Regular Meeting of the Truckee Surgery Center Board of Managers

Quarter 2

Wednesday, April 8, 2026 at 12:00pm

Tahoe Forest Hospital - Aspen Conference Room

10800 Donner Pass Rd., Suite 200, Truckee, CA 96161

2026-04-08 Regular Meeting of the Truckee Surgery Center Board of Managers Q2

Agenda Packet Contents

TRUCKEE SURGERY CENTER
REGULAR MEETING OF THE
BOARD OF MANAGERS
Q2 AGENDA

Wednesday, April 8, 2026, at 12:00 p.m.
Aspen Conference Room – Tahoe Forest Hospital
10800 Donner Pass Rd., Suite 200, Truckee, CA 96161

1. **CALL TO ORDER**

2. **ROLL CALL**

3. **CLEAR THE AGENDA/ITEMS NOT ON THE POSTED AGENDA**

4. **INPUT – AUDIENCE**
   This is an opportunity for members of the public to address the Board on items which are not on the agenda. Please state your name for the record. Comments are limited to three minutes. Written comments should be submitted to the Board Clerk 24 hours prior to the meeting to allow for distribution. Under Government Code Section 54954.2 – Brown Act, the Board cannot take action on any item not on the agenda. The Board may choose to acknowledge the comment or, where appropriate, briefly answer a question, refer the matter to staff, or set the item for discussion at a future meeting.

5. **CLOSED SESSION**
   - **5.1. Approval of Closed Session Minutes**◈
     - 5.1.1. 03/11/2026 Regular Meeting
   - **5.2. Public Employee Appointment (Gov. Code § 54957)**
     Title: Truckee Surgery Center Administrator

6. **OPEN SESSION**

7. **REPORT OF ACTIONS TAKEN IN CLOSED SESSION**

8. **APPROVAL OF MINUTES**◈
   - **8.1.** 03/11/2026 Regular Meeting Minutes◈ ..... ATTACHMENT

9. **ITEMS FOR BOARD ACTION**◈
   - **9.1. Truckee Surgery Center Administrator Employment Agreement**◈.....ATTACHMENT*
     Truckee Surgery Center Board of Managers will review and consider approval of the TSC Administrator Employment Agreement.
   - **9.2. Consulting Agreement** ◈..... ATTACHMENT
     Truckee Surgery Center Board of Managers will review and consider an extension of consulting agreement.
   - **9.3. Policies for Approval**◈
     Truckee Surgery Center Board of Managers will review the following policies:
     - 9.3.1 Emergency Operations Plan, EOC – 1902.....ATTACHMENT
     - 9.3.2 Quality Assessment and Performance Improvement Plan, QA – 2002..... ATTACHMENT
     - 9.3.3 Temperature, Humidity, and Air Exchanges, EOC – 1937.....ATTACHMENT

◈ Denotes Action Item

9.3.4 Fire Drills, EOC – 1909…… ATTACHMENT
9.3.5 Medication Management and Administration, OH – 1908…… ATTACHMENT

9.4. Review Patient Home Medication List ◈…… ATTACHMENT
Truckee Surgery Center Board of Managers will review the Patient Home Medication List.

9.5. Staff Bonus Plan ◈…… ATTACHMENT
Truckee Surgery Center Board of Managers will review Staff Bonus Plan discussed in March.

10. ITEMS FOR NEXT MEETING

11. ADJOURN

*Denotes material (or a portion thereof) may be distributed later.

A copy of the board meeting agenda is posted on Tahoe Forest Hospital District's web site (www.tfhd.com) at least 72 hours prior to the meeting or 24 hours prior to a Special Board Meeting. Materials related to an item on this Agenda submitted to the Board of Managers, or a majority of the Board, after distribution of the agenda are available for public inspection in the District's Administration Office, 10800 Donner Pass Rd., Suite 200, Truckee, CA 96161, during normal business hours.

Note: It is the policy of Tahoe Forest Hospital District to not discriminate in admissions, provisions of services, hiring, training and employment practices on the basis of color, national origin, sex, religion, age or disability including AIDS and related conditions.

Equal Opportunity Employer. The meeting location is accessible to people with disabilities. Every reasonable effort will be made to accommodate participation of the disabled in all of the District's public meetings. If particular accommodations for the disabled are needed (i.e., disability-related aids or other services), please contact the Executive Assistant at 582-3481 at least 24 hours in advance of the meeting.

◈ Denotes Action Item

TRUCKEE SURGERY CENTER REGULAR MEETING OF THE BOARD OF MANAGERS

MINUTES

Wednesday, March 11, 2026, at 12:00 p.m.
Aspen Conference Room – Tahoe Forest Hospital
10800 Donner Pass Rd., Suite 200, Truckee, CA 96161

1. CALL TO ORDER
Meeting was called to order at 12:03 p.m.

2. ROLL CALL
Board of Managers: Dr. Jeffrey Dodd, Crystal Felix, Anna Roth, Louis Ward
Board of Managers Absent: None

Staff in attendance: Jan Iida, Chief Nursing Officer; Heidi Fedorchak, Truckee Surgery Center Interim Administrator; Sydney Shelton, Executive Assistant

3. CLEAR THE AGENDA/ITEMS NOT ON THE POSTED AGENDA
None.

4. INPUT – AUDIENCE
No members of the public were in attendance.

5. APPROVAL OF MINUTES
5.1. 12/10/2025 Regular Meeting Minutes

ACTION: **Motion made by Manager Dodd, to approve the Truckee Surgery Center Board of Managers regular meeting minutes of December 10, 2025, as presented, seconded by Manager Roth.**
AYES: Dodd, Felix, Roth, Ward
Abstention: None
NAYS: None
Absent: None

6. ITEMS FOR BOARD ACTION◈
6.1. Healthy Tahoe Magazine Article◈
Truckee Surgery Center Board of Managers will discuss an opportunity with a local magazine.

ACTION: **Motion made by Manager Felix, to move forward with exploring the opportunity to advertise in the Healthy Tahoe Magazine, seconded by Chair Ward to more forward.**
AYES: Dodd, Felix, Roth, Ward
Abstention: None

NAYS: None
Absent: None

7. ITEMS FOR BOARD DISCUSSION

7.1. Financial Reports

Truckee Surgery Center Board of Managers will review the following financial reports:

7.1.1. Q2 FY26 Financial Statement
7.1.2. Q2 FY26 Balance Sheet
7.1.3. Monthly Dashboard – January 2026

Interim Administrator will look into a new ambulatory surgery center billing company.

7.2. Coding Audit Report

Truckee Surgery Center Board of Managers received an update on Third Quarter 2025 Coding Audit Report.

7.3. Staff Bonus Plan

Truckee Surgery Center Board of Managers discussed the staff bonus plan, including eligibility criteria and financial impact. The anticipated cost of the program is approximately $18,000, which has been incorporated into the FY27 budget.

The Board reviewed the proposed performance benchmark tied to patient satisfaction scores. While the current score is 90%, members discussed refining the metric to ensure it represents a meaningful performance standard. Rather than maintaining the current level, the Board emphasized the importance of establishing a stretch goal to encourage continued improvement.

Discussion also included how patient satisfaction responses are measured, noting that "disagree" and "strongly disagree" responses would negatively impact the metric.

Manager Roth recommended that the TSC Interim Administrator moves forward with the staff bonus plan as discussed.

7.4. Interim Administrator Update

Truckee Surgery Center Board of Managers received an update from the Interim Administrator on operations, staffing, facility and equipment needs.

A total of 137 cases were completed last quarter.

There is ongoing discussion regarding FY26 capital items, which are currently pending review and prioritization.

The operating room floors project has been deferred to next year's budget. In the interim, a patch solution will be implemented.

Additionally, ACHC survey has been completed with excellent scores. Interim Administrator and staff will address a small number of deficiencies, which are being followed up accordingly.

Open Session recessed at 12:43 p.m.

8. CLOSED SESSION

8.1. Approval of Closed Session Minutes

8.1.1. 12/10/2025 Regular Meeting Minutes

Discussion was held on a privileged item.

8.2. Hearing (Health & Safety Code § 32155)◈

Subject Matter: Fourth Quarter 2025 Infection Control Data Summary
Number of items: One (1)

Discussion was held on a privileged item.

8.3. Hearing (Health & Safety Code § 32155)◈

Subject Matter: 2025 Annual Infection Prevention Plan Evaluation
Number of items: One (1)

Discussion was held on a privileged item.

8.4. Hearing (Health & Safety Code § 32155)◈

Subject Matter: Fourth Quarter 2025 Quality Assurance Performance Improvement Data
Number of Items: Fourteen (14)

Discussion was held on a privileged item.

8.5. Hearing (Health & Safety Code § 32155)◈

Subject Matter: Emergency Management & Life Safety
Number of Items: Three (3)

Discussion was held on a privileged item.

8.6. Hearing (Health & Safety Code § 32155)◈

Subject Matter: Medical Staff Credentials
Number of items: One (1)

Discussion was held on a privileged item.

8.7. Conference with Labor Negotiator (Government Code § 54957.6) ◈

Name of District Negotiator(s) to Attend Closed Session: Louis Ward
Unrepresented Employee: Truckee Surgery Center Interim Administrator

Discussion was held on a privileged item.

8.8. Public Employment (Government Code § 54957)◈

Subject Matter: Truckee Surgery Center Administrator

Discussion was held on a privileged item.

Open Session reconvened at 12:57 p.m.

9. REPORT OF ACTIONS TAKEN IN CLOSED SESSION

Item 8.1. was approved on a 4-0-0 vote. Items 8.2. – 8.6. were accepted with a vote of 4-0-0. Item 8.7. was approved with contingency with a 4-0-0 vote. There were no reportable actions for items 8.8.

10. ITEMS FOR NEXT MEETING

The next meeting is scheduled for June 3, 2026, at 12:00pm.

11. ADJOURN

Meeting adjourned at 1:35 p.m.

TRUCKEE SURGERY CENTER, LLC
CONSULTING AGREEMENT

This Consulting Agreement is effective on October 1, 2025 (the "Effective Date") by and between **Truckee Surgery Center, LLC**, a California limited liability company with an address of 10770 Donner Pass Road Suite 201, Truckee, California 96161 (the "TSC") and **Courtney Leslie**, an individual ("Consultant").

Whereas, TSC intends to retain Consultant to render certain professional consulting services including, but not limited to, providing overall input, staff training, advice and guidance regarding Truckee Surgery Center Administration and Business Office.

Whereas, TSC intends to retain Consultant as mutually agreed to by TSC and Consultant at the hourly rates as set forth in this Agreement, and Consultant is willing to provide the Services for consideration and upon the terms stated in this Agreement.

In consideration of the mutual covenants in this Agreement, the parties agree as follows:

1. SCOPE OF WORK

1.1. This Agreement shall cover all consulting services to be performed by Consultant for TSC. Consultant represents that she has the requisite skill, ability, experience and knowledge to perform in accordance with and in a manner consistent with generally recognized standards and practices. Consultant will perform the services as outlined in **Exhibit A** (collectively, "Services") when requested by TSC. Consultant agrees to use best efforts to diligently provide the Services. The parties agree that time is of the essence in the performance of Services.

1.2. If additions to the scope of work are deemed necessary, this Agreement may be amended. Without prior written approval of TSC, Consultant is not authorized to perform additional Services beyond those set forth in this Agreement. TSC shall not be obligated to pay any additional fees, costs, or expenses incurred as a result of any unauthorized additional activities in the absence of a fully executed amendment to this Agreement.

1.3. It is understood and agreed, that Consultant is an independent Consultant, and Not the employee, agent, joint venture, or partner of TSC for any purpose whatsoever. TSC shall have no right to, and shall not control the manner or prescribe the method by which the Services are performed by Consultant hereunder. Consultant shall be entirely and solely responsible for its acts and acts of its agents, employees, subcontractor's while engaged in the performance of Services hereunder.

2. PAYMENT CONDITIONS

2.1. As full and complete compensation for the Services under this Agreement, District shall pay Consultant as follows:

a) One Hundred Fifty Dollars ($150.00) per hour for Services requested by TSC.

2.1.a.1. Not to exceed Forty Thousand Dollars ($40,000.00) in total for the term of this Agreement.

2.2. Consultant will be compensated for Services provided to TSC according to the schedule set forth in **Exhibit B**, attached hereto and incorporated herein by reference. Consultant shall provide TSC with their agreed upon hours of Services at the signing of this Agreement. Any changes by the Consultant to the hours provided shall be communicated fifteen (15) days prior to implementation of adjusted schedule. Minor adjustments on any given day are allowed by the Consultant to accommodate personal needs, illnesses, emergencies, or as a result of services not being needed.

2.3. To receive compensation, Consultant must submit an itemized monthly Service Time Log, attached as **Exhibit B**, or other written documentation as approved by TSC. TSC shall pay Consultant within thirty (30) days after receipt of the invoice. The Service Time Log must include a detailed description of services rendered including dates and hours worked.

2.4. If TSC has a good faith objection to any part of an invoice or an expense, TSC shall notify Consultant and pay the portion of the invoice or expense not in dispute. Any good faith dispute not resolved by the parties within thirty (30) days after TSC's notification of an objection will be submitted to mediation.

3. TERM AND TERMINATION

3.1. This Agreement shall begin on the Effective Date and shall continue for a term of six (6) months ("Initial Term").

3.2. Either party may terminate this Agreement at any time with or without cause upon thirty (30) days prior written notice to the other party. The contract may be renegotiated if there are material changes in the law.

3.3. If this Agreement terminates before the end term, TSC shall have no further obligations to Consultant under this Agreement other than payment for Services requested by TSC that were performed by Consultant before the date of such termination.

3.4. Article 9 (Confidentiality) and Article 7 (Product Ownership) shall survive the expiration or termination of this Agreement.

4. INDEPENDENT CONTRACTOR

4.1. Consultant is an independent contractor for all purposes and not an employee of TSC. Neither Consultant or any agent, representative, associate or employee of Consultant, will be considered an agent, representative or employee of TSC for any purpose including, but not limited to, workers' compensation insurance, unemployment insurance, social security insurance, federal, provincial and state taxes, TSC employee benefits and coverage's. Conduct and control of the work to be performed under this Agreement by Consultant lies solely with Consultant. Consultant shall perform the Services hereunder in accordance with all applicable legal requirements. If TSC is liable for any withholding taxes, unemployment compensation, workers' compensation, or other similar taxes or charges associated with Consultant's performance of this Agreement, Consultant agrees to repay TSC for all such payments. Consultant may not incur any liability on TSC's behalf nor bind TSC to any contractual or payment obligation without the prior written consent of TSC.

4.2. Consultant agrees and understands that as an independent Consultant, Consultant is responsible for the payment of all self-employment taxes, and other taxes which may arise as a result of it performing Services as an independent Consultant. It is further understood that TSC shall have no responsibility in withholding any taxes payable to the federal or state government, and that it is Consultant's sole responsibility to meet its tax obligations.

5. THE TSC

5.1. TSC shall provide all the instrumentalities, tools and equipment that may be necessary or required in the performance of the Services.

