Activation of the BCLS and ACLS Protocols.

1. At least two surgical team members must be certified in Basic Cardiac Life Support.
2. At least one member, to include Dr. Novoa, must be ACLS certified.
3. In case of emergency, both BCLS and ACLS protocols as certified by the American Heart Association (AHA) will be implemented and followed.
4. In case of emergency involving the patient:
   a. Dr. Novoa is considered to be the team leader and all orders will be initiated and directed by him.
   b. Upon activation, the circulating team member will dial 911 and then call Sierra Medical Center (747-4000) for immediate transfer of the patient to the Emergency Department of Sierra Medical Center for further monitoring. The time of activation of the BCLS/ACLS will be documented in the patient’s chart.
   c. If possible, the patient’s chart will be copied and transferred with the patient. If patient safety could be compromised, the chart will be faxed to the hospital as soon as possible.
   d. Dr. Novoa will travel with the patient to the Emergency Department of Sierra Medical Center and will serve as either the admitting physician or consulting physician.
5. In case of emergency involving the circulating team member:
   a. The first assist will break scrub and assess the patient while Dr. Novoa directly observes both the patient and first assist team member.
   b. Dr. Novoa will be responsible for the activation of either the BCLS/ACLS protocols.
   c. The first assist will then call 911 and Sierra Medical Center ER for immediate transfer of circulating team member.
   d. Dr. Novoa will only break scrub if the condition of the circulating team member is either unstable or life-threatening.
   e. Dr. Novoa will break scrub if he deems that the condition of the patient is also unstable or life-threatening and will activate ACLS for the patient as well. Dr. Novoa will then call 911 and activate the ACLS protocol for the patient. The first assist team member will then be responsible for the circulating assist while Dr. Novoa will be responsible for the patient.
   f. If it is decided by Dr. Novoa that the surgical case can continue, Dr. Novoa or the first assist will call Novoa Medical Services or Novoa MedSpa and order that the emergency surgical team travel to the assistance of the remaining members of the surgical team on the case.
   g. Once EMS stabilizes the circulating team member, at the discretion of Dr. Novoa, the surgical case will continue and be completed per procedure protocol.
6. In case of emergency involving the first assist team member:
   a. The circulating assist will assess the first assist while Dr. Novoa directly observes both the patient and first assist team member.
   b. Dr. Novoa will be responsible for the activation of either the BCLS/ACLS protocols.
   c. The circulating assist will then call 911 and Sierra Medical Center ER for immediate transfer of first assist team member.
   d. Dr. Novoa will only break scrub if the condition of the first assist team member is either unstable or life-threatening.
   e. Dr. Novoa will break scrub if he deems that the condition of the patient is also unstable.
or life-threatening and will activate ACLS for the patient as well. Dr. Novoa will then call 911 and activate the ACLS protocol for the patient. The circulating team member will then be responsible for the first assist while Dr. Novoa will be responsible for the patient.

f. If it is decided by Dr. Novoa that the surgical case can continue, Dr. Novoa or the circulating assist will call Novoa Women & Teen Center or Novoa MedSpa and order that the emergency surgical team travel to the assistance of the remaining members of the surgical team on the case.

g. Once EMS stabilizes the first assist team member, at the discretion of Dr. Novoa, the surgical case will continue and be completed per procedure protocol.

7. In the case of an emergency involving Dr. Novoa:
   a. The circulating assist will assess Dr. Novoa while the first assist directly observes both the patient and Dr. Novoa.
   b. If deemed to be an emergency, the senior team member or nurse team member will be responsible for the activation of either the BCLS/ACLS protocols.
   c. The circulating assist will then call 911 and Sierra Medical Center ER for immediate transfer of BOTH Dr. Novoa and the patient to Sierra Medical Center.
   d. The first assist will break scrub and either assist the circulating assist with the care of Dr. Novoa or prepare the patient for transfer to the Sierra Medical Center ER.
   e. If the senior team member or team nurse deems that the condition of the patient is also unstable or life-threatening she will activate the BCLS/ACLS protocols for the patient as well as notify the Sierra Medical Center ER of the change in status of the patient.
   f. Once EMS stabilizes Dr. Novoa, a second EMS team will transport the patient to Sierra Medical Center ER for observation and evaluation by either the ER doctor or General Surgery doctor on-call.
   g. The patient’s chart will be copied and faxed to Sierra Medical Center as soon as possible.
Saline and Silicone Breast Implants

1. The United States Food and Drug Administration (FDA), defines an implant as a device intended to be implanted into a surgically or natural cavity of the human body to assist, restore, or replace the function of an organ or structure of the human body for longer than one year. In the case of breast implants, the estimated maximum length of time of implantation is 10 years.

