed to reduce pressure.
19) A pillow may be placed under the back of the patient's knees to relieve pressure on the lower back.
20) If the patient is pregnant, a wedge should be inserted under the patient's right side to displace the uterus to the left and prevent supine hypotensive syndrome.
21) The patient's arms shall be placed on padded arm boards, extended less than 90 degrees from the long axis of the procedure bed, with the patient's palms up and gently secured. The arms should be tucked at the patient's sides only if surgically necessary. When it is necessary to tuck the arms at the patient's side, the elbows should be padded and the palms should be facing in toward the patient's body. The hands should be enclosed and secured within a foam protector.
22) Direct pressure on the patient's eyes should be avoided to reduce the risk of central retinal artery occlusion and other ocular damage, including corneal abrasion.
    a) Patients at risk for ocular injury should be positioned so that their heads are level with or higher than their hearts when possible. (Patients at risk are patients procedures are greater than 6.5 hours, have substantial blood loss and in the prone position.)
    b) The eyes of patients in prone position should be assessed regularly.
23) To minimize the risk of nerve injury, safely measures shall include by not limited to, the following:
    a) Padded arm boards shall be attached to the procedure bed at less than a 90-degree angle for supine position.

b) The patient's palms shall be facing up and the fingers shall be extended when his or her arms are placed on arm boards.
c) When the patient's arms are placed at the side of the body, they shall be in a neutral position (i.e., elbows slightly flexed, wrist in neutral position, palms facing inward).
d) Patient shoulder abduction and lateral rotation shall be kept to a minimum.
e) Patient extremities shall be prevented from dropping below procedure bed level.
f) The patient's head shall be placed in a neutral position, if not contraindicated by the surgical procedure or the patient's physical limitations.
g) Adequate padding is required for the saphenous, sciatic, and peroneal nerves, especially when the patient is in a lithotomy or lateral position.
h) A well-padded perineal post shall be placed against the perineum between the genitalia and the uninjured leg when a patient is position on a fracture table.

24) Perioperative team member shall implement measures to reduce the risk of injuries when positioning the patient in the:

a) Supine position

(1) A lateral transfer device should be used for supine-to-supine patient transfer.

b) Prone position

(1) The patient's cervical neck alignment shall be maintained.
(2) Protection for the patient's forehead, eyes, and chin shall be provided. Direct pressure on the patient's eyes and face should be avoided.
(3) A padded headrest should be used to provide airway access.
(4) Chest rolls should be used to allow chest movement.
(5) Breast and male genitalia should be positioned in a way that frees them from torsion or pressure.
(6) The patient's toes should be positioned to allow them to hang over the end of the bed by placing padding under the patient's shins so the shins are high enough to avoid pressure on the tips of the toes.
(7) Ideally, the patient's arms should be placed down by his or her sides. If this is not possible, each arm should be placed on an arm board with the arms abducted to less than 90 degrees, the elbows flexed, and the palms facing downwards. To safely secure the patient's arms at his or her sides, the palms of the hands should be facing in toward the thighs, the elbows and hands should be protected with padding, and the hands, and wrists should be kept in anatomical alignment.

c) **Trendelenburg and reverse Trendelenburg position**.

(1) Safety measures shall be taken to prevent patient from sliding on the procedure bed. Shoulder braces shall be avoided and a padded footboard should be used.

d) **Lithotomy position**

(1) Stirrups shall be placed at an even height.
(2) The patient's buttocks shall be even with the lower break of the procedure bed and positioned in a manner that securely supports the sacrum on the bed surface. Confirm proper positioning of the patients buttocks before surgery is initiated.
(3) The patient's legs shall be moved slowly and simultaneously into the leg holders to prevent lumbosacral strain.
(4) The patient's legs shall be removed from the stirrups slowly and brought together simultaneously before lowering the legs to the bed surface. This is to prevent lumbosacral strain. Then the patient's legs shall be slowly returned to the bed, one at a time if possible. This is to maintain the patient's hemodynamic status.