6. PUBLICATIONS AND PUBLICITY

6.1. The parties agree not to use, expressly or by implication, any trademark, trade name, logo, or any contraction, abbreviation or adaptation thereof of any other party, or the name of the other party's staff in any news, publicity release, policy recommendation, advertising, or any commercial communication, excluding routine business correspondence, without the prior written approval of the other party.

7. PRODUCT OWNERSHIP

7.1. All rights, title, and interests in all procedures, methods, equipment, displays, exhibits, techniques, strategies, mock-ups, devices, databases, forms and other services or products created or modified by Consultant in the performances of Services under this Agreement shall be owned by TSC. TSC shall have full ownership rights in all written or electronically submitted reports and photo-documentation prepared by Consultant.

8. INSURANCE AND INDEMNIFICATION

8.1. INSURANCE: TSC will extend Directors and Officers (D&O) liability coverage to contractor through its established insurance program with BETA Risk Management Authority, as outlined in the attached **Exhibit C** Certificate Number D&O-25-007, Amendment No: D334-04.

8.2. INDEMNIFICATION: Consultant is solely liable for all claims, liabilities, damages, and debts of any type whatsoever that may arise on account of Consultant's activities, or those of Consultant's employees, in the performance of this Agreement. Consultant shall exonerate, indemnify, defend, and hold harmless TSC and any director, officer or employee of TSC for any loss, damage, liability, or claim paid or incurred by TSC, director, officer, or employee by reason of liability resulting from Consultant's performance of the Services hereunder, or from the acts or omissions of Consultant or Consultant's employees, including without limitations, all consequential damages, attorney's fees and costs.

9. CONFIDENTIALITY

9.1. Consultant agrees that all information and knowledge, whether or not in writing, of a private, secret, or confidential nature, or obtained publicly, which concerns the TSC's business affairs, including its inventions, products, processes, projects, developments, and plans, are and shall be the property of the TSC, and Consultant will not disclose the same to unauthorized persons or use the same for any unauthorized purposes without prior written approval by an authorized officer of the TSC, either during or after the term of this Agreement.

9.2. Except as provided above, the Consultant agrees that all files, letters, memos, reports, sketches, drawings, notebooks, or other written material containing matter of the type set forth in Section 7.1 above, which shall come into the custody or possession of Consultant, shall remain the exclusive property of TSC, to be used by Consultant only in the performance of Consultant's duties herein. Consultant shall forfeit and return any and all such documents to TSC upon termination of this Agreement.

9.3. Any previous Nondisclosure, Confidentiality or Business Associate Agreement executed previously with Truckee Surgery Center will remain in full force and survive this Agreement.

10. REPRESENTATIONS AND WARRANTIES

10.1. Consultant represents warrants and covenants that upon execution and throughout the term of this Agreement that:

a) Consultant has the legal authority to enter into this Agreement;

b) Consultant is experienced and competent to perform the Services.

c) Consultant shall perform the Services in a manner consistent with the level of care, skill, practice and judgment exercised by other professional consultants in performing similar Services of a similar nature under similar circumstances.

d) Consultant shall comply with all applicable federal and state laws and regulations applicable to the Services provided under this Agreement.

e) Consultant will comply with all applicable TSC policies and procedures in the performance of Services under this Agreement.

f) Consultant has not been convicted of a crime relating to delivery of health care.

g) Consultant has not been suspended or excluded or otherwise restricted from any participating in any federal or state health care payment program and has not otherwise excluded from contracting with the federal government.

h) To Consultant's knowledge, Consultant is not under investigation or otherwise aware of any circumstances which may result in Consultant being debarred or excluded from participation in any federal or state healthcare program.

10.2. Upon occurrence of any event that causes any of the above representations to no longer be true, Consultant will give TSC written notice within 48 hours of such event.

11. MISCELLANEOUS

11.1. IMMUNIZATIONS AND BACKGROUND REQUIREMENT. Consultant shall communicate with the TSC Administrator to ensure immunizations and background requirement has been met. Standard immunizations, include chicken pox, measles, mumps, rubella, and Hepatitis B, and a negative Tuberculosis test or screening form, prior to the Effective Date of this Agreement.

11.2. ENTIRE AGREEMENT. This Agreement and the exhibits hereto and thereto contain the entire understanding between the parties with respect to the subject matter hereof and supersede all prior and contemporaneous agreements and understandings, express or implied, oral or written.

11.3. SEVERABILITY. If any provision of this Agreement is deemed unenforceable, all other provisions will be deemed severable and enforceable to the full extent permitted by law.

11.4. ASSIGNMENT DELEGATION. Consultant may not assign Consultant's rights nor delegate any obligations under this Agreement without District's prior written approval.

11.5. COUNTERPARTS. This Agreement may be executed in multiple counterparts, each of which will be deemed an original and all of which, when taken together, will constitute one instrument and any facsimile, pdf. or other electronic or digital version of any party's signature appearing on any such counterpart shall be deemed an original and shall fully bind such party.

11.6. GOVERNING LAW. This Agreement will be interpreted under the California law with venue in Nevada County for any action arising hereunder.

11.7. NOTICE. All notices under this Agreement shall be in writing sent by registered mail, certified mail, email or facsimile, confirmed by subsequent copy sent electronically or by First Class Mail to the Party's address.

11.8. WAIVER. The waiver of any breach of any provision of this Agreement shall not be deemed to be a waiver of any other breach of any provision.

11.9. CAPTIONS. All section captions and headings in this Agreement are provided for informational purposes only and do not affect the interpretation or construction of any provision of this Agreement.

[Signature Page Follows]

AGREED AND ACCEPTED:

TSC:	**CONSULTANT:**
Truckee Surgery Center 10770 Donner Pass Road Suite 201 Truckee, CA 96161 Phone: 530-550-2940	Name: Courtney Leslie [redacted]
Crystal Felix Managing Board Member	Consultant
Date: 09/24/2025	Date: 9/24/25
	[redacted]

TRUCKEE SURGERY CENTER

Exhibit A
Scope of Work

Consultant shall perform the following services:

- Training of the Interim Administrator
- Provide training and guidance for the overall operation of TSC. Including but not limited to; Business and Administrative Office functions, Environment of Care & Life Safety, Facility Management, and, Credentialing.
- Assist in the preparation for accreditation and state surveys, as well as other surveys as needed.
- Assist with the reaccreditation and state surveys if requested.
- Attend meetings if requested
- Provide up to 10 hours of services per week
    - Work on site 1 day per week as requested
    - Respond to questions via texts/calls

TRUCKEE SURGERY CENTER

Exhibit B
Service Time Log

Name:

Contract Name:

Each month please complete & submit this log for services rendered. Please add more pages to this log if needed to ensure all dates, times, services are listed. If you use a computer/phone application, please attach and sign this log to the documentation generated by the program. Thank you.

Date of Service	Description of Services as specified by the contract	Hours

Total time: _____hours @ $150.00 per hour = Balance due $_____

Contractor hereby attests that all of the services listed for the time periods indicated are accurate and that there has been no duplication of hours or services. Contractor declares that the above statement is true and accurate to the best of its knowledge.

Consultant's signature: _____ **Date:** _____

Approved by: _____ **Date:** _____

EXHIBIT C

BETA Risk Management Authority ("BETARMA")
A Public Entity

AMENDMENT
INDEPENDENT CONTRACTOR MEMBER

Certificate Number: D&O-25-007	Amendment No: D334-04

Issued to: Tahoe Forest Hospital District		
Effective Date: 09/29/2025 at 12:01 a.m.	Expiration Date: 07/01/2026 at 12:01 a.m.	Additional Contribution: Per Contract

It is understood and agreed that Section 1.13 (Definitions) is amended to include:

Courtney Leslie as an individual **Member**, regardless of his or her status as an independent contractor, but only for **Wrongful Acts** committed solely in his or her capacity as *Independent Consultant - Assisting Interim TSC Administrator* of the **Named Member** or a **Subsidiary**.

ALL OTHER TERMS, CONDITIONS AND EXCLUSIONS REMAIN UNCHANGED.

Michele D Reagen

Authorized Representative of BETARMA

TRUCKEE SURGERY CENTER, LLC
FIRST AMENDMENT TO CONSULTING AGREEMENT

This First Amendment to Consulting Agreement ("**Amendment**") is made and entered into as of April 1, 2026, by and between **Truckee Surgery Center, LLC** ("**TSC**") and **Courtney Leslie ("Consultant")** and shall amend and become a part of that certain agreement, made by and between TSC and Consultant, dated October 1, 2025 **("Base Agreement").**

NOW, THEREFORE, the parties agree on the following change(s):

1. **Section 3.1 Term,** of the Base Agreement shall be amended to extend the Term of this Agreement through October 1, 2026.

2. **Amendment.** Except as specifically revised by this Amendment and any and all subsequent amendments, the Base Agreement shall continue in full force and effect pursuant to the terms thereof.

3. **Full Force and Effect.** To the extent there is a conflict between the terms of this Amendment and the Base Agreement, this Amendment shall control.

4. **Definitions.** Capitalized terms not otherwise defined in this Amendment shall have the meaning ascribed to such terms in the Base Agreement.

IN WITNESS WHEREOF, the parties hereto, for themselves or by their authorized officers, as applicable, have executed this Amendment as of the first date written above.

TRUCKEE SURGERY CENTER, LLC

BY: _____ Date: _____
Crystal Felix, CFO

CONSULTANT

BY: _____ Date: _____
Courtney Leslie

Status Draft PolicyStat ID 20098481

Origination	N/A
Last Approved	N/A
Last Revised	N/A
Next Review	N/A
Owner	Heidi Fedorchak: Nurse Manager
Department	Environment of Care
Applicabilities	Truckee Surgery Center

Emergency Operations Plan, EOC-1902

RISK:

The lack of an Emergency Operations Plan (EOP) would affect the Truckee Surgery Center's (TSC) ability to mitigate a disaster's adverse effects, such as loss of life and property.

POLICY:

Truckee Surgery Center (TSC) will establish and maintain an Emergency Operations Plan designed to manage the consequences of natural disasters and other emergencies that disrupt the Surgery Center's ability to provide care.

TSC will work closely with the Tahoe Forest Hospital (TFH) Facilities Management Department in the event of an emergency, depending on the type of incident.

PURPOSE:

To conduct business normally, it is important for TSC to have a strategy on preparation for emergencies. This plan must provide an organizational structure so that TSC can effectively prepare for both external and internal disasters that can negatively affect its environment of care.

STRUCTURE:

A. TSC plays an important role as a provider of care to the residents of its community. TSC is ready to assist as needed in case of community emergency, and integrates its Emergency Operations Plan with community disaster plans, as appropriate, to support the community's response to disaster. TSC will train its personnel in this plan.

B. The patient population served at Truckee Surgery Center ranges from 12 months of age and older.

C. The scope of this emergency plan, both internal and external, will determine the role of the Surgery Center and its personnel in responding to an emergency. The Surgery Center will participate in at least one emergency preparedness drill annually.

D. The Administrator will tailor the TSC Emergency Operations Plan based on the outcomes and evaluations of the drills.

E. This plan contains processes for preparedness, response, mitigation, and recovery in the event of an emergency.

F. Mitigation activities are those a health care organization undertakes in attempting to lessen the severity and impact a potential disaster or emergency may have on its operation while preparedness activities are those an organization undertakes to build capacity and identify resources that may be utilized should a disaster or emergency occur.

DEFINITIONS:

A. *ASC:* Ambulatory Surgery Center

B. *External Disaster:* A civil catastrophe, either man made or caused by an act of God. An external disaster may overwhelm normal facilities. This condition can occur as a result of fires and explosions, storms, civil disorders, multiple injury accidents, avalanches, among other causes

C. *Internal Disaster:* An event such as a fire or explosion resulting in internal casualties or circumstances. If the situation requires the evacuation of patients, such evacuation will be coordinated with emergency service personnel from the fire and police agencies.

D. *Shelter in Place:* Means that staff, patients, and visitors will remain in the facility. Sheltering can be used due to severe weather, a fire, or hazardous/hazmat materials condition in the area.

E. *Approved Information:* Information, that is allowed to be shared, relating to a patient who is involved in a disaster, evacuation, event, or shelter in place while at Truckee Surgery Center. The patient's signed release of protected health information is to be referenced.

PROCEDURES

DISASTER PROCEDURES FOR STAFF MEMBERS

A. It is the responsibility of the Administrator or the Nurse Manager to activate the Emergency Operations Plan. In the event of either internal or external disaster, the Administrator or Nurse Manager can initiate the Disaster Phone Tree (attached) and the Disaster Resource List (attached).

B. The Disaster Resource List will be used to track on-duty and available staff who may need to respond to an emergency and are to be used in the event of an immediate evacuation so staff can be accounted for at the evacuation location.

C. On arrival at to TSC, staff members will report to the Administrator and/or Nurse Manager to log in and be assigned to whatever tasks are required: in direct patient care, preparing for evacuation, or other assignment.

D. If a regular work shift ends during the declared emergency period, all staff members will stay at their respective assignments until officially relieved by order of the Administrator or Nurse

Manager.

E. In the event that total evacuation of the clinic is necessary, the Administrator or his or her designee will assume the responsibility for evacuation. Each patient will be rated, by the Nurse Manager or his or her designee as to the type of transportation necessary:

1. Ambulatory
2. Ambulatory with assistance
3. Wheelchair
4. Gurney
5. Transfer via Ambulance

F. All staff members will report changes of address and telephone numbers, as well as their response time to TSC, to the Administrator as soon as a change becomes effective. The Administrator will continually update the Disaster Resource List and date the document with the most recent date it was updated.

DISRUPTION OF SERVICES AND MANAGEMENT OF SPACE, SUPPLIES, COMMUNICATIONS, AND SECURITY:

A. If a portion of the Surgery Center is incapable of supporting patient care but total evacuation is not required, the following procedures will be followed:

1. ***Space Allocation***: Patients will be served in unaffected areas of the Surgery Center that are able to safely provide services.
2. ~~***Supplies:***~~***Supplies:*** The Administrator and/or Nurse Manager will be immediately notified of any situation that necessitates an increased level of supply items. The existing supply areas will be automatically used to provide supplies to the extent possible.
3. ~~***Communications:***~~***Communications:*** Both the phone system and cell phones will be used to provide communications between TSC and outside agencies. If a total phone loss occurs, walkie talkies will be used to provide communication
4. ~~***Security:***~~***Security:*** Needs that might exceed the capability of the Surgery Center will be relayed to the local police department or contracted security service.

MANAGEMENT OF PATIENTS IN DISASTER SITUATIONS

A. If a disaster or an emergency involves TSC or its staff members, all less-than-essential services will be temporarily modified or discontinued until the situation allows for resumption of full program ability.

B. The Administrator and/or Nurse Manager will determine whether these less-than-essential services are to be effected and, if so, when.

C. Staff members normally involved in provision of services determined by the Administrator and/or Nurse Manager to be less than essential will make themselves available for other duties. These duties may include helping move patients from the affected area of Surgery Center to an unaffected section. These staff members will also be responsible for providing any patient transportation devices, such as wheelchairs, gurneys, and so forth, to facilitate the

movement or evacuation of patients from the TSC.