2. The following information should be documented in the chart:
   - identification numbers provided by the manufacturer of the implant (eg, lot or serial number);
   - patient’s name, address, telephone number, and social security number

3. The circulating assistant must confirm preoperatively that the necessary size and type of implant has been ordered and available before the day of surgery.

4. On the day of surgery, the size and type of implant will again be confirmed while informed consents are reviewed by Dr. Novoa. This will again be reviewed and confirmed during TIME OUT prior to the first incision.

5. Each implant will be provided to Dr. Novoa by the circulating assistant, and the proper size will be confirmed by the circulating assistant and first assist.

6. Prior to presenting each implant to the sterile field, both the circulating assistant and first assist will inspect the packaging material for the expiration date prior to the use of the implant.

7. Any explanted implants that has a visible serial number will be documented in the nursing record.

8. Any explanted implants will be disposed of according to OSHA regulations.

9. Explanted implants which are required to be returned to the manufacturer for evaluation will follow the specific regulations as requested by the manufacturer.
**Maintenance of the Sterile Field**

1. Scrubbed persons ONLY should function within a sterile field; scrubbed personnel who are independently donning sterile gowns and gloves should prevent contamination of the sterile field by gowning and gloving from a separate surface away from the main instrument table.

2. Sterile drapes should be used to establish a sterile field:
   a. Sterile drapes will be handled as little as possible before and during draping;
   b. During draping, gloved hands should be protected by cuffing the drape material over the gloved hands to reduce the potential for contamination;
   c. The portion of the surgical drape that establishes the sterile field should not be moved after it is positioned.

3. Items used within the sterile field should be sterile:
   a. All items should be inspected immediately before presentation to the field for proper packaging, processing, seal, package container integrity, and inclusion of a sterilization indicator;
   b. Indicators will be inspected immediately to verify the appropriate color change for the sterilization process selected;
   c. If an expiration date is provided, the date should be checked before the package is opened and the contents are delivered to the field.

4. All items introduced to a sterile field should be opened, dispensed, and transferred by methods that maintain item sterility and integrity:
   a. All invasive surgical procedures should be performed using sterile instruments and supplies, and the surgical team should practice aseptic technique for all surgical patients;
   b. Unscrubbed individuals should open wrapped sterile supplies by opening the wrapper flap farthest away from them first, to prevent contamination from passing an unsterile arm over a sterile item. Next, they should open each of the side flaps. The nearest wrapper flap should be opened last;
   c. All wrapper edges should be secured when supplies are presented to the sterile field;
   d. Sterile items should be presented to the scrubbed person or placed securely on the sterile field.
   1. Sharps and heavy objects should be presented to the scrubbed person or opened on a separate surface
   2. Peel pouches should be presented to the scrubbed person to prevent contamination of the contents.
   3. Rigid container systems should be opened on a separate surface. The external indicator should be verified for appropriate color change. Locks should be inspected for security to verify there has not been a breach of the container seal prior to use. The lid should be lifted toward the person opening the container and away from the container. The filter should be checked.
   e. All items should be delivered to the surgical field in a manner that prevents non-sterile objects or people from extending over the sterile field;
   f. When solutions are dispensed, the labeled solution receptacle on the sterile field should be placed near the table’s edge or held by the scrubbed person. The entire contents of the container should be poured slowly to avoid splashing. Solutions should not be recapped for later use;
g. Medications stoppers should not be removed from vials for the purpose of pouring medications unless manufactured with break-away tops. Sterile transfer devices (e.g., sterile vial spike) should be used to dispense medications to the sterile field.

5. A sterile field should be maintained and monitored constantly:
   a. The sterile field should be prepared in the location in which it will be used
   b. Sterile fields should be prepared as close as possible to the time of use and may not be left unattended;
   c. Sterile fields should not be covered for later use;
   d. Surgical equipment (e.g., cables, tubing) should be secured to the sterile field with non-perforating devices;
   e. Non-sterile equipment (e.g., Mayo stands) should be covered with sterile barrier material(s) before being introduced to or brought over a sterile field.

6. All personnel moving within or around a sterile field should do so in a manner that maintains the sterile field:
   a. Scrubbed personnel should remain close to the sterile field;
   b. Scrubbed personnel should move from sterile areas to sterile areas to prevent contamination, using back-to-back or face-to-face movements or after assuring clear distance from other sterile areas;
   c. Unscrubbed personnel should face sterile fields on approach, should not walk between two sterile fields, and should be aware of the need for a minimum of 12” distance from the sterile field;
   d. Scrubbed personnel should keep their arms and hands above the level of their waists at all times. Hands should remain in front of the body above waist level so the hands remain visible; arms should not be folded with the hands in the axilla;
   e. Scrubbed personnel should avoid changing levels and should be seated only when the entire surgical procedure will be performed at that level;
   f. Gloves should be examined when donned and periodically during the procedure; regloving should be done by the open gloving technique;
   g. When a break in sterile technique occurs, corrective action should be taken immediately unless the patient’s safety is at risk. If the patient’s safety is at risk, correct the break in technique as soon as it is safe to do so; when a break in sterile technique occurs, adjust the wound class accordingly (see Wound Classification appendix).