(5) The patient's fingers should be protected from injury when the foot of the procedure bed is repositioned.
(6) The patient's heels should be placed in the lowest position possible.
(7) Support should be provided over the largest surface area of the leg possible.
(8) The patient's legs should not rest against the stirrup posts.
(9) Scrubbed personnel should not lean against the patient's thighs.
(10) The patient should be in the lithotomy position for the shortest time possible.
(11) Care should be exercised to avoid shearing when moving the patient to the break in the procedure bed during repositioning.
(12) Consideration should be given in repositioning the patient after prolonged procedures longer than four hours.

e) **Lateral position**
(1) Right lateral position is when the patient is lying on his or her right side down.
(2) The patient's spinal alignment should be maintained during turning.
(3) The patient's dependent leg should be flexed for support.
(4) The patient's straight upper leg should be padded and supported with pillows between the legs.
(5) Padding should be used under the patient's dependent knee, ankle, and foot.
(6) A headrest or pillow should be placed under the patient's head to keep the cervical and thoracic vertebrae aligned.
(7) The patient's dependent ear should be assessed to ensure that t is not folded and the ear should be well padded.
(8) The patient's arm should be secured to prevent movement during the procedure.

H. Safety consideration for positioning the morbidly obese patient should include, but not limited to, the following:
1) Ensuring patient is on procedure bed that designed to support the patient's weight.
2) Mattresses should provide sufficient support and padding.
3) Use of side attachments on bed when width of legs extends beyond the bed width.
4) Padded sleds/toboggans may be used to contain the patient's arms when necessary.
5) An extra-long safety straps should be used for patients who exceed the length limits for a regular size safety strap.
6) When in the supine position, a roll or wedge should be placed under the patient's right flank to relieve compression of vena cava.
7) Patients may need to have head elevated to assist with respiratory function.
8) When in the prone position, the patient's upper chest and pelvis should be adequately supported to free the abdominal viscera to reduce pressure on the diaphragm and inferior vena cava.
9) If the patient is placed in the lithotomy position, heavy-duty stirrups should be used.

I. After positioning the patient, the perioperative registered nurse shall assess the patient's body alignment, tissue perfusion, and skin integrity.
1) The perioperative registered nurse shall monitor the patient for external pressure from surgical team members leaning against the patient's body.
a) The perioperative registered nurse shall communicate with the surgical team about the position of surgical instruments, retractor frames, Mayo stands, or other items placed on or over the patient throughout the procedure.
2) The perioperative registered nurse shall reassess the patient's body alignment, placement of the safety strap, and the placement of all padding after repositioning or any movement of the patient, procedure bed, or any equipment that attaches to the procedure bed. The perioperative Registered nurse shall:

a) Communicate with anesthesia personnel and the surgeon when assessing the need for repositioning the patient every two hours for prolonged procedures.
b) Place his or her hand between the safety strap and the patient to ensure the strap is not applying excessive pressure to the patient's tissue.
c) Assess the patient for adequate padding by positioning hand, palm up, below the part of the body at risk to be sure there is more than an inch of support material between the body part and any hard surface.
d) Confirm that prep solutions have not pooled beneath the patient and check for excessive moisture (e.g., urine from incontinence) between the patient and positioning devices before the start of the surgical procedure.

J. The perioperative registered nurse shall collaborate with the postoperative patient caregiver to identify injury due to intraoperative positioning.
   1) Perioperative registered nurses shall evaluate the patient for signs and symptoms of physical injury related intraoperative positioning.
   2) Perioperative registered nurses shall identify patients who are high risk for postoperative injuries due to positioning and communicate areas of concern with postoperative care provider.

K. Perioperative personnel shall receive initial education, competency validation and updated information on patient positioning, new positioning equipment and procedures and ergonomic safety.

L. Patient care and use of positioning devices shall be documented on the intraoperative record by the registered nurse circulator.