D. All staff members will be familiar with the overall Emergency Operations Plan.

E. Facilitation of patient movements, including admissions, transfers, and control of patient information, will be directed by the individual assigned by the Administrator or Nurse Manager. Information concerning any patient will be released only by a qualifying physician or at the direction of the Administrator or Nurse Manager.

F. In disaster or emergency situations requiring additional physicians, those physicians will be directed by the Administrator, Nurse Manager or Medical Director.

G. The surgery center will identify and manage vulnerable patient populations. The National Institute for Health defines "vulnerable population patients" as "patients who are racial or ethnic minorities, children, elderly, socioeconomically disadvantaged, under-insured or those with certain medical conditions."

1. The surgery center staff will identify patients, staff and visitors who may require assistance during an emergency and will implement procedures to ensure their safe movement during emergencies.
2. Patients with limited mobility, including those with disabilities, chronic medical conditions, pharmacological dependence, language barriers or other access and functional needs will require additional assistance to ensure safe evacuation. Staff will be trained in procedures for assisting these individuals.
3. Patients who cannot ambulate independently will be assisted by staff using appropriate methods including:
    a. Wheelchairs
    b. Gurneys
    c. Crutches
    d. Staff assistance
4. Staff will provide clear instructions to individuals. For patients with limited English proficiency or communication challenges, translation services are available via Language Line. In the event the phone lines are down, Google Translation services can be used via cell phones. Staff or patient family members, when available and appropriate, can also be used to communicate.
5. Staff will communicate with emergency responders for patients with chronic medical conditions or those that have pharmacological dependence to ensure these individuals are transferred to Tahoe Forest Hospital or other acute care facility to meet their needs.

TRAINING OF STAFF IN EMERGENCY PREPAREDNESS

A. All TSC personnel are made familiar with the disaster, fire, and emergency plans during the orientation process, policies are reviewed upon hire and annually, and health stream modules are completed upon hire and annually.

B. Staff will receive education on emergency preparedness, emergency equipment and supplies during orientation and on an annual basis. TSC employees will receive specific training in their

individual and service roles during both internal and external disasters.

C. The Administrator is responsible for scheduling emergency preparedness training with all facility employees. The Administrator is responsible for the content of the training to ensure that all employees know their roles as outlined in the Emergency Operations Plan. It is the responsibility of the Administrator to ensure that this training occurs annually and to obtain appropriate documentation.

D. Training will include: Specific roles and responsibilities during emergencies, information and skills required to perform duties during emergencies, The backup communication system used during disasters and emergencies, how supplies and equipment are obtained during disasters or emergencies, emergency equipment available during an emergency, and resuscitation techniques.

    1. All staff will maintain BLS certification. RNs will also maintain ACLS and PALS certification.
    2. Whenever there is a patient present in the surgery center there will be clinical personnel present who have appropriate training and competence in the use of the emergency equipment and supplies.

EMERGENCY EQUIPMENT AND SUPPLIES

A. Adequate emergency equipment and supplies are kept on site.
    1. A list is attached to this policy and will be updated as needed.

B. Medical, non-medical supplies, equipment, and personal protective equipment (PPE), will be replenished via normal supply means as well as through any backup supplies maintained by the Surgery Center.

C. Surgery Center resources and assets will be shared with TFH if needed.

EMERGENCY PREPAREDNESS DRILLS

Implementation of the Emergency Operations Plan will be conducted at least annually at TSC either in response to an emergency or as a planned drill. One internal and one external disaster will be rehearsed.

A. The Administrator and/or Nurse Manager has the responsibility to develop the scenario and disseminate the necessary information to employees. The time and other details concerning the disaster will be controlled by the Administrator and/or Nurse Manager.

B. Cooperation with city, county, and State agencies in large-scale drills, where available, will be ongoing and coordinated by the Administrator.

C. Actual emergencies may be counted towards the required annual drill. All emergency preparedness drills or actual occurrences will be critiqued by the Administrator and documented on the Disaster Drill Form. Areas of evaluation will include but are not limited to: activation process, coordination of services and patients, implementation of policies and procedures , utilization of resources and communication, areas of effectiveness and areas for improvement. This evaluation will be reviewed and evaluated at the next Medical Executive Quality Committee and Board of Managers meetings. Feedback concerning any type of drill conducted or actual event will be reviewed by leadership at the Medical Executive Quality Committee and Board of Managers for necessary action and changes to the EOP will be made

based on recommendations.

D. ~~Feedback concerning any type of drill conducted will be reviewed by leadership at the Medical Executive Quality Committee and Board of Managers for necessary action and changes to the EOP will be made based on recommendations.~~

E. The Administrator will be responsible for communication of any information or recommendations about proposed changes in the emergency preparedness policy. The Administrator will ensure that proposed changes are implemented as specified.

F. Management will, on a random basis, quiz staff members concerning the Emergency Operations Plan and their roles in any drill. This process serves as a source of feedback, which management can use for evaluation of the overall effectiveness of the program.

HAZARD VULNERABILITY ASSESSMENT & RISK ASSESSMENT

A. A Hazard Vulnerability Analysis (HVA) is completed to asses the impact of likely emergencies.

1. The HVA is used to as a basis to define our Emergency Management program to analyze mitigation, preparedness and response and recovery activities.
2. The mitigation activities are designed to reduce the risk of and potential damage related to an actual emergency.
3. The HVA is reviewed and updated annually to determine if the likely emergencies have changed

B. Availability and functionality of critical emergency equipment is maintained by the TFH Facilities Management Department.

C. The HVA is shared with local, state, and federal emergency preparedness officials annually and during a disaster or emergency situation.

D. A Utility Risk Assessment is completed on an annual basis. The Risk Assessment is approved by the ~~MEC~~MEQC and shared with TFH Facilities Management Department.

STAFF AND STAFF FAMILY SUPPORT ACTIVITIES

A. This plan acknowledges that the staff of this organization is its greatest asset. If staff or staff family members are directly impacted by a community emergency or disaster, TSC leadership will be sensitive to this and attempt to ameliorate this. Support of impacted staff and families may include: referrals to disaster relief organizations and referrals for incident stress debriefing. The Administrator or Nurse Manager will be available to discuss any staff or family needs based on staff family impact or community emergency or disaster.

PERFORMANCE STANDARDS

A. Performance standards for this plan will include:

1. Emergency preparedness knowledge and skill for staff
2. Completion of an annual emergency preparedness drill
3. The level of staff participation in emergency preparedness management
4. Monitoring and inspection activities
5. Emergency and incident reporting procedures that specify when and to whom

reports are communicated

6. Inspection, preventive maintenance, and testing of applicable equipment
7. Use of space
8. Replenishment of supplies
9. Management of staff.

ANNUAL EVALUATION

A. Annual evaluation of the effectiveness of the Emergency Operations Plan undertaken at TSC will include performance measures, using the previous year's reports; recommendation from the Medical Executive Quality Committee and Board of Managers; and input from TSC staff and other relevant sources of safety outcome sources. These reports will be presented to the Medical Executive Quality Committee & Board of Managers.

B. Leadership will prioritize opportunities for improvement in this function.

COMMUNITY EMERGENCY TELEPHONE NUMBERS:

A. American Red Cross: 916-993-7070

B. California Emergency Management Agency: 916-845-8510

C. California Health & Human Services: 916-654-3454

D. Federal Bureau of Investigation: 916-481-9110

E. Nevada County Emergency Management: 530-265-1515

F. Law Enforcement:

1. Truckee Police Department 530-550-2323
2. Nevada County Sheriff Department 530-265-1471
3. California Highway Patrol 530-563-9200
4. Coroner 530-265-1321

G. Fire Departments:

1. Fire Department (local)911
    a. Truckee Fire Protection District 530-582-7850

H. Utilities:

1. Electricity: Truckee Donner PUD 530-587-3896
2. Gas: Southwest Gas 530-582-7200
3. Sanitation Agency 530-587-2525
4. Medical Gas: Airgas 775-358-2260

I. Service Contractors:

1. Computer Service (TFH IT) 530-582-3494
2. AAA Smart Business (Burglar/Fire alarm) 530-587-6278

3. Linen Supply: Aramark 800-272-6275

J. Ambulance Services:
   1. Truckee Fire District 530-582-7850
   2. Care Flight Truckee 530-587-8397

K. Pharmaceutical Supplies:
   1. Tahoe Forest Outpatient Pharm 530-587-7607
   2. Tahoe Forest Inpatient Pharm 530-582-3430

L. CAMCO Property Management: Tim Sawyer 530-308-1079

M. Tahoe Forest Hospital
   1. Facilities Management Dept. 530-582-3510
   2. Materials Management Dept. 530-582-3520
   3. Emergency Department (Transfer Agreement) 530-582-3208
   4. CNO, Jan Iida 530-582-3544

COMMUNICATION WITHIN AND OUTSIDE OF THE SURGERY CENTER

A. TSC understands the importance and need of communication both internally and externally in the event of an emergency.

B. Staff notification of activation of emergency response procedures, advisories, actions, and pre-planning initiatives will be accomplished in several manners:
   1. Overhead page
   2. Disaster Phone Tree
   3. Disaster Resource List
      a. ~~TSC has a Disaster Resource List that contains the name, title, contact information for home, cell and work, on duty/off duty status, travel time (if available), neighborhood they reside in, and bilingual language if spoken.~~
      b. ~~The~~TSC has a Disaster Resource List that contains the name, title, contact information for home, cell and work, on duty/off duty status, travel time (if available), neighborhood they reside in, and bilingual language if spoken. The Disaster Resource List is located in the following locations:
         i. G:/Truckee Surgery Center/EOC & Emergency Management
         ii. The Emergency Management Binder
         iii. The Nurse Managers schedule clipboard
      c. The Disaster Resource list is updated every 6 months, or more frequently if needed, and the date will be documented on on the list when it was updated.
      d. Medical Staff Contact information is located on the TSC phone list.
   4. Phone Messaging

5. Email
6. Text Messages
7. General Media (TV & radio)
8. Runners

C. In addition, staff will communicate to patients, families, and visitors, at the time of the notification/activation, what the emergency procedure is as well as how it may affect/impact them and any actions needed to be taken at that time or in the future.

D. TSC will make every effort to communicate to all external authorities and stakeholder agencies and suppliers of the existence of an emergency condition as appropriate as soon as possible.

E. In the event that it is necessary, existing partnerships with local, state, and federal law enforcement agencies will be activated and appropriate officials notified depending on the situation.

F. TFH Facilities Management will be contacted in the event of a non clinical emergency.

G. The TFH Emergency Room will be notified of any potential transfers.

H. TFH Administration will be notified of activation of emergency response procedures, advisories, actions, and pre-planning initiatives as soon as possible.

1. The Public Information Officer of TFH will be notified for any communication with the media.

I. Vendors will be contacted if needed. Vendor phone numbers can be found on the G drive and in the emergency management binder. TFH Facilities Management Department can also be contacted for phone numbers.

1. G:/Truckee Surgery Center/EOC & Emergency Management/ Phone Lists

VOLUNTEERS

A. Truckee surgery Center does not accept external volunteers.

B. TFH Staff may assist as needed. They will properly ~~signin~~sign in/out utilizing the visitor log at the front desk.

INTERNAL SECURITY AND SAFETY OPERATIONS DURING AN EMERGENCY

A. TSC staff is responsible for controlling access, crowds, and traffic into the Surgery Center.

B. The Administrator will coordinate with local law enforcement agencies with regard to lock down, suspension of visitors, and restriction of of movement in an emergency depending on the type of incident.

1. This could include placement of uniformed officers at entrances, controlling access via available physical and/or electrical systems, and manual controls such as key access only.

C. TFH Facilities Management Department will be contacted for any additional security needs.

INVOKING THE 1135 WAIVER

A. Due to the limited amount of staff please refer to the working hours of the facility. The facility

can share the limited available surgical supplies if needed. The facility will not begin providing surgical services at an alternate site during internal disaster. Patients will be canceled and rescheduled to a later date, after facility services have been restored.

1. In the event that an emergency occurs, and the 1135 waiver is invoked, and we have patients we are currently caring for, those patients will be moved to an alternate location for care by our staff, in which we will be reimbursed under the 1135 waiver.

B. Once the emergency is over, the Administrator and/or Nurse Manager will notify the staff and physicians.

C. Evidence of damage caused by the emergency or response to the emergency will be documented through photographs or descriptive writing. An emergency action report and critique will be completed by leadership and presented at the next Medical Executive Quality Committee and Board of Manager's meeting. Any emergency supplies used will be restocked.

EXTERNAL DISASTER PROCEDURES

A. In the event there is an external disaster event in the community all subsequent surgeries will be canceled and space made available for triage.

B. In the event that our space was not needed, the facility will finish up the procedures in progress as quickly as possible, the patients discharged or transferred to the hospital according to their needs and the facility closed.

1. Any staff of Truckee Surgery Center available to help in the event of disaster would report to TFH as soon as possible to provide additional support.

C. TSC may be used to triage patients ages 18-99. TSC will only provide basic first aid to ambulatory and alert and oriented patients.

1. TSC will not provide care to the following: injuries requiring suturing or surgery, patients with chest pain or shortness of breath, crushing injuries, and head injuries.

D. The Administrator and/or Nurse Manager will be the person in charge with the following duties:

1. Approving the implementation of the Emergency Operations Plan and evacuations
2. Maintaining information flow throughout TSC
3. Maintaining approved information flow to the public
4. Maintaining approved information flow to families of people involved in the disaster
    a. When such information pertains to a patient the patient's protected health information (PHI) release will be reviewed.
    b. In the event that there is no release on file, on will be obtained prior to sharing information if the patient is still on the premise.
    c. If the patient has been evacuated and/or is unable to give consent, the facility must exercise professional judgment to determine what PHI may be released.
5. Maintaining the waiting area for patients and visitors
6. Identifying new designated areas if needed and communicating this information to

the staff.

7. A staff list will be located at the front desk in the lobby. The staff conference room or kitchen area will be used if the waiting room has been affected by the disaster.

E. The Administrator and/or Nurse Manager will be the person in charge with the following duties:

1. Determining the extent of employees needed at the ASC.
2. Maintaining and distributing a log for the Red Cross, if appropriate.

F. If treatment areas are undamaged, they will be used as usual

EVACUATION PROCEDURE

A. When evacuation of patients from threatened or affected areas of TSC is required, safety of lives is the primary concern. Therefore, the evacuation must be carried out as quickly and efficiently as possible.

B. *Authority To Evacuate*

1. Authority to order evacuation is vested in the Administrator or Nurse Manager.

C. *Types of Evacuation*

1. *Immediate Evacuation*
   a. First move patients and others who are closest to the danger.
   b. Separate an emergency area from people by a fire door.
   c. Move medical records with patients, if possible.
   d. In event of a fire- lead ambulatory patients to exits using the evacuation plan posted in the area.
   e. Move non-ambulatory and helpless patients to the exit routes by means of Gurneys or wheelchairs

2. *Planned Evacuation*
   a. Planned evacuation will be initiated by the Administrator or Nurse Manager only. The Administrator, Nurse Manager, or designee will notify the modalities of services of need, extent, and time frame of the evacuation.

3. All patients will be evacuated in the event of
   a. Disruption or discontinuance of services
   b. Power outage or other calamity that causes damage to the facility or threatens the safety and welfare of patients and staff
   c. Natural disaster of such magnitude or threat that it endangers the safety and welfare of patients and staff members.