7. Vigilant attention will be paid to the sterile field when the risk for fire safety is great related to the use of fiberoptic light sources, electrocautery (disposable hot wire cauterization), high speed burs, and defibrillators. If there is alcohol in the skin prep, the risk for fire will be minimized by allowing the prep to dry completely prior to using beginning the procedure and using any instrumentation or equipment that increases the risk of fire, as listed above.

8. The surgical team will collaborate regarding the need to maintain sterility of instrumentation, equipment, and supplies until the patient is transferred from the OR. In most instances, it is acceptable to contaminate / dismantle the setup prior to discharging the patient from the OR. If there is any question as to patient stability, the setup will remain sterile until the patient leaves the OR.
Visitors and Observers in the Perioperative (PO) and Operating Room (OR) Area

1. Visitors (family and/or significant others) and observers in the PO/OP area must comply with all mandates established by the facility and regulatory agencies.

2. Visitors and observers will be asked to leave should their behavior become obstructive to patient care and/or the situation changes to make the visitor’s presence inappropriate.

3. Visitors and observers will be kept to a minimum in patient care and support areas. Clearly visible identification will be worn by all non-visitor observers while in the Perioperative Area.

4. Dr. Novoa or his designee’ must obtain consent from the patient or his/her legal guardian to have observers in the operating room during the procedure.

5. Visitors are allowed in pre and post-procedure patient care areas under the supervision of staff assigned to the specific area.

6. Visitors with apparent communicable diseases will not be allowed in direct patient care areas.
   a. Preoperative, Holding Area: Patients will be encouraged to have no more than two visitors at a time and only pending approval by the surgical team working in the area. Requests for more than two visitors will be evaluated on an individual basis.
   b. Intraoperative, Operating Room: Only by authorization by Dr. Novoa will any guest in appropriate dress be allowed to be present in the operating room.
   c. Postoperative: According to their level of recovery and the needs of other patients in the recovery room, the following will be allowed:

      Outpatients:
      Visitors are allowed in as soon as the patient has stabilized, pending approval by the surgical team. Generally only two visitors per patient are allowed at one time.

7. Observers must be at least 18 years of age to be present in the Perioperative and Operating room, due to risk of exposure to blood borne pathogens.
Patient Positioning

1. At least two surgical assist team members should review and inspect the positioning and equipment needed for the surgical procedure.
2. Risk factors related to the surgical procedure will be reviewed.
3. The circulating assist should confirm that the room is set up properly before the patient is move to the procedure room.
4. At least one team member should inspect the surgical table and transporting equipment prior to use for smooth and intact surfaces and for proper working condition before use.
5. Identify unique patient considerations that require additional precautions for procedure-specific positioning during the preoperative assessment
6. Use proper body mechanics when transporting, moving, lifting, or positioning patients by assuring adequate personnel are available and by using safe patient handling devices.
7. Potential hazards associated with patient transport and transfer activities should be identified, and safe practices should be established.
8. The patient should be attended during transport and transfer
9. Safety measures to be implemented during transport and transfer activities should include, but are not limited to locking wheels, side rails, safety straps, ensuring the patient’s body is protected, and avoiding rapid movement.
10. Use positioning equipment in a safe manner and according to manufacturers’ written instructions
11. Movement or positioning of the patient should be coordinated with the surgical team
12. The ACLS protocol should be followed at all times and the patient’s airway should be protected at all times
13. To reduce falls risk apply safety strap and assure the patient is attended by surgical team members at all times when on the procedure bed
14. Assure sufficient staff are present to safely position patient in a way that provides optimal surgical exposure and anesthetic access yet minimizes compromise to the musculoskeletal, circulatory, respiratory, neurological and integumentary systems.