Related Documents:

- Surgical Services Pressure Ulcer Prevention Guidelines Algorithm

References/Standards:

- 2019 Perioperative Standards and Recommended Practices, Association of PeriOperative Registered Nurses, Inc, Denver, CO, 2019.
- Rothrock, Jane C., Alexander's Care Of The Patient In Surgery, 16th ed., Mosby, St. Louis, Missouri, 2018

SAINT JOSEPH
Regional Medical Center

Version #: 5

Title: Blood Borne Pathogen Exposure

Document Owner: Susan Honick	PI Team: Infection Prevention Team	Date Created: 09/1992
Approver(s): Arthur Schroeder MD, Kathryn Park, Donna Hofstra, Amy Bennitt	Date Approved with no Changes:	Date Approved: 1/23/2020
Location: Saint Joseph Regional Medical Center (SJRMC)		Department: Employee Health (14001_83200)

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

POLICY:

1. Healthcare workers may be exposed to persons with known disease. Hepatitis B, Hepatitis C and HIV may be transmitted via needle punctures, cutaneous exposure, or body fluid splashes from infected individuals to health care workers. An exposure incident is defined as a specific eye, mouth, or other mucous membrane, non-intact skin, or parenteral contact with blood or other potentially infectious material. Post exposure prophylaxis (PEP) recommendations are based on the most recent CDC recommendations.

GUIDELINES:

A. When a blood exposure has occurred do the following:
   1) Provide immediate care to the exposed site;
      a) Wash wound and skin with soap and water;
      b) Flush mucous membranes with water immediately or as soon as feasible following contact;
   2) Inform Employee Health Services or Administrative Supervisor immediately after the exposure. **DO NOT GO TO THE EMERGENCY DEPARTMENT**
   3) **Complete a THEIR, Trinity Health Employee Incident Report form, icon found on Novell-delivered applications. Obtain and initiate a "Red Packet" for instructions, lab slips and consent forms.** Red packets are available in Employee Health Services or from Administrative Supervisor/Clinical Director when Employee Health is not available.

B. Identification of the source patient and the status of the source patient, if possible.
   1) If there is no previous testing for Blood borne Pathogens on the source patient, consent from the source should be obtained and placed in the patient's chart. Lab should be paged for STAT lab draw. A lab requisition for the following is in the red packet.
      a) Stat HIV AG-AB combo, Point of Care with confirmation
      b) HBsAg
      c) HCV
      d) The source patient's physician shall be responsible to notify and counsel patient if baseline labs indicate the presence of blood borne pathogens.
   2) If baseline testing indicates that the source patient is not infected with a blood borne pathogen, further follow-up testing of the exposed employee is NOT necessary. SJRMC will provide associate baseline testing for Blood borne Pathogens upon request.
   3) If source patient is known to be positive for HIV, Hepatitis B or Hepatitis C as documented on his/her chart, proceed with immediate treatment of the employee as appropriate. Source patient lab testing can be deferred for any test which is documented as positive on his/her chart.
   4) If source is unknown, the employee will have baseline testing at the time of exposure by utilizing the anonymous lab requisition found in the red packet. See post exposure evaluation and follow up testing, #1 for laboratory tests.