4. Evacuation will be partial or full, depending on whether an area is uninhabitable for patient safety, requiring partial or complete closure of a modality or an area of service

D. *Procedure for Evacuation and Discharge of Patients*

1. TSC's nursing staff will prepare patients to be evacuated.
2. An individual appointed by the Administrator or Nurse Manager will notify patients' families of the location of patients and will make a list of patients evacuated to other areas or facilities. This list will be given to the Administrator or Nurse Manager.
3. The ancillary staff will provide additional help as needed.
4. Patients will be evacuated to an area of safety by whatever means are available, and provision will be made for patients' comfort and safety.
5. The intercom will be used to announce evacuation plans. If the intercom is not available, the Administrator or Nurse Manager will designate a runner to announce the evacuation.
6. An evacuation route and meeting place will be the same as that for fire (facility parking lot by generator).

E. *Visitors*

1. Visitors should leave the premises when an evacuation is ordered.
2. If visitors can't safely leave the premises on their own when an evacuation is ordered, a staff member will be assigned to escort visitors to the designated staging area using the safest and most direct route possible.

F. *Evacuation Areas*

1. The parking lot near the generator will be the designated evacuation area except that in inclement weather, the Administrator or Nurse Manager will indicate a secondary evacuation area.
2. Dr. Leslie Joseph's office or TFH Center for Sports and Performance may be used as an alternative area in inclement weather.

G. The fire evacuation route as designated by maps posted throughout the building will be followed.

SHELTER-IN-PLACE

A. Shelter-in-Place might result from a fire, severe weather, or hazardous materials incident and is the preferred decision over evacuation unless the circumstances of the incident make this option unsafe.

1. If necessary, initiate lock down procedures, seal the facility (i.e. sealing vents, doors, and windows with tape or plastic) and shut down the HVAC to outside airflow.
2. Supplies will not be able to enter the building.
    a. The Administrator and/or Nurse Manager will inventory and conserve resources that may run low if not replenished.
        i. Food/Water
            a. There is an emergency kit located in the staff kitchen/ breakroom that includes items such as: food, water, walkie talkies, and emergency blankets.

ii. Pharmaceuticals
iii. Medical supplies/equipment
iv. Linens
v. Personal Protective Equipment

3. Initiate and maintain internal communication through signage and other means.
4. Establish a patient management plan.
    a. Identify the current census,
    b. Cancel elective admissions and procedures
5. Establish a work force plan, including a plan to address staff needs for the expected duration of the shelter-in-place
   The Administrator and/or Nurse Manager are to determine, in collaboration with the response agency, when shelter-in-place can be terminated.
6. Identify issues that need to be addressed to return to normal business operations, including notification of local authorities, of the termination of shelter-in-place.

POSSIBLE EMERGENCY SITUATIONS

BIOTERRORISM ATTACK

DEFINITIONS:

A. Terrorism – A violent act or an act dangerous to human life, an act in violation of the laws of the United States, an act intended to intimidate or coerce a government of the civilian population in regards to the furtherance of political or social objectives.

B. Weapons of Mass Destruction – Any destructive device including all that are explosive or incendiary, a poisonous gas, bomb, grenade, rocket or missile, any weapon involving a disease organism, any weapon designed to release radiation at levels harmful to human life.

C. Bioterrorism – The intentional use of biological agents as weapons to kill or injure humans, animals or plants. Biological toxins are organisms that cause disease or disrupt physiological activity. Biological agents may be used as liquid droplets, aerosols, or dry powders.

PROCEDURE:

A. Recommendations for Any Suspected or Real Bioterrorism Event:

1. Healthcare facilities may be the initial site of recognition and response to bioterrorism events. If a bioterrorism exposure/event is suspected, Truckee Surgery Center's Plan should be activated including notification of the Infection Control Nurse, Nurse Manager, Medical Director, and Administrator.
2. The Medical Director, Administrator, Nurse Manager and Infection Control Nurse will determine and organize immediate response and will coordinate/conduct appropriate internal and external notification, including notification to the TFH Infection Control RN. Any exposed patients presenting to TSC should be taken to the

nearest Emergency Room. The ER attending Physician will be the primary triage doctor and the ER charge nurse will designate a nurse to act as the primary triage nurse.

B. In the event of a bioterrorism attack:

1. All patients with suspected or confirmed bioterrorism-related illnesses, should be managed utilizing Standard Precautions.

2. **STANDARD PRECAUTIONS**

a. Standard Precautions, as defined by the Centers for Disease Control and Prevention (CDC), are designed to reduce the risk of transmission of most disease causing microorganisms in any type of health care setting regardless of the patient's presumed or diagnosed infectious status. With the exception of smallpox, viral hemorrhagic fevers, and pneumonic plague, most infectious diseases caused by bioterrorism agents are rarely, if ever, transmitted from person-to-person. Standard Precautions should be integrated into all healthcare worker/patient care interactions that include contact with:

i. Blood

ii. Non-intact skin

iii. Body fluids regardless of the presence or absence of visible blood (urine, feces, vomitus, wound and lesion drainage, pulmonary secretions including nasal and salivary secretions and tears)

iv. Skin soiled with visible blood or other body fluids

v. Mucous membranes

vi. Bioterrorism Agents – Diseases Requiring Standard Precautions Only

a. Bacillus anthracis – Anthrax (See contact Precautions)

b. Brucellae species – Brucellosis

c. Clostridium Botulinum - Botulism

d. Coxiella burnetii - Q fever

e. Francisella tularensis – Tularemia (See Contact Precautions) California Hospital Bioterrorism Response Planning Guide

3. **CONTACT PRECAUTIONS**

a. Place patients in an available bed on any nursing unit. Patients with similar syndromes may also be cohorted (grouped) in semi-private or multiple-bed rooms. Special ventilation is not required. Consider placing patients who consistently soil the immediate environment with visible blood or body fluids (e.g., incontinence, wound drainage not contained by a dressing or poor hygienic habits) in a private room.

b. **Visitors**

i. Limit visitors to immediate family members and significant others. Instruct visitors to wash their hands before and after patient contact and before leaving the patient's room.

c. **Personal Protective Equipment (PPE)**

i. **Gloves**

a. Wear disposable gloves when contact with visible blood and body fluids is anticipated. Gloves should also be worn when touching environmental surfaces and patient care articles visibly soiled with blood or body fluids. Gloves should be put on just prior to performing a patient care task that involves contact with blood or body fluids and removed immediately, without touching non-contaminated surfaces, when the task is complete. When performing multiple procedures on the same patient, gloves should be changed after contact with blood and body fluids that contain high concentrations of microorganisms (e.g., feces, wound drainage or oropharyngeal secretions) and before contact with a clean body site such as non-intact skin and vascular access sites.

ii. **Facial Protection**

a. Wear disposable, fluid-resistant masks and eye shields (goggles with side-shields) or a face shield if the patient is coughing or when performing patient care tasks likely to generate splashing or spraying of blood and body fluids onto the mucous membranes of the face.

iii. **Gowns**

a. Wear disposable, fluid-repelling gowns to protect skin and clothing when performing procedures likely to generate splashing or spraying of blood and body fluids. Plastic aprons may be worn for procedures likely to soil clothing but are unlikely to generate splashing or spraying of blood or body fluids (e.g., cleaning incontinent patients). The material composition of the gown should be appropriate to the amount of fluid penetration likely to be encountered. Remove soiled gowns after patient contact. Reusable cloth gowns may be used for patient contacts, if splashing or spraying of blood and body fluids is unlikely. Disposable or reusable gowns should be worn once and then discarded.

d. **Handwashing**

i. Wash hands with soap (antimicrobial or non-antimicrobial) and water after protected (gloved) and unprotected (ungloved) contact with visible blood, body fluids (secretions, excretions [urine and feces], wound drainage and skin visibly soiled with blood and body fluids). Wash hands before leaving the immediate vicinity of patient contact (patient room, cubicle, or bathroom). After handwashing, avoid touching the patient and surfaces or items in the immediate vicinity of the patient (bedpans, bed rails, and bedside tables). Decontaminate hands with an alcohol or quaternary ammonium-based ("quat") product after contact with invisible soil (protected or unprotected hands have not been in contact with visible blood or body fluids) and after prolong contact with the
clean, dry intact skin of the patient (lifting, turning, ambulating).

e. **Laboratory Specimens**

i. Transport specimens to the laboratory according to facility procedure. Laboratory personnel should adhere to the chain of custody protocols developed by CDHS and the FBI.

f. **Patient Care Equipment**

i. Equipment such as bedpans, urinals, and emesis basins should be cleaned in a manner that prevents splashing and spraying of blood and body fluids onto the healthcare worker's clothing, skin and mucous membrane. Reusable equipment that requires cleaning and disinfection or sterilization should be sent to sterile processing in covered containers for reprocessing. Disposable equipment not intended for reuse should be discarded.

g. **Housekeeping**

i. Clean environmental surfaces daily, when visibly soiled with blood and body fluids, and after the patient is discharged from the room with an Environmental Protection Agency (EPA) registered disinfectant.

h. **Soiled Linen**

i. Place soiled linen in leak-proof bags and seal. Call for immediate pick up from contracted linen service.

i. **CONTACT PRECAUTIONS**

i. Cutaneous anthrax and tularemia can be transmitted to healthcare workers by contact with the infected patient's wound or lesion drainage. In addition to Standard Precautions, Contact Precautions should be followed.

ii. **Patient Placement**

a. Place patients with open draining lesions in a private room, if available. Patients with the same diagnosis may be cohorted (grouped) in semi-private rooms. When a private room or cohorting is not achievable, separate infected patients at least three (3) feet away from non-infected patients.

iii. **Visitors**

a. Limit visitors to immediate family members or significant others. Instruct visitors to wash their hands their hands before and after patient contact and before leaving the patient's room.

4. **HANDLING OF SUSPICIOUS PACKAGES OR ENVELOPES**

a. If a package or envelope appears suspicious, DO NOT OPEN IT.

b. Do not shake or empty the contents of any suspicious package or envelope.

c. Do not carry the package or envelope, show it to others or allow others to examine it.

d. Put the package or envelope in a biohazard bag, on a stable surface; do not sniff, touch, taste, or look closely at it or at any contents which may have spilled.

e. Alert others in the area about the suspicious package or envelope. Leave the area, close any doors, and take action to prevent others from entering the area. If possible, shut off the ventilation system.

f. WASH hands with soap and water to prevent spreading potentially infectious material to face or skin.

g. Seek additional instructions for exposed or potentially exposed persons.

h. Notify the Administrator and/or Nurse Manager immediately (Centers for Disease Control and Prevention, 2001).

CODE BLUE

A. Code Blue in the **Operating Room:**

1. The circulating nurse or any available person overhead pages by dialing 2348 and announcing "Code Blue, OR ____". This is an important first step, as it alerts everyone in the facility to respond immediately.
2. Anesthesia acts as code director. If no anesthesia provider is in attendance, the surgeon is the code director.
3. Any BLS certified staff member may begin CPR.
4. Scrub nurse maintains sterile field, and assists surgeon with closing and dressing the patient.
5. Recovery nurse brings crash cart, and assists rest of team with additional needs.

6. Circulator acts as medication nurse, assists with defibrillator, assists anesthesia as necessary.
7. The Administrator or designee directs outside activity, calls 9-911, arranges lab courier, calls for assistance as needed, communicates with family, makes transfer arrangements if necessary.
8. Ancillary staff gathers and delivers necessary supplies, per type of code.

B. Code Blue in the **Recovery Room**:

1. Recovery room nurse or any available person overhead pages by dialing 2348 and announcing "Code Blue Recovery Room".
2. Nurse in attendance begins CPR.
3. Pre-op or second post-op nurse brings crash cart to bedside. Assists with CPR, medications, and defibrillation setup.
4. Any available anesthesia provider or MD responds to code, code is directed by anesthesia if present, otherwise most appropriate M.D. in attendance.
5. OR nurse responds if available.
6. The Administrator or designee directs outside activity, calls 9-911, arranges lab courier, calls for assistance as needed, communicates with family, makes transfer arrangements if necessary.
7. Ancillary staff acts as scribe and gathers/delivers necessary supplies, per type of code.

C. All patients undergoing resuscitative measures at Truckee Surgery Center will be transported to TFH for further evaluation and treatment. All paperwork that has been with the patient since admission will be photocopied and attached to the transfer order to remain with the patient/ EMS staff. The nurse or physician caring for the patient at TSC will call report directly to the ER nurse receiving the patient at TFH. The nurse caring for the patient will document all calls made and care given on the patient care record at TSC.

D. If a patient has been transferred to the hospital for any reason, the Administrator and/or Nurse Manager will follow up with the hospital to obtain follow-up paperwork/documentation. The patient's record will also be pulled to be used in the peer review process.

FIRES

A. For fires at **Truckee Surgery Center**, actions should proceed in the following order:

1. RESCUE - remove patients or personnel from immediate danger.
2. ALARM - activate the fire alarm by using the fire pull or by calling 911.
3. CONTAIN - contain the fire to keep it from spreading: close doors, turn off oxygen if possible, etc.
4. EXTINGUISH - if possible, without placing yourself or others in danger, attempt to extinguish the fire.

All personnel must know the locations of the fire extinguishers and pull alarms.

B. For fires in the Operating Rooms:

1. Remove all persons from immediate danger
2. Pull the nearest fire pull or call 911
3. Close all doors and move people accordingly
4. If the fire is manageable, use a fire extinguisher, in the following manner:
    a. *Pull* the pin on the fire extinguisher
    b. *Aim* the nozzle towards the fire
    c. *Squeeze* the handle to dispense fire retardant
    d. *Sweep* - spray the fire retardant in a sweeping motion
    e. Check with the Nurse Manager for additional assignments/duties
    f. If evacuation is necessary, stable patients can be moved to another part of the building or to the outside (weather permitting), unstable patients will need to be transferred via ambulance to TFH for further care

BOMB THREAT

A. A bomb threat against the facility requires an immediate, informed response. Time is of the essence in protecting the patients committed to our care. Adherence to the following procedures will help avert possible injury to persons or damage to the facility.

B. The Administrator or Nurse Manager will coordinate the bomb threat response procedures.

C. Should a suspected device be found, the decision to evacuate must be resolved through consultation between the police department and surgery centers leadership to balance the risk of a potential explosion versus the risk of moving patients.

D. At no time should the staff try to touch a bomb or a suspected bomb.

PROCEDURE:

A. Receiving Threats

1. Police records indicate that a telephone warning is the most common way of receiving bomb threats.
2. ***If you receive a bomb threat by phone:***
    a. — IMMEDIATELY UTILIZE THE BOMB THREAT LOG SHEET —
    b. Remain calm. Do not hang up.
    c. Take note of the callers exact words. Pay close attention to the caller's voice and any background noise.Try to prolong the conversation and get as much information as possible.
    d. Attempt to ascertain when the bomb will detonate, where the device is located, what it looks like, and why it was placed in this location.
    e. When the call is over, immediately notify the Administrator or Nurse

Manager and give them the completed Bomb Threat Checklist.