CLINICAL ASSESSMENT:

1. Preoperative assessment for positioning needs will be made before transferring the patient to the procedure bed, including neuropathies, preexisting conditions and diseases, physical limitations, age, height/weight/body mass index, skin condition, nutritional status, procedure type, and required position. Hand-off communication between preoperative and intraoperative nursing staff will address identified concerns, as appropriate.
2. The intraoperative plan of care will address unique patient considerations that may require additional precautions for procedure-specific positioning such as pre-existing conditions, laboratory results, physical or mobility limitations, presence of prosthetic or corrective devices, presence of implanted devices, presence of peripheral pulses, perception of pain, level of consciousness, and individual psychosocial and cultural considerations.
3. During positioning, the surgical team will monitor patient body alignment and tissue integrity, with emphasis on protecting the airway and maintaining anesthesia care provider access to the patient, and with respect to the estimated length of procedure and desired procedural position.

4. After positioning, the surgical team will evaluate the patient’s body systems for any compromise in integrity: positions that can limit rib cage and abdominal expansion; factors leading to nerve damage, including members of the surgical team leaning on the patient, twisting or stretching of extremities; hyperextension of joints; or pooling of prep solutions that may cause chemical burns.

5. Have stretcher or bed available postoperatively that accommodates at least a 30 degree elevation of the patient’s upper body and head to avoid respiratory distress.

6. Monitor the patient for external pressure from surgical team members leaning against the patient’s body.

7. Retractors, equipment, instruments or members of the perioperative team resting on the patient may cause nerve or tissue pressure injuries.

8. Assure patient head is at the correct end of the device; place a pad/draw sheet under patient, as appropriate.

9. Evaluate the patient for signs and symptoms of injury related to positioning. Communicate areas of concern to postoperative care providers.

10. Unless necessary for surgical reasons, avoid tucking patient’s arms at their side when in the supine position. If there are surgical reasons to secure the patient’s arms with the use of a draw sheet, the draw sheet should extend above the elbows be tucked between the patient and the procedure bed’s mattress in a way that avoids excessive compression of the limb(s).

11. Pad occiput, heels, and sacrum for vulnerable patients and for lengthy procedures.

12. Place lumbar support for patients with history of lumbosacral pain; shoulder roll of appropriate size may be placed for selected neck procedures.

**Lithotomy Position**

1. Center the patient on the OR bed. The patient’s buttocks should be even with the lower break of the procedure bed and positioned in a manner that securely supports the sacrum on the bed surface.

2. Confirm proper positioning of the patient buttocks before surgery is initiated

3. Place stirrups at an even height and the proper angle to support alignment of joints, prevent peroneal /popliteal nerve damage.
Sterilization

1. Items to be sterilized should be cleaned, decontaminated, sterilized, and stored in a controlled environment, per OSHA regulations.

2. Items to be sterilized will be packaged in systems (indicators, containers, etc.) that are approved for the specific type of sterilization used. Medical-grade, pouches will be used for organization of items within sets.

3. The sterilizer manufacturer’s written instructions for use, monitoring, and maintenance of each specific sterilizer will be followed during use.

4. Load configuration and placement of items inside the sterilizers will comply with the sterilizer manufacturer’s recommendations and/or accepted guidelines from OSHA.

5. Saturated steam under pressure should be used to sterilize heat- and moisture-stable items unless otherwise indicated by the device manufacturer:
   a. manufacturers’ written instructions for operating steam sterilizers and for items sterilized should be followed; certain types of equipment and breast implants;
   b. following steam sterilization, the contents of the sterilizer should be removed from the chamber and left untouched for a period of at least 30 minutes;
   c. warm or hot items should not be placed on cool or cold surfaces;
   d. sterilized packages or containers that have formed condensate should be considered unsterile and none of the contents used;
   e. steam sterilization integrators will be used internally and indicators used externally for all sterilized items. Rapid-action biological spore-test indicators will be used according to manufacturer’s recommendations.

6. Use of flash sterilization should be kept to a minimum:
   a. flash sterilization should be used only when there is insufficient time to process by the preferred wrapped or container method.
   b. items that are flash sterilized should be noted on the Flash Sterilization Log to guide purchase of additional inventory;
   c. packaging and wrapping (eg, textiles, paper/plastic pouches, nonwoven wrappers) should not be used in flash sterilization cycles
   d. a rapid-action biological spore-test indicator must be run for a minimum of 10 minutes with any implant that is flash sterilized; each flash sterilization cycle should be monitored to verify that parameters required for sterilization have been met and the results are acceptable. Label indicator with last name of patient for whom the implant has been flash sterilized for traceability.
   e. users should adhere to aseptic technique for flash sterilized items during transport to the point of use;
   f. it is strongly preferred that a rigid sterilization containers designed and intended for flash-sterilization cycles be used
   g. the surgical team is responsible for documenting patient and device information on the Flash or Autoclave Log responsible for maintaining documentation of sterilizer cycle information.
   h. recommendations will be followed for preparation, exposure, and aeration of items sterilized.
7. Low-temperature or cold temperature sterilization will comply with manufacturer recommendations.