C. Post exposure evaluation and follow-up testing of exposed employee:

Title: Blood Borne Pathogen Exposure

1) Follow-up testing of employees exposed to blood borne pathogen, or if source is unknown:
   a) HIV exposure – HIV 1&2 antibody screen with Western Blot if indicated at baseline, 6, 12 and 26 weeks
   b) HBV exposure-
      (1) Establish HBsAB status of associate, if immune-no treatment indicated
      (2) If HBsAB non immune, then HBIG x1 and initiate revaccination.
   c) HCV exposure – HCV, HCV-RNA, and ALT at 6 weeks, HCV and ALT at 12 and 26 weeks
      (1) All positive HCV source results will be confirmed by HCV-RNA Quant, RT-PCR.
      (2) If the employee becomes positive for HCV, Employee Health Services will refer the employee to Physicians Urgent Care or designee.
   d) Unknown source, employee has immune HBsAb –
      (1) HIV 1&2 antibody screen with Western Blot if indicated, HCV, and ALT
      (2) HIV 1&2 antibody screen with Western Blot if indicated, HCV-RNA, and ALT at 6 weeks
      (3) HIV 1&2 antibody screen with Western Blot if indicated at 12 weeks, HCV, ALT at 12 weeks
      (4) HIV 1&2 antibody screen with Western Blot if indicated, HCV, and ALT at 26 weeks
   e) Unknown source, employee has non-reactive HBsAb –
      (1) HIV 1&2 antibody screen with Western Blot if indicated, HBV,HCV, and ALT
      (2) Offer Hepatitis B series (or booster) within 7 days of exposure. Complete series and send for HbsAb.
      (3) HIV 1&2 antibody screen with Western Blot if indicated, HBV, HCV-RNA, and ALT at 6 weeks.
      (4) HIV 1&2 antibody screen with Western Blot if indicated at 12 weeks, HBV, HCV, ALT
      (5) HIV 1&2 antibody screen with Western Blot if indicated, HBV, HCV, and ALT at 26 weeks.
2) Any employee with positive baseline results including HIV, HBV,HCV or ALT will be referred to his/her personal physician for follow up.
3) Any employee that becomes positive for HIV, HBV or HCV will be referred to Physicians Urgent Care or designee for evaluation and treatment if indicated.

D. The employee will be given appropriate counseling concerning current CDC precautions to take during the period after the incident, potential illnesses to be alert for, and to report any related experiences to Employee Health Services.

E. **Any person exposed to a source patient who is known to be HIV positive-**. Stat HIV 1&2 results should be available in 1-2 hours. If indicated, the Medical Director of Employee Health, designee, or Emergency Department physician will order the appropriate anti-viral medication recommended by the CDC. A prescription will be given to the employee, with all treatment being covered under Worker's Compensation. For post-exposure prophylaxis information, contact the CDC/PEP hotline at 1-888-448-4911. The following information is beneficial to obtain prior to calling the hotline:
   1) Source patient's viral load;
   2) Source patient's HIV medications;
   3) Source patient's daily medications.

F. Documentation of exposure shall include:
   1) Time and date of exposure;
   2) Route of exposure;
   3) Immunization status of the employee;

4) Circumstances of the exposure.

G. Results of employee and source patient lab results will be kept in the employee's confidential Health File in the Employee Health Office and separate from the personnel files.

1) Results will be sent to the employee.
2) Source results will be sent as positive or negative.
3) The employee will be counseled regarding the confidentiality of source patient information.
4) The employee will be informed that positive results will be reported to the Indiana Department of Health.

H. Saint Joseph Regional Medical Center will pay for baseline testing of the source patient involved in an exposure to medical staff, contracted staff, contract service providers, patients, visitors or other customers who experience a blood exposure incident at SJRMC.

Related Documents:

Recommended HBV PEP

Vaccination and antibody response status of exposed healthcare personnel*	Treatment		
	Source HBsAg† positive	Source HBsAg† negative	Source unknown or not available for testing
Unvaccinated	HBIG§ x 1 and initiate hepatitis B vaccine series	Initiate hepatitis B vaccine series	Initiate hepatitis B vaccine series
Previously vaccinated			
Known responder¶	No treatment	No treatment	No treatment
Known nonresponder**	HBIG x 1 and initiate revaccination or HBIG x 2††	No treatment	If known high risk source, treat as if source were HBsAg positive
Antibody response unknown	Test exposed person for anti-HBs§§ 1. If adequate,¶ no treatment is necessary 2. If inadequate,** HBIG x 1 and vaccine booster	No treatment	Test exposed person for anti-HBs§§ 1. If adequate, no treatment is necessary 2. If inadequate, administer vaccine booster