3. ***If you receive a written threat:***
    a. Gather all materials as evidence, including any envelopes or containers.
    b. Avoid further handling to prevent the contamination of evidence.
    c. Notify the Administrator or Nurse Manager immediately.
4. ***If a suspicions letter/package is received by mail:***
    a. Do not accept unsolicited packages. If any doubts exist about the package, treat it as a suspicious package.
    b. Mail bombs have been contained in letters, books, and parcels of varying sizes, shapes, and colors. When examining suspicious packages, look for the following characteristics of a letter bomb.
        i. No return address
        ii. Restrictive markings such as Confidential, Personal, Private etc.
        iii. Endorses with "Fragile – Handle with Care" or "Rush – Do Not Delay."
        iv. Excessive postage
        v. Misspelled words
        vi. Incorrect titles or names
    c. If you have a suspicious package
        i. Do not handle the item.
        ii. Do not open, smell or taste the article.
        iii. Isolate the mailing and secure the immediate area.
5. ***Evaluate the Threat***
    a. The Administrator or Nurse Manager will evaluate the threat utilizing the categories outlined in the policy Code Yellow, EOC-1901
        i. If it is determined that a Code Yellow Alerting & Notification should be initiated
            a. The Administrator or Nurse Manager will call 9-911
            b. Should a search of the facility be warranted, the Administrator or Nurse Manager will dial 2348 and page overhead "Code Yellow"
    b. Search Procedures
        i. After a bomb threat is received, the Administrator or Nurse Manager may divide the building into sections and organize search teams to cover specific areas.
        ii. A search, if required, needs to be done by people familiar with what does and does not belong in their work areas.

a. The Administrator and/or Nurse Manager should designate specific search assignments based upon availability of current staffing.
    i. Generally, teams composed of a Law Enforcement/Bomb Disposal Unit and, if necessary, a designated staff members from the Surgery Center will assist in conducting the search.
    ii. The removal or disarming of a bomb must be left to the professionals in explosive disposal.
b. The objective is to search for and report suspicious objects only.
c. Emphasis should be given to areas open to public access.
d. Those areas locked and unavailable to the public should be searched last.
e. Do not leave your work area to search other areas or evacuate unless told to do so.

iii. The Administrator and/or Nurse Manager will coordinate activities with the Police and/or fire personnel and keep the rest of TSC staff informed of all events.

iv. If a suspicious device is located
    a. Do not touch it.
    b. Note the location, description and proximity to utilities, gas lines, water pipes, and electrical panels.
    c. Do not allow media to use satellite dish for transmitting or reporting purposes as this is a possible source of detonation.
    d. Remove flammable material from the suspected area.
    e. Isolate the object by closing doors.
    Keep everyone away from window areas.
    f. Evacuate to a distance of at least 300 feet from the suspected item.
    g. Ensure Law Enforcement has been notified.
    h. Once Law Enforcement arrives, they are in charge; all staff will follow their instructions.

c. Evacuation
    i. An evacuation decision should be made only if an actual device has been located or substantiated through clear and reliable

information.

ii. The decision to evacuate should be made through Unified Command consisting of the surgery center's leadership and the Police Department.

iii. The building will be evacuated according to the established evacuation procedure unless otherwise directed

a. Give a brief explanation, then evacuate ambulatory patients and visitors first.

b. Surgeons will close surgery sites as quickly as possible and non-ambulatory patients will be evacuated via wheelchair and gurney.

c. A designated staff member will keep a log of all personnel, visitors and patients present in the building.

d. Explosion

i. If an explosion occurs, initiate Internal Triage.

ii. Treat injured victims in an area away from the blast site. Transfer patients as needed to the hospital.

iii. Support Law Enforcement as requested

e. All Clear

i. When it has been determined that there is no evidence of a device in the facility, or the suspected device has been rendered safe, the Administrator or Nurse Manager call 2348 and page overhead, "Code Yellow, All Clear".

ii. All personnel will return to their normal duties.

EARTHQUAKE

A. The actual movement of the ground in an earthquake is seldom the direct cause of death or injury. Most casualties result from falling objects and debris because the shocks can shake, damage, or demolish and cause great damage. Earthquakes usually strike without warning. In most cases, the shock occurs and is ended in seconds, which precludes any personal protective action during the tremor. If the seismic action is a prolonged shaking and rolling, it is prudent to take protective measures such as taking cover in a doorway or under a table. If there is time, people should cover their heads and shoulders and try to protect themselves from falling objects or shattered glass. The scope of this procedure covers response to all types of earthquakes.

B. Injuries are commonly caused by:

1. Partial building collapse; collapsing walls; falling ceiling plaster, light fixtures, and pictures

2. Flying glass from broken windows and mirrors
3. Overturned bookcases, fixtures, and other furniture and equipment
4. Fires, broken gas lines, and similar causes, with danger aggravated by the lack of water due to broken mains
5. Fallen power lines
6. Drastic human actions resulting from panic

C. Immediate response measures for all personnel:

1. On detection of shock, remain in place.
2. Remain calm. Think through the consequences of any action. Try to calm and reassure others.
3. If indoors, watch for falling plaster, light fixtures, and other objects. Watch out for high storage areas, shelves, and tall equipment that might slide or topple. Stay away from windows and mirrors. If in danger, get under a table, desk, or gurney, in a corner away from windows, or in a strong doorway. Encourage others to follow your example. Usually, it is best not to run outdoors.
4. After the initial shock has ended, and a reasonable interval has passed with no further shock, survey immediate surroundings to determine injuries and damage. Do not attempt to move seriously injured persons unless they are in immediate danger of further injury.
5. If telephones are operating, call the Administrator and/or Nurse Manager, if they are not on site, to report the condition of patients and estimated damage in your area.
6. If you are in the area of damage and are not seriously injured, your first responsibility is to the patients in your vicinity. If possible, reassure them and attempt to calm those who may be hysterical or panic stricken. If there are obvious injuries from falling objects, shattered glass, or patients or personnel trapped under debris, you must request assistance and perform first aid within your capability where possible until medical personnel arrive to assist in treatment or rescue.
7. Check for fire or fire hazards from broken electrical lines or short circuits, and follow the fire response procedures if a fire is discovered or can reasonably be expected.
8. Do not attempt to lead or assist any patients to leave the Surgery Center until you are directed to do so by the Administrator or Nurse Manager. If TSC has not been made unsafe by the earthquake, it is advisable to encourage patients to stay inside until they have arranged safe transportation home or have determined the conditions of the roadways.
9. Make sure all patients wear shoes in areas near debris and glass. Immediately clean up spilled medications, drugs, and other potentially harmful materials. If the water is turned off, emergency water can be obtained; assess bottled water inventory. Check to see that sewage lines are intact before permitting flushing of toilets. Check closets and storage shelve areas. Open closet and cupboard doors carefully, and watch for objects falling from shelves.

10. Be prepared for additional aftershocks. Although most of these are smaller than the main shock, some may be large enough to cause additional damage.

D. Responsibilities:

1. Administrator:

a. Initiate the phone tree as necessary

b. THE PHONE TREE = The Administrator notifies all of the following:

i. *TFHD CNO*

ii. *Medical Director*

iii. *Anesthesia Director*

iv. *Medical Staff*

v. *Nurse Manager*–> who notifies all staff, reps & vendors

c. After receiving damage assessment reports from all modalities and services, determine the advisability of partial or complete evacuation of the Surgery Center.

d. If evacuation is deemed advisable, determine the condition of exit areas and avoid those that are obstructed or otherwise hazardous. Follow the posted signs for nearest exit from current location.

e. Conduct an immediate check of all communications systems including the telephones and overhead paging. Initiate actions to restore service or use other communication resources, including cellular telephones, walkie talkies, or messengers.

f. Direct implementation of evacuation procedures outlined in the Emergency Operations Plan.

g. Ensure that all local emergency service authorities are informed of the degree of damage and extent of injuries sustained by the site, its patients, and personnel.

2. Nurse Manager:

a. Establish transport teams to assist in transport of patients within the ASC as required.

b. Provide for emergency messenger service.

c. Establish casualty information, and instruct the Administrator or designee about information to be released to media and concerned individuals.

d. Establish an injured patients list, and indicate where each patient is located for incoming medical personnel.

e. Have any physicians at the clinic activate major and minor treatment areas and provide examination and treatment to patients and personnel as required. Be aware that, depending on the magnitude of the earthquake, physicians may be called to serve in other healthcare clinics or organizations in the area.

f. Assign an individual to establish and maintain a master list of patients and treatment.

g. Request additional professional assistance, as needed, through the local emergency medical services network.

h. Instruct the front desk to direct incoming employees or members of the public to appropriate areas.

i. Ascertain the need for emergency generator capacity. If it is determined that temporary emergency power is needed for essential staff functions, refer to the Emergency Electrical Power policy.

E. Ensure that the Administrator and/or Nurse Manager check utility lines and appliances for damage. Only the Administrator or Nurse Manager, or a representative of the power company, may shut off any valves or circuits. If gas leaks exist, the Administrator or Nurse Manager will shut off the main gas valve. If there is damage to wiring, the Administrator or Nurse Manager will shut off electrical power. The Administrator/Safety Officer will report damage to the appropriate utility companies and follow their instructions. No one should use matches, lighters, or open flame appliances until it is determined that no gas leaks exist. Electrical switches or appliances should not be operated if gas leaks are suspected; sparks can ignite gas from broken lines.

SNOW AND ICE REMOVAL

To create safe entry and exit to the facility, snow and ice removal and melting will be ensured by the following preventive procedure:

A. A walk-around of the facility will be conducted to identify specific challenges for snow removal.

B. An average first snowfall date can be ascertained by contacting the local weather service.

C. The following provisions will be stored at the Surgery Center before the anticipated date: Adequate manual equipment, snow shovels, ice scrapers, brooms, and sand. Enough ice-melt for at least two storms, adequate walk-off mats, interior and exterior.

D. The snow and ice removal contractor is responsible for any damage to facility grounds during snow and ice removal activities.

E. Reminders of ice and snow safety will be distributed to staff before the projected first snowfall date.

F. The ice and snow removal contractor is:

1. CAMCO
2. Telephone number: 530-587-3355

BLIZZARD/EXTREME SNOWFALL

Severe winter weather producing prolonged exposure to extreme cold and blizzards with blowing snow may put TSC staff and patients at risk; therefore, Truckee Surgery Center employees/staff are required to become familiar with this blizzard response procedure and be prepared to take appropriate action.

DEFINITIONS:

A. Winter Storm Watch - Be alert, severe weather is likely

B. Winter Storm Warning - Severe winter weather is expected

C. Blizzard Warning - Severe winter weather with sustained winds or frequent gusts to 35 mph or greater and considerable falling or blowing snow (reducing visibility to less than one quarter mile) are expected to prevail for a period of 3 hours or longer. Deep drifts and life threatening wind chill result.

D. Traveler Advisory - Severe winter conditions may make driving difficult and dangerous

E. Wind Chill - A calculation of how cold it feels outside when the effects of temperature and wind speed are combined. A strong wind combined with a temperature of just below freezing can have the same effect as a still air temperature about 35 degrees colder.

F. Frostbite - A severe reaction to cold exposure that can permanently damage its victims. Symptoms include loss of feeling and white or pale appearance to fingers, toes, or nose and earlobes.

G. Hypothermia - A condition occurring when body temperature drops below 90 degrees Fahrenheit. Symptoms include uncontrollable shivering, slow speech, memory lapses, frequent stumbling, drowsiness and exhaustion.

PROCEDURE:

A. ADMINISTRATOR AND NURSE MANAGER CHECKLIST

1. When informed of a Winter Storm Warning, Blizzard Warning, or Traveler's Advisory, The Administrator or Nurse Manager shall initiate notification procedures as appropriate.
2. Immediately inform employees to take appropriate measures.
3. Listen to NOAA Weather Radio and local radio and television stations for weather information.
4. Provide for early release or extended staff or employees as appropriate while providing optimal patient care.
5. Provide food, water, blankets, flashlights with extra batteries and other emergency supplies for employees who become stranded at the facility.
6. Provide sleeping accommodations for employees who become stranded at the facility.
7. Ensure back-up power source passes checklist and has adequate fuel (see weekly generator checks)
8. Arrange for snow and ice removal from parking lots with contractor unless already completed.

B. STAFF RESPONSE CHECKLIST

1. Staff will:
    a. Listen for weather warnings

b. Use only approved portable space heaters

c. Follow utility failure procedures if there is a disruption or failure of electrical power

2. If outside:

a. Dress warmly in layers to prevent perspiration and chill. Keep dry. (Mittens are warmer than gloves.)

b. Cover mouth to protect lungs from extremely cold air

c. Avoid exertion (cold weather puts extra strain on the heart)

d. Watch for signs of frostbite and hypothermia

e. First Aid response:

i. If frostbite or hypothermia is suspected, begin warming the person slowly. Warm the person's trunk (mid-body) first. Arms and legs should be warmed last because stimulation of the limbs can drive cold blood toward the heart and lead to heart failure. Put the person in dry clothing and wrap their entire body in a blanket.

ii. Never give frostbite or hypothermia victims something with caffeine in it (i.e. coffee or tea) or alcohol. Caffeine, a stimulant, can cause the heart to beat faster and hasten the effects the cold has on the body. Alcohol, a depressant, can slow the heart and also hasten the ill effects of cold body temperatures.

f. Recovery:

i. After blizzards, heavy snows or extreme cold:

a. Notify Leadership of any injuries

b. Notify Leadership of any facility damage

c. Resume normal schedule

d. Before driving, check road status, ensure car has at least 1/2 tank of fuel

AVALANCHE

Truckee Surgery Center shall participate in the response of patients in the event of an avalanche. Staff shall be encouraged to be prepared at their homes to protect themselves, their families and their property.

A. STAFF RESPONSE CHECKLIST:

1. Off duty staff:

a. *Before intense storms*:

i. Become familiar with the land around you

ii. Learn whether avalanches and debris flows have occurred in

your area by contacting local officials, state geological surveys or departments of natural resources.

iii. Watch the patterns of storm drainage on slopes near your home, and especially the places where runoff coverages, increasing flow over snow covered slopes. Watch the hillsides around your home for any signs of snow movement, such as small avalanches or debris flows, or progressively tilting trees.

iv. Watching small changes could alert you to the potential of a greater avalanche threat.

b. *During intense storms*:

i. Stay alert and awake. Many debris/snow-flow fatalities occur when people are sleeping.

ii. Listen to NOAA Weather Radio or portable, battery-powered radio or television for warnings of intense snowfall. (Be aware that intense, short bursts of snow may be particularly dangerous, especially after longer periods of snowfall and cold weather.)

iii. If you are in areas susceptible to avalanches and debris flows, consider leaving if it is safe to do so. (Remember that driving during an intense storm can be hazardous.)

iv. If you remain at home, move to a second story if possible. Staying out of the path of the avalanche or debris flow saves lives.

v. Listen for any unusual sounds that might indicate moving debris, such as trees cracking or boulders knocking together.

vi. Be especially alert when driving. Embankments along roadways are particularly susceptible to avalanches.

vii. Watch the road for heavy snow, fallen rocks and trees, and other indications of possible debris flows.

c. *If you suspect imminent avalanche danger*:

i. Contact your local fire, police or public works department. Local officials are the best persons to assess potential danger.

ii. Inform affected neighbors. Your neighbors may not be aware of potential hazards. Advising them of a potential threat may help save lives. Help neighbors who may need assistance to evacuate.

iii. Evacuate. Getting out of the path of an avalanche or debris flow is your best protection.

d. *During an avalanche*:

i. Quickly move out of the path of the avalanche or debris flow. Moving away from the path of the flow to a stable area will

reduce your risk.

ii. If escape is not possible, move your arms rapidly to try and stay afloat in the snow and do whatever possible to protect the rest of your body from injury.

e. *After an avalanche*:

i. Stay away from the slide area. There may be danger of additional slides.

ii. Check for injured or trapped persons near the slide, without entering the direct slide area. Direct rescuers to their locations.

iii. Help a neighbor who may require special assistance - infants, toddlers, elderly people, and people with disabilities. Elderly people and people with disabilities may require additional assistance. People who care for them or who have large families may need additional assistance in emergency situations.

iv. Listen to local radio or television stations for the latest emergency information.

v. Look for and report broken utility lines to appropriate authorities. Reporting potential hazards will get utilities turned off as quickly as possible, preventing further hazard and injury.

vi. Check the building and surrounding land for damage. Damage may help you assess the safety of the area.