8. All loaned instrumentation and equipment that must be sterilized will be handled according to the sterilization protocol.

9. Sterilized materials should be packaged, labeled, and stored in a manner to ensure sterility, and each item should be marked with the sterilization date. Shelf life is to be considered event-related unless the manufacturer requires/recommends use of an expiration date.

10. Transportation of sterile items should be controlled:
   a. sterile items should be transported in covered or enclosed carts; items transported outside the perioperative area should be transported in carts with closed bottoms;
   b. items that are processed may be kept in the operating rooms (ORs) without re-sterilization at the alternate site as long as transportation between sites maintains sterility, preferably by use of the transport bins maintained for this purpose.

11. As part of overall quality monitoring, all OR gravity displacement autoclaves will undergo biological monitoring prior and sensory strip confirmation per manufacturer recommendations.

12. All sterilizer failures and corrective actions will be documented and reported to Dr. Novoa. Load inventory records/flash sterilization log of the affected autoclave will be reviewed and Dr. Novoa will be notified if patient exposure occurred.

13. Sterilization records and logs shall be maintained for at least 2 years.
Preparation and Maintenance on the Sterile Field

1. Prior to passing any medication to the sterile field each member of the surgical team should confirm the product label of the medication to confirm the name, strength, and expiration date.
2. If there is no designated first assist, the circulating assist should confirm the medication visually and verbally with Dr. Novoa.
3. Medication should be passed onto the field one at a time.
4. Care should be taken when removing stoppers from vials for the purpose of pouring the medications; the use of sterile needles or spikes are recommended when possible.
5. Tumescent solutions should be labeled with the strength or concentration of lidocaine used.
6. Tumescent solutions MUST be prepared with no fewer than 2 assistants preparing and visually and verbally confirming each ingredient.
7. Tumescent solutions cannot be used if prepared more than 3 hours prior to surgery start time.
8. Tumescent solutions which have not be used in one case may be used in a subsequent case as long as all preparatory protocols have been maintained and the solution is not older than 3 hours from the time of preparation.
9. Discard any solution or medication found on or off the sterile field without an identification label.
10. When passing a medication to Dr. Novoa both the circulating and first assist should verbally verify the medication, strength, and dosage of the medication.
## Staff Emergency Protocol

### Medical assistants (runners)
- If patient is procedure room, do not move as this is optimal location for management.
- If patient in rooms 1-3, evaluate possibility of transfer to procedure room for continued management.
- Alert Dr. Novoa and nurses of the emergency and the patient's location.
- Bring all emergency equipment to the site of the emergency (if not already in the procedure room).
- Obtain initial set of vital signs.
- If oxygen saturation is less than 93 percent, start oxygen by face mask.
- Assist in code.

### Front desk
- Prepare for transport EMS team to facility by moving furniture.
- Alert waiting patients about EMS arrival and potential delay.

### Staff nurses
- Act as medication nurse or code nurse in resuscitation.

### Physicians
- Respond to call for assistance.
- Dr. Novoa is designated code team leader and activator of ACLS protocol.
- Dr. Novoa to order call to 9-1-1 and give information to EMS transport team.
- Dr. Novoa to control airway.
- Dr. Novoa to transport with EMS team via ambulance to Sierra Medical Center.
- Nurse practitioner or Physician Assistant to assist in resuscitation and/or act as float Physician Extender.

### Checkout desk
- When necessary, dial 9-1-1, give location and description of the emergency.

### Additional office staff
- Keep flow of patients moving out of office.
<table>
<thead>
<tr>
<th>Staff</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Front desk</td>
<td>Identify patient in distress at check-in.</td>
</tr>
<tr>
<td></td>
<td>Periodically assess waiting room for patients in distress.</td>
</tr>
<tr>
<td></td>
<td>Move furniture for EMS transport team.</td>
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<tr>
<td></td>
<td>Alert waiting patients about potential delay.</td>
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<tr>
<td>Medical assistants</td>
<td>Situate ill patient in designated resuscitation room.</td>
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<tr>
<td></td>
<td>Alert physicians and nurses of the emergency and the patient's location.</td>
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<td></td>
<td>Bring all emergency equipment to the site of the emergency (if not already in the treatment room).</td>
</tr>
<tr>
<td></td>
<td>Obtain initial set of vital signs.</td>
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<tr>
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<td>If oxygen saturation is less than 93 percent, start oxygen by face mask.</td>
</tr>
<tr>
<td></td>
<td>Assist in code.</td>
</tr>
<tr>
<td>Staff nurses</td>
<td>Act as medication nurse or code nurse in resuscitation.</td>
</tr>
<tr>
<td></td>
<td>Act as code team leader if emergency occurs when no physician is in the office.</td>
</tr>
<tr>
<td>Physicians</td>
<td>Respond to call for assistance.</td>
</tr>
<tr>
<td></td>
<td>Dr. Novoa to act as code team leader and activator of ACLS protocol.</td>
</tr>
<tr>
<td></td>
<td>Dr. Novoa to order call to 9-1-1 and give information to EMS transport team.</td>
</tr>
<tr>
<td></td>
<td>Dr. Novoa to control airway.</td>
</tr>
<tr>
<td></td>
<td>Nurse practitioner or Physician Assistant to assist in resuscitation and/or act as float Physician Extender.</td>
</tr>
<tr>
<td>Checkout desk</td>
<td>When necessary, dial 9-1-1, give location and description of the emergency.</td>
</tr>
<tr>
<td>Additional office staff</td>
<td>Keep flow of patients moving out of office.</td>
</tr>
</tbody>
</table>