* Persons who have previously been infected with HBV are immune to reinfection and do not require postexposure prophylaxis
† Hepatitis B surface antigen
§ Hepatitis B immune globulin; dose is 0.06 mL/kg intramuscularly
¶ A responder is a person with adequate levels of serum antibody to HBsAg (i.e., anti-HBs ≥10 mIU/mL)
** A nonresponder is a person with inadequate response to vaccination (i.e., serum anti-HBS <10 mIU/mL)
†† The option of giving one dose of HBIG and reinitiating the vaccine series is preferred for nonresponders who have not completed a second 3-dose vaccine series; for persons who previously completed a second vaccine series but failed to respond, two doses of HBIG are preferred
§§ Antibody to HBsAg

Recommended HIV PEP

Percutaneous injuries					
	Infection status of source				
	HIV-positive, class 1*	**HIV-positive, class 2***	**Source of unknown HIV status**	**Unknown source**	**HIV-negative**
Exposure type	Asymptomatic HIV infection or known low viral load (e.g., <1500)	Symptomatic HIV infection, AIDS, acute seroconversion, or known high viral load	e.g., deceased source person with no samples available for HIV testing	e.g., a needle from a sharps disposal container	
Less severe, e.g. solid needle, superficial injury	Recommend basic 2-drug PEP	Recommend expanded ≥3-drug PEP	Generally, no PEP warranted; however, consider basic 2-drug PEP† for source with HIV-risk factors§	Generally, no PEP warranted; however, consider basic 2-drug PEP† in settings in which exposure to HIV-infected persons is likely	No PEP warranted
More severe, e.g., large-bore hollow needle, deep puncture, visible blood on device, or needle used in patient's artery or vein	Recommend expanded ≥3-drug PEP	Recommend expanded ≥3-drug PEP	Generally, no PEP warranted; however, consider basic 2-drug PEP† for source with HIV-risk factors§	Generally, no PEP warranted; however, consider basic 2-drug PEP† in settings where exposure to HIV-infected persons is likely	No PEP warranted
Mucous membrane exposures and nonintact skin¶ exposures					
	Infection status of source				
	HIV-positive, class 1*	**HIV-positive, class 2***	**Source of unknown HIV status**	**Unknown source**	**HIV-negative**
Exposure type	Asymptomatic HIV infection or known low viral load (e.g., <1500)	Symptomatic HIV infection, AIDS, acute seroconversion, or known high viral load	e.g., deceased source person with no samples available for HIV testing	e.g., splash from inappropriately disposed blood	
Small volume, e.g., few drops	Consider basic 2-drug PEP†	Recommend basic 2-drug PEP	Generally, no PEP warranted§	Generally, no PEP warranted	No PEP warranted
Large volume, e.g., major blood splash	Recommend basic 2-drug PEP	Recommend expanded ≥3-drug PEP	Generally, no PEP warranted; however, consider basic 2-drug PEP† for source with HIV-risk factors§	Generally, no PEP warranted; however, consider basic 2-drug PEP† in settings in which exposure to HIV-infected persons is likely	No PEP warranted

* If drug resistance is a concern, obtain expert consultation; initiation of PEP should not be delayed pending expert consultation, and, because expert consultation alone cannot substitute for face-to-face counseling, resources should be available to provide immediate evaluation and follow-up care for all exposures

† The designation "consider PEP" indicates that PEP is optional; a decision to initiate PEP should be based on a discussion between the exposed person and the treating clinician of the risks versus benefits of PEP

§ If PEP is offered and taken and the source is later determined to be HIV-negative, PEP should be discontinued

¶ For skin exposures, follow-up is indicated only if evidence exists of compromised skin integrity (e.g., dermatitis, abrasion, or open wound)

References/Standards:

- CR MMWR September 30, 2005 / Vol. 54 / No. RR-9
- www.osha.gov/pls/oshaweb/owadisp.show_document_table=STANDARDS&p_id
- http://www.cdc.gov/hepatitis/HBV/PEP.htm
- The Joint Commission: Infection Prevention and Control Chapter

SAINT JOSEPH
HEALTH SYSTEM

Version #: 5

Title: TRAFFIC CONTROL

Document Owner: Stephanie Luther	PI Team: Environment of Care	Date Created: May 1, 1994
Approver(s): Suzanne Risner		Date Approved: 05/29/14
Location: Saint Joseph Health System (SJHS)		Department: Operating Room (14030_37020)

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

POLICY:

1. Prescribed patterns to control the traffic flow of personnel, patients and materials to, from and within the surgical services departments will be strictly followed.

PROCEDURE:

A. Traffic Control Zones: All workflow, staff and patient traffic patterns, and materials handling must follow a unidirectional course from an unsterile to an aseptic environment state, and then to an unsterile environment for disposition.
   1) Intermediate or Interchange Zone: Areas serving as intermediate access between unrestricted corridors and semi-restricted corridors includes Endoscopy Lab, Pre-op and Post-op II, Post Anesthesia Care Unit, locker rooms and lounges, Sterile Processing Department drop-off areas and other designated drop-off areas/rooms.
   2) Semi-restricted Zone: Personnel must wear scrub attire and head and facial hair covering, including clean storage areas, anesthesia supply room, center cores, the corridors accessing the operating rooms, sterile processing room and the decontamination room.
   3) Restricted Zone: Personnel must wear scrub attire, head and facial hair covering and mask where a sterile field exists, including operating rooms.
   4) Unrestricted Zone: Street clothes are worn in this zone, including area outside exits from semi-restricted and interchange areas.

B. Only authorized personnel may enter the operating room suite and Sterile Processing Department. These are limited to the medical staff, nursing staff, sales reps/vendors, and support service personnel working in the area and, upon authorization, other persons not directly involved in operational functions.

C. Personnel shall change into prescribed operating room attire in the locker rooms located in the interchange zone prior to entering the semi-restricted and restricted zones.
   1) Traffic in restricted zones shall be limited to properly attired personnel involved in the care of the patient.
   2) Entrance into the operating room directly from corridors should be limited to those people caring for the patient in that room. Operating rooms shall not be used as a thoroughfare.
   3) Traffic activity and talking within the operating room should be kept to a minimum.
   4) Doors in the operating room shall be kept closed except at times of patient, personnel, supplies and equipment movement.
   5) Operating/procedure room doors shall be closed after the patient is transported into the operating/procedure room.

6) After a procedure is started, personnel should enter and exit through the center core door.

D. The movement of clean and sterile supplies and equipment should be separated from contaminated supplies, equipment, and waste by space, time, or patterns.

1) Surgical supplies prepared for surgical procedures outside the surgical suite shall be transported to the surgical suite to maintain cleanliness and sterility and to prevent physical damage.

2) Containers brought in by vendor reps/private scrubs should be disinfected prior to being brought into the semi restricted and restricted areas of the surgical suite.

3) Supplies and equipment shall be removed from external shipping containers and web edged or corrugated cardboard boxes in the unrestricted area before transfer into the surgical suite or sterile processing area.

4) Fanny packs, backpacks, briefcases, and electronics need to be disinfected before entering the semi restricted or restricted areas of the surgical suite.

5) Movement of supplies shall be from the clean core through the operating /procedure room to the peripheral corridor.

a) **Mishawaka Specific:** Soiled supplies and instruments shall not reenter the clean core area. These items shall be contained in closed or covered carts or containers for transport to the designated decontaminated/dirty area. Equipment stored in clean core areas shall be properly disinfected before being returned to the core.

References/Standards:

- 2018 Perioperative Standards and Recommended Practices Association of PeriOperative Registered Nurses, Inc. Denver, CO 2018