2. On duty staff:

a. In the event of an avalanche, the phone tree will be initiated by the Administrator, or his/her designee, to call in all available medical/ professional personnel for assistance.

i. THE PHONE TREE = The Administrator notifies all of the following:

a. *TFHD CNO*

b. *Medical Director*

c. *Anesthesia Director*

d. *Medical Staff*

e. *Nurse Manager*–> who notifies all staff, reps & vendors

b. Truckee Surgery Center (TSC) will provide all available staff to TFH for additional assistance.

c. If necessary, elective cases scheduled for the day at the TSC will be postponed in order to provide staff for the avalanche emergency.

d. In the event that more beds than are available at TFH are needed, TSC will open the facility to those in need.

e. Supplies and pharmaceuticals will be distributed as necessary and re-

ordered as soon as possible.

f. As soon as possible, the patients triaged at TSC will be transported to TFH (when space becomes available) or to Reno for further care.

g. The receptionist will make sure all emergency calls are passed to the Administrator.

h. The Administrator and Nurse Manager will delegate duties to available staff, as required.

i. Once all patients have been safely transported to other facilities, available staff from Truckee Surgery Center will offer their assistance to TFH.

j. When the patients have been properly cared for, TSC can return to its schedule.

3. Utility Systems:

   a. The Administrator or designee will ensure that the utility systems at the facility have not been interrupted.

   b. If at any time, during an external avalanche, the facilities power or water supply is interrupted, the Emergency Quick Reference Guide will be used to determine the appropriate response.

   c. The Administrator will be notified of any utility systems failures/ interruptions.

WILDFIRE

During the warmer months, there is a likelihood of wildfire which may put TSC staff and patients at risk. Therefore, all Truckee Surgery Center employees/staff are required to become familiar with this wildfire response procedure and to be prepared to take appropriate action.

A wildfire in the Tahoe Basin and surrounding areas may be extremely dangerous. As seen in years past, the Tahoe Basin is subjected to many wildfires based on dry seasons and wet seasons causing growth in the forest around us. The threat of a wildfire can cause the community to shut down, and as a major medical provider for the area, leave the residents and visitors without medical care they may need.

A. ADMINISTRATOR & NURSE MANAGER CHECKLIST:

1. When informed of a wildfire in the Tahoe Basin or surrounding area:

   a. Initiate notification procedures as appropriate using the phone tree.

   b. THE PHONE TREE = The Administrator notifies all of the following:

      i. *TFHD CNO*

      ii. *Medical Director*

      iii. *Anesthesia Director*

      iv. *Medical Staff*

      v. *Nurse Manager*--> who notifies all staff, reps & vendors

c. If wildfire is close, activate Emergency Response in anticipation of potential evacuation.

d. Immediately inform employees to take appropriate measures to prepare patients for evacuation and transport.

e. Prepare to make overhead announcements as necessary.

B. STAFF RESPONSE:

1. To prepare for wildfires:

a. Listen to local radio and television stations for information.

b. Prepare for potential patients needing assistance with breathing problems, smoke inhalation, eye issues, traumatic injuries, burns and mediation issues (when there is overflow from TFH).

c. Close all windows to the building.

d. Finish any surgical cases in progress as expediently and safely as possible and do not proceed with any further scheduled cases.

e. Standby to evacuate, if instructed by the Administrator or Nurse Manager.

2. For employees coming to, or leaving, work:

a. Wear protective clothing, sturdy shoes, cotton or woolen clothing, long pants, long sleeve shirts, eye protection, and a handkerchief to protect your face.

b. Choose a route away from fire hazards.

c. Use caution and exercise good judgment when re-entering a burned wildfire area.

d. Avoid damaged or fallen power poles or lines and downed wires. Immediately report electrical damage to authorities.

e. Be careful around burned trees and power poles. They may have lost stability due to fire damage. If a power pole should fall next to your, DO NOT RUN OUT OF THE AREA. To avoid being shocked, you must shuffle your feet on the ground without lifting them up off the ground. This will reduce the chance of electrocution.

C. ALL CLEAR:

1. When wildfire evacuation is not required and facility is no longer at imminent risk of danger, the Administrator or Nurse Manager will call off the Emergency Response and assist with resume normal operations as required.

PANDEMIC- LOCALIZED AND WIDESPREAD

A. Truckee Surgery Center will participate with the TFH incident command center in the event of a pandemic.

1. The need for additional PPE and supplies will be evaluated.

2. Closure of the facility will be determined through the Incident Command and TSC Leadership.

B. State and Federal guidelines and mandates will be adhered to.

1. The Administrator and Nurse Manager will monitor guidelines and make any required changes immediately.

C. Policies and Procedures will be implemented as necessary.

ESSENTIAL EQUIPMENT OR SERVICE/UTILITY FAILURE

A. In the event of essential equipment or service failure, TSC Leadership will take action to restore the system as soon as possible. If required the TFH Facilities Management Department will be contacted for assistance

ELECTRICAL POWER FAILURE UNPLANNED

A. In case of normal electrical power failure, the emergency generator will provide power, in less than ten seconds.

B. If the facilities electrical power supply is compromised or unavailable the Administrator and/or Nurse Manager will determine whether the Surgery Center should remain open or should close. If it appears that electrical power will be resumed in a short time, patients and staff may be advised to wait.

C. If the Administrator and/or Nurse Manager determine that the power will not be resumed before the end of the business day, they may close the Surgery Center. In such a case, patients will be rescheduled.

D. If the Administrator and/or Nurse Manager determines that it is appropriate for the Surgery Center to remain open or open for staff, but not patients, emergency lighting and power is supplied by the emergency backup generator maintained by Cashman Equipment telephone # 775-332-2588. This temporary electrical power will be used to accomplish only essential business functions.

E. The Administrator or Nurse Manager will contact TFH Facilities Management to notify them of the power outage and request assistance if needed.

F. If assistance is required TFH will send the Engineer on duty to the facility. The Engineer will:

1. Check for generator operation during a power outage.
2. Check for transfer switch operation.
    a. If there is no transfer and power is still off, manually transfer the switches.
3. For emergency problems with the generator see the building maintenance contact list.
4. Walk through the facility to check equipment operation in the order of importance (i.e., life and safety first, air conditioning equipment last).
5. Call TDPUD (See Community Emergency phone list) and try to find out if the problem is in their equipment or internal malfunctioning.
    a. If it is theirs, try to get an estimated time of repair.

b. If it is ours, determine if outside help is needed.

c. If outside help or rental generator is needed see building maintenance contact list.

6. Determine whether extra fuel will be needed for extended generator operation.

a. If additional fuel is required see building maintenance contact list.

G. If a power outage occurs during patient care, the surgeon will finish the surgical case in progress using backup power and no new surgeries will be performed until power has been restored.

ELECTRICAL POWER FAILURE PLANNED (PSOM)

A. Truckee Donner PUD distributes electrical power received from NV Energy from their Reno sub-station to TSC.

B. High winds can cause trees or debris to damage electric lines and cause wildfires. As a result, NV Energy may need to turn off power during severe weather. NV Energy refers to these power shut off events as Public Safety outage Management (PSOM) events.

C. 48-24 hour notification will be provided before the power shut off event is activated.

D. If the PSOM is scheduled to occur during business hours, surgeries will be rescheduled and staff may be called off. The Administrator and Nurse Manager will determine the need to reschedule cases and cancel staff assignments.

OXYGEN SUPPLY FAILURE

A. In the event of a failure in the system that supplies oxygen to the surgery center, prompt action will be taken by TSC leadership to restore the system to operating condition as soon as possible.If required the TFH Facilities Management Department will be contacted for assistance.

B. If appropriate, advise staff to utilize portable oxygen tanks until repairs are made.

C. TFH or the Vendor will assess the problem: Determine estimated repair time, and notify the Administrator and/or Nurse Manager.

D. Initiate repairs utilizing TFH maintenance personnel and outside agencies as needed.

1. Backup cylinders and regulators are located in the Med Gas Storage Room.

E. Call medical gas supplier (See building maintenance contact list) for additional oxygen tanks that may be needed.

1. Full oxygen tanks can be used from the reserve supply if failure is in the switching units.

NATURAL GAS FAILURE

A. In the event of a disruption of the natural gas supply, prompt action will be taken by TSC leadership to restore the system to operating condition as soon as possible. If required the TFH Facilities Management Department will be contacted for assistance.

1. Call gas company (See building maintenance contact list).

a. Try to find out if the problem is in their lines or in our equipment.

b. Try to get an estimate of repair time, and keep in close contact with them.

2. Advise staff and leadership of the problem and how long repairs will take.
    a. The Surgery Center and Apartment would be affected by the lose of domestic hot water.
    b. Equipment affected: hot water is required for the sterilizers in Sterile Processing. Natural gas is required for the boilers that provide heating to the facility and the appliances and heating in the apartment.
3. Initiate repairs, if needed, utilizing TFH Facilities Management personnel and outside agencies, if required.
    a. If necessary, call for fuel service (See building maintenance contact list) for service, assistance, and parts.

FIRE SPRINKLER WATER LOSS

A. In the event of loss of water to fire protection system, ultimate measures must be taken to prevent possible loss of life and/or property until repairs are made. If required the TFH Facilities Management Department will be contacted for assistance.
    1. Notification and cooperation with the Fire Department is essential.
B. Contact the TFH Facilities Management Department to determine if the Vendor needs to be contacted.
C. Contact TDPUD, if it seems to be an external problem.
    1. Try to get an estimate of the time needed for repairs.
D. If it is an internal problem, TFH or the vendor will assess the situation to determine actual repair time and advise the Administrator of their findings.
E. Contact the Truckee Fire Protection District for possible standby fire protection until repairs can be made.
F. If it is an internal problem, initiate repairs utilizing TFH Facilities Management staff or outside contractors as needed. See building maintenance contact list.
G. Notify Fire Department when repairs are completed.
H. A fire watch must be conducted should the sprinkler system be out of service for more than 10 hours in a 24-hour period.

FAILURE OF NURSE CALL SYSTEM

A. In the event of a failure of the nurse call system, action will be taken by TSC leadership to repair the system as soon as possible. If required the TFH Facilities Management or IT Department may be contacted for assistance.
B. The vendor, TFH facilities staff, or TFH It staff will assess the problem and determine actual estimated repair time and advise the Administrator and/or Nurse Manager of the situation.
C. Initiate the repairs with the vendor as soon as possible.

D. Departments involved will keep up vigilance in the affected areas to ensure patient needs are met.

    1. utilize bells, gongs, or similar devices of notification.

FAILURE OF MEDICAL AIR SYSTEM

A. In the event of failure of the medical air system, swift action will be taken by TSC Leadership to ensure that an adequate supply of medical air is reestablished as soon as possible. If required the TFH Facilities Management Department will be contacted for assistance.

B. A failure in this system would interrupt the supply of medical air to areas that use it in delivery of patient care.

C. The vendor or TFH facilities staff will assess the problem and determine repair time and advise the Administrator and/or Nurse Manager of the situation.

D. Initiate repairs using TFH Facilities Management personnel and outside contractors as required.

    1. If necessary, call emergency repair vendor (see building maintenance contact list) for assistance in repair or for rental replacement unit.
    2. If line repair is necessary, secure the particular zone, purge the zone with nitrogen, and certify the system prior to restarting the equipment.

FAILURE OF MEDICAL VACUUM SYSTEM

A. In the event of the failure of the medical vacuum system, swift action will be taken by TSC leadership to restore the system to operating condition as soon as possible. If required the TFH Facilities Management Department will be contacted for assistance.

B. A failure in this system would interrupt the supply of vacuum to the operating rooms, preop, andrecovery and negatively impact routine patient care.

C. TFH Facilities Management and/or the Vendor will assess the problem, determine actual estimated repair time, and advise affected departments.

D. Facilities Management will initiate repairs and will use outside agencies as, and if, needed.

E. Portable suction machines will be used until repairs can be made.

    1. Additional portable rental units, if necessary, will be obtained through TFH Materials Management Department.
    2. The TFH Facilities Management Department may obtain rental or replacement equipment or repair assistance from emergency vendor.
    3. Anesthesia cases will not take place until the vacuum system has been repaired.

EMERGENCY WATER SUPPLY

A. In case of normal water supply interruption, TSC Leadership will take all necessary steps to obtain and provide emergency water as needed.

B. If TSC's drinking water supply is contaminated or unavailable the Administrator or Nurse Manager will determine whether TSC should remain open.

C. Emergency water should be available at all times.

1. Potable water is stored and secured in the womens locker room.
2. If additional bottled water is required TFH Materials Management will be contacted at 530-582-3510. If they are unable to provide additional water leadership will designate a staff member to go to Safeway, Savemart, Riteaid, or CVS to purchase more.

D. Upon water interruption, the Administrator will contact TFH Facilities management and alert staff of the need to conserve water.

E. If problem is internal due to main line failure:
    1. Call TDPUD to advise normal water supply interruption since they may be able to provide portable water.

F. In case of major disaster, with water supply failure:
    1. Human waste disposal:
        a. Non-potable water, if available, can be used to flush toilets. Portable restrooms can be used to reduce the amount of water needed for flushing toilets (i.e. patients use non-potable water, staff us portable restrooms).

G. Upon restoration of normal water supply, TFH Facilities Managment will assist the hospital in taking water samples for analysis for potability to an outside agency e.g. TTSA, Cranmer or Sierra Environmental Monitoring.
    1. As this analysis can take up to 24 hours, continue using alternative sources of potable water.

MAJOR SEWER LINE FAILURE

A. In case of main or branch sewerage line failure, action shall be taken to restore sewage disposal capabilities as soon as possible.

B. If a sewer problem occurs, the TFH Facilities Management Department should be called, and a response time determined immediately.