OFFICE EMERGENCY PROTOCOL
(NON-SURGICAL PATIENT)
<table>
<thead>
<tr>
<th><strong>Staff</strong></th>
<th><strong>Role</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Front desk</strong></td>
<td>Identify patient at check-in</td>
</tr>
<tr>
<td></td>
<td>Have chart available for Medical Assistant on Surgical Team</td>
</tr>
<tr>
<td><strong>Medical assistants</strong></td>
<td>Prep Surgical Room</td>
</tr>
<tr>
<td></td>
<td>Review chart for all necessary documents</td>
</tr>
<tr>
<td></td>
<td>Document initial vital signs of patient</td>
</tr>
<tr>
<td></td>
<td>Perform Pregnancy Test and Nicotine Test</td>
</tr>
<tr>
<td></td>
<td>Prepare analgesic medication per Klein technique based on patient weight (Must be confirmed by at least one other team member)</td>
</tr>
<tr>
<td></td>
<td>Document all records in chart during surgical procedure</td>
</tr>
<tr>
<td><strong>Staff nurses</strong></td>
<td>Review chart information and assist with answering questions regarding informed consent</td>
</tr>
<tr>
<td></td>
<td>Document vital signs of patient</td>
</tr>
<tr>
<td></td>
<td>Confirm results of Pregnancy Test and Nicotine Test and notify Dr. Novoa of positive results</td>
</tr>
<tr>
<td></td>
<td>Prepare analgesic medication per Klein technique based on patient weight (Confirm measurements with assisting team member)</td>
</tr>
<tr>
<td></td>
<td>Assist Dr. Novoa during surgical procedure</td>
</tr>
<tr>
<td></td>
<td>Review discharge information and schedule follow-up appointment with patient</td>
</tr>
<tr>
<td><strong>Physicians</strong></td>
<td>Dr. Novoa is required to perform immediate Pre-Op H and P and co-sign all informed consents</td>
</tr>
<tr>
<td></td>
<td>Dr. Novoa is to administer all Pre-Op medications brought by patient.</td>
</tr>
<tr>
<td></td>
<td>• Patient is to maintain ambulatory status at all times during procedure</td>
</tr>
<tr>
<td></td>
<td>Dr. Novoa to perform final evaluation of patient prior to discharge home in ambulatory condition</td>
</tr>
<tr>
<td></td>
<td>Dr. Novoa is team leader if ACLS protocol activated</td>
</tr>
<tr>
<td><strong>Staff</strong></td>
<td><strong>Role</strong></td>
</tr>
<tr>
<td>-------------------------</td>
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</tr>
</tbody>
</table>
| Front desk              | Identify patient at check-in  
Have chart available for Medical Assistant on Surgical Team                                                                                   |
| Medical assistants      | Prep Surgical Room  
Review chart for all necessary documents  
Document initial vital signs of patient  
Perform Pregnancy Test and Nicotine Test  
Prepare analgesic medication per Klein technique based on patient weight (Must be confirmed by at least one other team member)  
Document all records in chart during surgical procedure |
| Staff nurses             | Review chart information and assist with answering questions regarding informed consent  
Document vital signs of patient  
Confirm results of Pregnancy Test and Nicotine Test and notify Dr. Novoa of positive results  
Prepare analgesic medication per Klein technique based on patient weight (Confirm measurements with assisting team member)  
Assist Dr. Novoa during surgical procedure  
Review discharge information and schedule follow-up appointment with patient |
| Physicians               | Dr. Novoa is required to perform immediate Pre-Op H and P and co-sign all informed consents  
Dr. Novoa is to administer all Pre-Op medications brought by patient.  
• Patient is to maintain ambulatory status at all times during procedure  
Dr. Novoa to perform final evaluation of patient prior to discharge home in ambulatory condition  
Dr. Novoa is team leader if ACLS protocol activated |
Environmental Cleaning