C. Human waste disposal:
    1. Obtain plastic liners to place in toilets or bedside commodes and/or bed pans for patient collection of urine, stool and other wastes. Instruct staff and patients not to flush toilets.
        a. Kitty litter can be used to help absorb liquid.
        b. Place large plastic containers with lids (garbage size) in dirty utilities areas identified as hazardous waste.
        c. Waste can be transported to Porta Potties for disposal.
    2. If required, Porta Potties can be used by staff and visitors until the issue is resolved.

D. TFH Facilities Management will assess the situation.
    1. If TFH Facilities Management is unavailable refer to building maintenance contact list.
    2. TFH Facilities Management will coordinate delivery of Porta Potties until the issue

can be resolved.

FAILURE OF FIRE ALARM SYSTEM

A. A fire watch must be conducted should the fire alarm system in whole or in part, be out of service for more than 4 hours in a 24 hour period.

1. Personnel will be designated to perform a continuous fire inspection of the Surgery Center.
2. The Administrator will contact the local fire department at the beginning and end of the fire watch.
3. This inspection will need to be logged and documentation then kept in the Emergency Management binder.
4. The continuous fire inspection is a visual inspection of all affected areas of the Surgery Center including unoccupied areas to ensure that a fire has not gone undetected.

RELATED POLICIES:

Code Red, EOC-2205, Code Yellow, EOC-1901, Code Orange, EOC-2204, Code Gray, EOC-2201, Code Purple, EOC-2206, Code Silver, EOC-2203, Code Blue/Code White Protocol, NS-1905, Fire Drills, EOC-1909, Fire Safety & Staff Response, EOC-1910, Fire Safety-Oxygen Enriched Atmosphere in the Operating Room, EOC-1911, Fire Watch, EOC-1913, Handling Hazardous Chemicals, EOC-1916, Alternate Life Safety Measures, EOC-1922,

REFERENCES:

1. APIC Bioterrorism Task Force and CDC Hospital Infections Program Bioterrorism Working Group. (1999, April 13).
Bioterrorism Readiness Plan: A Template for Healthcare Facilities. Retrieved March 24, 2011, from Centers for
Disease Control and Prevention: http://www.cdc.gov/ncidod/dhqp/pdf/bt/13apr99apic-cdcbioterrorism.pdf
2. Centers for Disease Control and Prevention. (2001, October 26). Update: Investigation of Bioterrorism-Related
3. Anthrax and Interim Guidelines for Exposure Management and Antimicrobial Therapy. Morbidity and Mortality
4. Weekly Report , 50(42), 909-919. Retrieved March 24, 2011, from Centers for Disease Control and Prevention: http://www.cdc.gov/mmwr/PDF/wk/mm5042.pdf
5. ACHC Standard 07.00.01
6. ACHC Standard 15.02.02

Effective: August 2013, Revised: June 2014, July 2019

Attachments

- Bomb Threat Checklist
- Disaster phone tree
- Disaster Resource List
- Emergency equipment
- Emergency Quick Reference Guide

Approval Signatures

Step Description	Approver	Date

Status Draft PolicyStat ID 20112779

TRUCKEE SURGERY CENTER

Origination	N/A
Last Approved	N/A
Last Revised	N/A
Next Review	N/A
Owner	Heidi Fedorchak: Nurse Manager
Department	Quality and Patient Safety
Applicabilities	Truckee Surgery Center

Quality Assessment & Performance Improvement (QAPI) Plan, QA-2002

RISK:

Organizations who respond reactively, instead of pro-actively, to unanticipated adverse events, and/or outcomes, lack the ability to mitigate organizational risks by reducing or eliminating contributing factors. This is a risk for poor quality care and patient outcomes.

PURPOSE:

A. To provide a framework for promoting and sustaining performance improvement at Truckee Surgery Center (TSC), in order to improve the quality of care and enhance organizational performance. The goals are to pro-actively reduce risk to our patients by eliminating or reducing factors that contribute to unanticipated adverse events and/or outcomes and provide high quality care and services to ensure a safe care experience for our patients and customers. This will be accomplished through the support and involvement of the Truckee Surgery Center Medical Executive Quality Committee (MEQC), Board of Managers, Medical Director, Leadership, Medical Staff, Employees, and Tahoe Forest Hospital District's (TFHD) Quality/Infection Control Department leaders, in an environment that fosters collaboration and mutual respect. This collaborative approach supports innovation, data management, performance improvement, proactive risk assessment, commitment to customer satisfaction, and High Reliability tenets to promote and improve awareness of patient safety.

B. To utilize the Plan-Do-Check-Act (PDCA) Cycle or other established Quality Assurance and Performance Improvement (QAPI) methodology as the standard in our QAPI Program, in order to enhance patient safety and quality of care, and deliver cost effective services.

C. To use an ongoing, data-driven system-wide QAPI Plan that will serve TSC and its patients long into the future.

PROGRAM SCOPE:

A. The program is system-wide. It focuses on high risk, high frequency and/or known problem-prone and safety issues first. It includes but is not limited to the following:

1. Governance Issues
2. Surgical and Medical Services
3. Anesthesia Services
4. Pharmaceutical Services
5. Nursing Services
6. Environment & Safety
7. Medical Records
8. Medical Staff Performance, clinical and other
9. Allied Health Practitioners Performance, clinical and other
10. Laboratory & Radiological Services
11. Radiation Safety
12. Infection Control
13. Patients' Rights
14. Contracted Services
15. Regulatory Compliance

B. The program includes, but is not limited to, an ongoing program that demonstrates measurable improvement in patient health outcomes, and improves patient safety by using quality indicators or performance measures associated with improved health outcomes and by the identification and reduction of medical errors.

C. At Truckee Surgery Center:

1. Designated quality indicators for each of the above service areas will be measured and analyzed.
2. Adverse patient events of all types will be measured, analyzed, and the lessons learned will be established as quality indicators (QI) and will be measured, analyzed, and tracked.
3. Infections and parameters (indicators) for infection control will be established, measured, analyzed, and tracked over time.
4. Other indicators of the care and services furnished in TSC will be established, measured, analyzed, and tracked as above.

PROGRAM DATA:

A. TSC's QAPI Program incorporates quality indicator data, including patient care and other relevant data regarding services furnished at TSC. The goal is 100% compliance with each identified quality metric. TSC uses the data collected to:

1. Monitor the effectiveness and safety of services and quality of care.
2. Identify opportunities that could lead to improvements and changes in its patient care.

B. Data includes:

1. Procedures Provided at TSC:
    a. Surgical/invasive and manipulative procedures
    b. Pain management procedures
2. Radiological Services:
    a. Radiation safety screening results
        i. Badge reports
    b. Radiation equipment monitoring
        i. Phantom tests/Jug tests
        ii. Physicist checks
        iii. Lead shield integrity
        iv. Quarterly fluoroscopy monitoring
3. Infection Control:
    a. Hand hygiene surveillance
    b. Safe Injection Practices
    c. Infection control monthly walk-throughs
    d. Sterile processing surveillance
    e. Environmental rounds
    f. Monitoring of immediate use sterilization
    g. Surgical Site Infections (SSI's)
    h. Timing of prophylactic antibiotic administration
4. Adverse Events:
    a. Unplanned hospital transfer/admission
    b. Adverse events including wrong site, side, patient, or implant
    c. Medical errors including medication, surgical, and diagnostic errors; equipment failures,
5. Pharmacy:
    a. Medication therapy
    b. Medication errors
    c. Adverse drug reactions
    d. Formulary

e. Quarterly chart reviews

6. Environment of care:
    a. Fire & Disaster Preparedness
    b. Monitoring of temperature and humidity in OR's, preop/PACU, SPD and sterile storage
    c. Refrigerator(s) temperature monitoring
    d. Blanket warmer temperature monitoring
    e. Fluid warmer temperature monitoring
    f. Cleaning logs
7. Medical Staff:
    a. Credentialing
    b. Peer Review
8. Nursing Services:
    a. ~~Nursing chart~~Chart review
    b. Annual competencies
    c. Safe surgery checklist
9. Patient Safety & Care:
    a. Resuscitation and critical incidents, including debriefings
    b. Clinical record reviews, surgery and pain
    c. Patient unexpected complications monitoring
    d. Tracking of delayed surgical start times and extended PACU stays
    e. Patient Satisfaction Survey surveillance
    f. Complaints and grievances

PERFORMANCE IMPROVEMENT INITIATIVES:

A. TSC has prioritized its Performance Improvement initiatives with the goals of meeting and exceeding the national benchmark standards of the Ambulatory Surgery Center Organization (ASCA) and the California state benchmark standards of the California Ambulatory Surgery Association (CASA).

B. TSC's designated initiatives were also prioritized with the intention of survey readiness, and compliance with federal and state regulations, to result in the successful accreditation survey.

C. The 2025 Performance Improvement priorities identified include:
    1. Exceed national benchmark standard of reported surgical site infections (SSIs)
        a. Utilize the PDCA method to obtain, measure, analyze, and track prior data, with the goal of promoting and guiding new and continued policies and procedures in the prevention of infections.

b. Continue to implement and monitor infection control and quality indicators.

2. Encourage and maintain patient safety. Specifically, maintaining a heightened awareness for facility and/or equipment failures, including the immediate remediation of any issue(s) that arise. This to include the prompt response by TSC leadership and staff in resolving urgent and/or emergent matters, which may include the canceling or rescheduling of patient cases.
3. Promoting patient safety and best-practice by ensuring the level of cleanliness of patient care area(s) meets or exceeds policy standards
4. Promoting smooth preoperative procedure in preventing day-of issues, cancellations and/or delays, by creating process(es) that encourage patients' day-of surgery knowledge and compliance.
5. Upholding ongoing accreditation standards and compliance with federal and state regulations
6. Sustain a culture of safety, transparency, accountability, and system improvement

D. TSC's priority QAPI activities will:

1. Focus on high risk, high volume, and problem-prone issues,
2. Consider incidence, prevalence, and severity of any noted problem areas,
3. Place our healthcare outcomes, patient safety and the overall quality of our care as high priority.

E. Decisions to improve TSC's processes are based on the following:

1. TSC's mission and goals
2. A change in the facility's Scope of Services
3. An undesirable change occurs, such as an Adverse or Unanticipated Patient Care Outcome, Sentinel Event or Near Miss
4. An issue defined and/or determined by the Performance Improvement process
5. It is part of an important function as defined by a regulatory health care body such as the Department of Health Services, Medicare, an accrediting agency such ACHC or is an accepted community health care standard.

F. Our program will track all known adverse patient events, and a Root Cause Analysis (RCA) will be performed for each event. The initial plan will use cause and effect diagrams and flow diagrams for the RCA. As the plan progresses, other formats will be explored and when the long-term plan is developed other RCA methodology could be developed.

G. Truckee Surgery Center will utilize baseline data and aggregated data to determine the following quality of care goals:

1. Improving existing processes
2. Developing new processes
3. Development of action plans for improvement

4. New goals for improvements of past processes that have not been maintained
5. Comparisons with internal and external quality benchmarks
6. Determining whether Risk Management/Patient Safety issues are being addressed and evaluated appropriately

H. The lessons learned from any RCA will be used to design Performance Improvement (PI). The PI methodology will utilize the Deming Cycle of PDCA to test and refine our implementation of improvement.

I. Improved performance derived by these PI activities will be monitored over time utilizing repeated PDCA analysis to ensure that our improved performance will be sustained over time.

J. Periodically (at least annually) the medical staff and nursing staff at TSC will be provided specific QAPI training about PI methodology and TSC's evolving improvement strategies derived for our QAPI program. The goal is to ensure that all staff is familiar with these strategies.

K. Recent focus of our QAPI Program has been placed on opportunities for improvement including the following:

1. Radiological Services:
    a. Radiation Safety Screening is performed by an outside vendor. The exposure time is validated and a report is provided quarterly. The Radiation Safety Officer audits and reviews the reports for any outliers and reports any issues to the Nurse Manager and/or Administrator. The facility works cooperatively with the Radiology department of TFHD who provides additional review as needed and documents any findings.
    b. Phantom/Jug Tests are performed weekly by the Radiology department of TFHD. These results are input into a formula to determine outliers; any abnormal results are reported to the Nurse Manager and/or Administrator and documented in the fluoroscopy binder.
    c. TSC's contracted physicist provides an annual check of all radiological equipment in the facility for safety and effectiveness. A report is produced and is reviewed by the MEQC, Board of Managers, and TSC's Administrator and Nurse Manager. Abnormal findings are reported to the Radiology Director of TFHD for resolution.
    d. Lead Shield Integrity is evaluated annually by the Radiology department of TFHD. Results are reported to the MEQC, Board of Managers, and TSC's Administrator and Nurse Manager.
2. Infection Control:
    a. Unannounced hand hygiene and infection control walk through surveillances are performed monthly by the QAPI/IC Coordinator using the audit tools.
    b. The Sterile Processor will perform monthly audits of all Immediate Use Sterilization and will provide a report on this information to the QAPI/IC Coordinator.

c. Surgical Site Infection data is obtained from the physicians via a monthly memorandum/physician letter. The reports are provided to the Nurse Manager and/or QAPI/IC Coordinator and reported to the MEQC and Board of Managers.

3. Adverse Events:
    a. Hospital Transfers/Admissions are documented on Occurrence/ Notification Reports by the attending staff and provided to the QAPI/IC Coordinator, Nurse Manager, and the Administrator for immediate review.
    b. Adverse Events are documented on an Occurrence/Notification Report by the attending staff and provided to the QAPI/IC Coordinator, Nurse Manager, and the Administrator for immediate review.
4. Pharmacy:
    a. Medication Errors are documented on an Occurrence/Notification Report by the attending staff and provided to the QAPI/IC Coordinator and Nurse Manager for immediate review.
    b. Adverse Drug Reactions are documented on an Occurrence/Notification Report by the attending staff and provided to the QAPI/IC Coordinator and Nurse Manager for immediate review.
    c. A formulary has been created by the nursing staff in cooperation with the contracted Pharmacist. The formulary will be updated as necessary and reviewed and approved by the MEQC and Board of Managers annually.
    d. A Medication Reconciliation will be completed for each patient. This will be reviewed for completion during chart reviews.
5. Environment of Care:
    a. The Emergency Operations Plan including the Fire and Disaster Preparedness Plans are reviewed with the facility staff, Medical staff, MEQC and Board of Managers. All drills including quarterly Fire Drills and annual Disaster Preparedness Drills will be performed with written evaluation including areas for improvement. Changes to the Emergency Operations Plan will be implemented based on recommendations from the drill or actual event evaluations. All evaluations will be reported to the MEQC and Governing Board and all staff and physicians will be educated on changes to the plan.
    b. Temperature and Humidity logs are maintained by the nursing staff. Any values outside of acceptable parameters will be reported to the Nurse Manager and/or Administrator immediately for documentation and corrective action.
6. Medical Staff:
    a. Credentialing will be performed biennially per facility policy and Medical Staff Bylaws. The credential file will be reviewed by the Medical Director and then reviewed and approved by the MEQC & Board of Managers.

b. Peer Review will be performed quarterly by all practitioners at the facility. Peer review will be performed per facility policy, MS-1906.

c. ~~Medical chart~~Chart reviews will be performed quarterly on ~~100~~10% of patient cases by the QAPI/IC Coordinator or designee. Any discrepancies or fall-outs ~~from surgeons and/or anesthesiologists~~, unless deemed necessary for immediate action, will be reviewed, summarized, and reported at the MEQC and Board of Managers quarterly meetings.