1. Patients will be provided with a clean and safe environment.
   a. Housekeeping is responsible for terminal cleaning of the OR; OR staff are responsible for routine cleaning ORs between cases and after last case of day.
   b. Perioperative staff will assess the perioperative environment frequently for cleanliness and take action to implement cleaning and disinfection procedures or to notify housekeeping if needed.
   c. Equipment from areas outside the semi-restricted and restricted areas of the OR will be inspected for cleanliness and/or cleaned before being brought into an OR.
   d. Gloves used for environmental cleaning and disinfection will be made of natural rubber latex or nitrile, and will not be made of vinyl.
   e. Reusable string mops and cleaning cloths will be changed after each use; used cleaning mops or cloths will not be returned to the cleaning solution container.
   g. Measures will be taken to prevent vermin infestation of the perioperative environment, as deemed appropriate.

2. A safe, clean environment will be reestablished after each surgical procedure.
   a. Operating rooms will be cleaned after each surgical or invasive procedure with a cloth moistened with a detergent/disinfectant and water; if a procedure does not create splashing of blood/body fluids and there are no visibly soiled areas, floor cleaning can be performed as needed and confined to the immediate area of the OR bed/sterile field between cases such as minor procedures.
   b. Mattresses and padded positioning device surfaces (eg, OR beds, arm boards, patient transport carts) should be moisture-resistant and intact for ease of cleaning.
   c. Patient transport vehicles including straps and attachments should be cleaned after each patient use.
   d. All receptacles (eg, bins, kick buckets, pails), work surfaces, and tables should be cleaned and disinfected.
   e. Contaminated laundry should be handled as little as possible, by using standard precautions.
   f. Keyboards, monitor screens, telephones, and other electronic devices will be cleaned according to manufacturers’ recommendations.

3. Contaminated disposable and reusable items should be handled safely according to state and federal regulations.
   a. Disposable items contaminated with blood and/or tissue that would release blood or other infectious materials must be placed in closable, leak-proof biohazard containers.
   b. Containers or bags containing biohazardous/regulated waste will be transported according to applicable regulations, which is the responsibility of housekeeping.
   c. Personal protective equipment must be worn to prevent a splash or splatter when disposing of liquid waste; splash guards may be installed to confine areas with higher risk of splashing.

4. Surgical and invasive procedure rooms will be terminally cleaned regularly.
   a. Housekeeping is responsible for terminal cleaning and disinfection of operating and invasive procedure rooms, including developing and maintaining a schedule for such activities.
b. Cleaning and disinfection of operating and invasive procedure rooms will be done each 24-hour period during the regular week when scheduled procedures are completed for the day.

C. Cleaning and disinfection also will include horizontal surfaces; hallways and floors; substerile areas; scrub/utility areas; sterile storage areas.

d. Housekeeping is responsible for disassembling, cleaning, and disinfecting all equipment used for cleaning and disinfecting.

e. Refillable liquid hand soap dispensers will not be used.

5. All areas in the surgical practice setting should be cleaned according to an established schedule.

a. A cleaning schedule for areas that should be cleaned on a daily, weekly, or monthly basis will be established/maintained by housekeeping and the OSHA liaison.

b. Areas to be cleaned on a weekly, monthly, or quarterly basis should include, but are not limited to heating and air-conditioning equipment; sterilizers and their loading carts/carriages; clean and soiled storage areas; walls and ceilings.

c. The eye wash station will be checked routinely by staff on that unit to ensure that it is in working order per hospital policy, with accompanying documentation.

6. All personnel should take precautionary measures to limit transmission of microorganisms when performing routine environmental cleaning and disinfection activities.

PROCEDURE FOR:
Environmental Cleaning

1. All personnel must comply with OSHA’s bloodborne pathogen standards when performing cleaning and disinfection procedures involving contact with blood and other potentially infectious materials.

2. Healthcare personnel handling contaminated items must wear appropriate PPE to reduce the risk of exposure to bloodborne or other potentially infectious microorganisms and hazardous materials; depending on the risk of exposure, this will include gloves and may include gowns, mask, eye protection, and/or face shields.

3. Hand hygiene should be performed when gloves are removed and as soon as possible. When hands are soiled, antimicrobial soap and water must be used.

4. When visible soiling by blood or other potentially infectious materials appear on OR surfaces or equipment during or after a surgical procedure, disinfectant approved by the OSHA liaison will be used to clean the area as soon as possible.

5. Contaminated sharps (e.g., needles, blades, sharp disposable instruments) must be discarded in a closable, puncture-resistant, leak-proof (on both sides and bottom) receptacle. The receptacle must be marked with a biohazard label that meets OSHA bloodborne pathogen standards.

6. Procedures for environmental cleaning and disinfection must be followed for circumstances that may require contact or airborne precautions.

   a. Extraordinary cleaning procedures or closure of operating rooms following procedures identified as contaminated or dirty-infected.

   b. Access to the OR for cleaning without wearing PPE devices may be done after 30 minutes.

7. Annual education regarding bloodborne pathogens will be completed by all personnel who perform environment cleaning in the perioperative setting.

8. Ongoing review of products, processes, and outcomes of the environmental cleaning and disinfection program will be a collaborative effort that involves OSHA, housekeeping and the surgical team.
EQUIPMENT:
Cleaning disinfectant, as approved by the OSHA liaison
Reusable mops, impregnated wipes

PROCEDURE:
Routine cleaning of ORs between cases and after last case of day Action Points of Emphasis

1. Gather cleaning supplies, including clean mop head and wiping cloth.
2. Cleaning/disinfectant solution must be prepared according to manufacturer’s recommendations for proper concentration of solution.
3. Gloves are required; additional protection may include gowns, mask, eye protection, and/or face shields, as appropriate to the risk of splashing or potential exposure.
4. Confine and remove trash, soiled linen, suction canisters, and other gross debris. Add solidifying agent to bloody suction fluid.
5. Solidifying agent is not indicated for non-bloody suction contents nor any other type of body fluid.
6. Immerse reusable cloth(s) in solution or use pre-saturated wiping cloth(s) to wipe down all horizontal surfaces and equipment used during procedure, including cords, hoses, and lines. Inspect all items on periphery of room for contaminants and clean as needed.
7. Proper cleaning of surfaces between cases involves both mechanical friction to remove soil and recommended contact time of 3 minutes. Do not hasten turnover by wiping off dampness from surfaces in an effort to open sterile supplies as soon as possible.
8. Remove any equipment not routinely kept in OR and/or not needed for subsequent procedures.
9. Move OR bed aside and mop floor below; reposition OR bed in center of room and continue mopping to perimeter of space.
10. Additional suture and other debris must be collected and removed for disposal.
11. Make up room by distributing clean trash and laundry bags and new suction canisters to nursing and anesthesia, and place fresh linen on OR bed.
12. Lock both OR bed and head piece of bed in place.
13. Inspect any equipment that is being brought into the room for subsequent cases for cleanliness; perform cleaning, as needed.
14. Transfer all soiled linen and trash bags and suction canisters to decontamination area.
15. Remove personnel protective equipment (PPE) when completed in room and/or when transfer to decontamination is completed, as appropriate. Do not flush disposable wipes of any type; dispose of in trash.
16. Remove soiled PPE only after
   a. soiled equipment and trash are removed;
   b. OR and floors have been cleaned;
   c. OR bed has been made up with fresh linen.
17. Wash hands thoroughly with antimicrobial soap and water after removing PPE.
18. Return cleaned equipment that is no longer needed for patient care to appropriate storage area(s) when OR cleaning is completed.
**Procedure Room Clean Field Maintenance**

1. Preparation for a next day or next case surgical procedure will follow the Practice Guidelines established for an end of the day case.

2. Both Housekeeping and at least two surgical team members will inspect the procedure room/operating room and follow all cleaning procedures as established in Practice Guidelines for Environmental Cleaning, Maintenance of Sterile Field and Operating Room.

3. The surgical team is solely responsible for the next case or next day final inspection of the procedure room/operating room.

4. Once the procedure/room operating room is prepared for the next case, the room will not be used for evaluation or care of any patient other the patient scheduled for the next surgical case.

5. Once prepared for the next surgical case, the room is to be closed with minimal employee/surgical team traffic in that room.

6. The room may be prepared for a next day case; protocols for a next case scenario will be repeated to include an inspection of the room at least 1 hour prior to the case.

7. At least two surgical team members must inspect the procedure room/surgical room prior to allowing the patient for the next assigned case to enter the room.

8. Dr. Novoa will make a final inspection of the procedure room/surgical room before the patient is allowed to enter the room.

9. An additional inspection of the room, to include the inspection and proper working of each piece of surgical equipment will be performed by Dr. Novoa and at least one other member of the surgical team prior to allowing the patient to enter the room.

10. If a defect, concern or non-correctable situation should arise associated with the clean areas or sterile field of the procedure/operating room, the surgical team will prepare the alternate procedure/operating room for operation. Preparation of the alternate room will follow all Practice Guidelines established for Environmental Cleaning, Maintenance of Sterile Field and Operating Room.