7. Nursing Services:

a. ~~Nursing~~ Chart Reviews will be performed ~~monthly~~quarterly on 10% of patient cases by the QAPI/IC Coordinator or designee. ~~Documentation and nursing care~~Any discrepancies or fall-outs, unless deemed necessary for immediate action, will be ~~evaluated~~reviewed, summarized, and reported ~~to TSC staff as needed~~at the MEQC and Board of Managers quarterly meetings. Trends are analyzed and opportunities for improvement are discussed with staff.

b. Annual competencies, per facility policy, will be evaluated by the Administrator and/or Nurse Manager.

L. A Safe Surgery Checklist is performed by the medical and/or nursing staff prior to each surgery to ensure that all personnel are introduced, confirmation of the correct patient is made, allergies discussed, procedure confirmed, the site is marked, and the patient is positioned correctly. There is confirmation that the surgeon and anesthesiologists needs for equipment are met and readily available, that pre-op antibiotics have been administered within 60 minutes prior to surgical cut time, a fire risk assessment is complete, and that fluoroscopy badges are worn by all personnel (when applicable). At the conclusion of the surgery, there is verbal communication of **correct** counts, name of the procedure, and specimen label(s) (when applicable), and the physician and anesthesiologist are then asked to state any recovery or equipment concerns. This checklist becomes a permanent part of the patient's record.

CLINICAL PRACTICE GUIDELINES:

A. A Clinical Practice Guideline (CPG) is used to design or to improve process(es) that evaluate/ treat specific diagnosis, condition, symptoms, or procedure. Clinical practice guidelines help practitioners and patients make decisions about preventing, diagnosing, treating, and managing selected conditions. These guidelines can also be used in designing clinical processes or in checking the design of existing processes. TSC identifies criteria that guide the selection and implementation of clinical practice guidelines which are consistent with its mission and priorities.

B. The following steps will be completed in the development of clinical practice guidelines:

1. The MEQC and TSC leadership will discuss the most likely processes, procedures or diagnoses to be reviewed based on TSC's Scope of Services and approved procedure list. A high volume, high risk or problem prone process will be selected when needed.

2. Clinical practice guidelines for the chosen project will be reviewed via the Internet using multiple sources. Sources of clinical practice guidelines include the Agency for

Healthcare Research and Quality, the National Guideline Clearinghouse (www.ihi.org), and professional organizations in an effort to provide current Evidence Based Practice (EBP) guidelines in effect within healthcare specialties.

3. An appropriate team will be formed to assist with the development of the CPG. The team will follow the PDCA process for development of the CPG.
4. The CPG project may be identified by clinical staff within TSC based on risk factors or difficult processes currently part of the healthcare delivery system.
5. Variation in practice with regards to the Clinical Practice Guideline will be tracked by the facility and significant variances and/or adverse patient outcomes will be communicated to the MEQC and Board of Managers.
6. Variations in practice from the suggested CPG parameters does not necessarily mean potential negative outcomes are imminent, but should be used to re-evaluate the parameters of the CPG in use within the facility.

ORGANIZATIONAL FRAMEWORK:

Processes cross many departmental boundaries and performance improvement requires a planned, collaborative effort between all departments, services, and external partners, including third-party payers and other physician groups. Though the responsibilities of this plan are delineated according to common groups, it is recognized that true process improvement outcomes occur only when each individual works cooperatively and collaboratively to achieve improvement.

Board Of Managers

A. The Board of Managers has the ultimate responsibility for the quality of care and services provided at TSC. The Board of Managers assures that a planned and systematic process is in place for measuring, analyzing and improving the quality and safety of the Surgery Center activities.

B. The Board:

1. Delegates the authority for developing, implementing, and maintaining performance improvement activities to the Administrator, Nurse Manager, Medical Director, Anesthesia Director, Medical Staff, and employees;
2. Recognizes that performance improvement is a continuous, never-ending process, and therefore they will provide the necessary resources to carry out this philosophy;
3. Provides direction for the organization's improvement activities through the development of strategic initiatives;
4. Evaluates the organization's effectiveness in improving quality through reports from Leadership, the MEQC, and Medical Staff.

Medical Executive Quality Committee (MEQC)

The MEQC is to provide oversight for TSC's QAPI Plan and set expectations of quality care, patient safety, environmental safety, and performance improvement throughout the organization. The committee will

monitor the improvement of care, treatment and services to ensure that it is safe, timely, effective, efficient, equitable, and patient-centered. They will oversee and be accountable for the organization's participation and performance in national quality measurement efforts, accreditation programs, and subsequent quality improvement activities. The committee will assure the development and implementation of ongoing education focusing on service and performance excellence, risk-reduction/ safety enhancement, and healthcare outcomes.

A. The MEQC provides effective mechanisms to monitor, assess, and evaluate the quality and appropriateness of patient care and the medical performance of all individuals with delineated clinical privileges. These mechanisms function under the purview of the Medical Staff Peer Review Process. Consistent with this process, performance improvement opportunities are addressed, and important problems in patient care or safety are identified and resolved.

B. The MEQC delegates the oversight authority for performance improvement activity monitoring, assessment, and evaluation of patient care services provided through TSC to the QAPI/IC Coordinator and leadership team. QAPI reports are provided quarterly to assess TSC's plan.

Medical Staff

A. The Medical Staff is expected to participate and support performance improvement activities.

B. The Medical Staff provides effective mechanisms to monitor, assess, and evaluate the quality and appropriateness of patient care and the clinical performance of all individuals with delineated clinical privileges. These mechanisms are under the purview of the Medical Staff Peer Review Process. Consistent with this process, performance improvement opportunities are addressed, and important problems in patient care or safety are identified and resolved.

Quality Assurance/Performance Improvement/ Infection Prevention Coordinator (QAPI/IP)

The QAPI/IC Coordinator creates a vision and direction for clinical quality and patient safety throughout TSC. The QAPI/IC Coordinator, in conjunction with the Administrator, Nurse Manager, Medical Director, Medical Staff, and TSC employees, directs and coordinates quality, patient safety, and performance improvement initiatives to enhance the quality of care provided to TSC patients. The QAPI/IC Coordinator communicates patient safety, best practices, and process improvement activities to the Administrator, Nurse Manager, Medical Director, Medical Staff, TSC staff, and engages them in improvement activities.

TSC Employees

A. The role of the individual employee is critical to the success of a performance improvement initiative. Quality is everyone's responsibility and each employee is charged with practicing and supporting TSC's plan.

B. Employees are expected to do the following:

1. Contribute to improvement efforts, including reporting Sentinel/Adverse Event/Error or Unanticipated Outcomes, to produce positive outcomes for the patient and their

families.

2. Make suggestions/recommendations for opportunities of improvement or for a cross-functional team; including risk reduction recommendations and suggestions for improving patient safety, by contacting the QAPI/IP Coordinator, Nurse Manager and/or the Administrator. All employees must feel empowered to report, correct, and prevent problems.

BENCHMARKING:

Measurement is the foundation of all Performance Improvement activities. Measurement involves the collection of data and forms the basis for determining the level of performance of existing processes and functions within TSC, and the outcomes resulting from these processes and functions.

A. INTERNAL BENCHMARKING:

1. The measurement system includes data on:
    a. Outcomes both directly and indirectly related to patient care
    b. A comprehensive set of Quality Indicators, including not limited to, the ASC Division Quality Indicators which track both the quality and quantity of those designated patient care areas
    c. Risk Management issues and occurrences, inclusive of Sentinel/Adverse Events
    d. Patient satisfaction surveys and patient complaints/grievances
    e. Human Resource and staff learning needs identified
    f. The Environment of Care safety - Fire and Disaster plans

B. EXTERNAL BENCHMARKING:

1. External benchmarking for other patient care issues and activities may include, but is not limited to:
    a. American Society of Anesthesiologists
    b. American College of Surgeons
    c. American Academy of Orthopedic Surgeons
    d. National Association of Orthopedic Nurses
    e. American Association of Peri anesthesia Nurses
    f. Associate of Perioperative Nurses, etc.
    g. Clinical Practice Guidelines, published at a National Guideline Clearinghouse
    h. Center for Disease Control
    i. Association for Professionals in Infection Control (APIC)
    j. Recognized practice guidelines relevant to a community standard of care

PERFORMANCE IMPROVEMENT:

Education

A. Training and education are essential to promote a culture of quality within TSC. All employees and Medical Staff receive education about performance improvement upon initial orientation. Employees and Medical Staff receive additional annual training on various topics related to performance improvement.

B. The QAPI/IC Coordinator, Nurse Manager and/or Administrator will provide education to all staff members on the QAPI Plan and their role in performance improvement activities.

Priorities

A. The QAPI program is an ongoing, data driven program that demonstrates measurable improvement in patient health outcomes, improves patient safety by using quality indicators or performance improvement measures associated with improved health outcomes, and by the identification and reduction of medical errors.

B. Improvement activities must be data driven, outcome based, and updated annually. Careful planning, testing of solutions and measuring how a solution affects the process will lead to sustained improvement or process redesign. Improvement priorities are based on the mission, vision, and strategic plan for TSC. During planning, the following are given consideration:

1. Processes that are high risk, high volume, or problem prone areas with a focus on the incidence, prevalence, and severity of problems in those areas
2. Processes that affect health outcomes, patient safety, and quality of care
3. Processes related to patient advocacy and the perfect care experience
4. Processes related to the National Quality Forum (NQF) Endorsed Set of Safe Practices
5. Processes related to patient flow
6. Processes associated with Near Miss, Sentinel/Adverse Event/Error or Unanticipated Outcome

C. Because TSC is sensitive to the ever changing needs of its facility, priorities may be changed or re-prioritized due to:

1. Identified needs from data collection and analysis
2. Unanticipated adverse occurrences affecting patients
3. Processes identified as error prone or high risk regarding patient safety
4. Processes identified by proactive risk assessment
5. Changing regulatory requirements
6. Significant needs of patients and/or staff
7. Changes in the environment of care
8. Changes in the community

9. Identified process improvements from emergency drills or actual events

Project

A. The Performance Improvement (PI) Projects at TSC reflect the scope and complexity of the facility's services and operations, and are based off of noted areas for improvement from practice.

B. The Deming Cycle:

1. TSC uses the Plan-Do-Check-Act (PDCA) Cycle to evaluate, plan, design, and implement processes to improve within the surgery center.
2. PLAN:
    a. Project Start-Up
        i. Decide the focus of improvement or issue to be improved
        ii. Confirm the aim of the project
    b. Current Situation - identify and collect baseline data
        i. Confirm that problem exists with data
        ii. Analyze your current process
        iii. Develop a measurable goal for the project
    c. Perform Cause Analysis
        i. Evaluate the following:
            a. Resources
            b. Equipment
            c. People
            d. Methods
3. DO:
    a. Develop and implement solutions
        i. Perform a pilot/trial run on a small scale or time frame
        ii. New solutions may require that the DO step is repeated
4. CHECK:
    a. Analyze the effect of solutions implemented
        i. Compare with baseline data and goal of the project
        ii. Has improvement been gained?
        iii. Has the goal been met?
        iv. Standardize the successful solutions
    b. Adopt, adapt for alternative solutions
        i. Repeat the DO and CHECK processes for failed solutions

5. ACT:
    a. Standardization
        i. Fully implement the solutions by defining the new process and the methods for communicating, training and maintaining the goal of the project
    b. Future Plans
        i. Evaluate what was learned from the project
        ii. Continue the project if the goal was not met
        iii. Develop new solutions and checks as needed

C. SMART Projects and Areas of Focus Studies are mini PI Projects which TSC conducts on an as needed basis, determined by quality indicator data that is obtained. These projects help facilitate quick interventions and necessary procedural changes.

AGGREGATION AND ANALYSIS OF DATA:

A. In addition to the Program Data listed above, the following clinical and administrative data is aggregated and analyzed to support patient care and operations:
    1. Quality Measures delineated in clinical contracts will be reviewed annually
    2. Summaries of performance improvement actions and actions to reduce risks to patients
    3. Pharmacy transactions as required by law and to control and account for all drugs
    4. Information about hazards and safety practices used to identify safety management issues to be addressed by TSC
    5. Reports of required reporting to federal and state authorities
    6. Performance measures of processes and outcomes, including measures outlined in clinical contracts

B. This data is reviewed regularly by the MEQC and Board of Managers with a goal of 100% compliance. The review focuses on any identified outlier and the plan of correction.

C. TSC believes that excellent data management and analysis are essential to an effective performance improvement initiative. Statistical tools are used to analyze and display data, and are in compliance with the TFHD plan. All performance improvement teams and activities must be data driven and outcome based. The analysis includes comparing data within TSC, within TFHD, with other comparable organizations, with published regulatory standards, and best practices. Data is aggregated and analyzed within a time frame appropriate to the process or area of study. Data will also be analyzed to identify system changes which will help improve patient safety and promote an excellent care experience.

D. The data used to monitor the effectiveness and safety of services and quality of care. The data analysis identifies opportunities for process improvement and changes in patient care processes. Adverse patient events are analyzed to identify the cause, implement process improvement and preventative strategies, and ensure that improvements are sustained over time.

E. Data is analyzed in many ways including:

1. Using appropriate performance improvement problem solving tools
2. Making internal comparisons of the performance of processes and outcomes over time
3. Comparing performance data about the processes with information from up-to-date sources
4. Comparing performance data about the processes and outcomes to other hospitals and reference databases

F. Intensive analysis is completed for:

1. Levels of performance, patterns or trends that vary significantly and undesirably from what was expected
2. Significant and undesirable performance variations from recognized standards
3. A sentinel event that has occurred (see policy Sentinel/Adverse Event/Error or Unanticipated Outcome, QA-2001)
4. Variations which have occurred in the performance of processes that affect patient safety
5. Hazardous conditions which would place patients at risk
6. The occurrence of an undesirable variation which changes priorities

G. The following events will automatically result in intense analysis:

1. Significant adverse drug reactions
2. Significant medication errors
3. All major discrepancies between preoperative and postoperative diagnosis
4. Adverse events or patterns related to the use of sedation or anesthesia
5. Hazardous conditions that significantly increase the likelihood of a serious adverse outcome
6. Staffing effectiveness issues
7. Deaths associated with a hospital acquired infection
8. Core measure data, that over two or more consecutive quarters for the same measure, identify TSC as a negative outlier

REPORTING:

A. Results of the outcomes of performance improvement and patient safety activities identified through data collection and analysis, performed by medical staff, ancillary, and nursing services will be reported to the MEQC and Board of Managers quarterly.

B. TSC also recognizes the importance of collaborating with state agencies to improve patient outcomes and reduce risks to patients by participating in external quality reporting initiatives.

CONFIDENTIALITY AND CONFLICT OF

INTEREST:

All communication and documentation regarding performance improvement activities will be maintained in a confidential manner. Any information collected by any TSC employee or Medical Staff in order to evaluate the quality of patient care, is to be held in the strictest confidence, and is to be carefully safeguarded against unauthorized disclosure.

Access to peer review information is limited to review by the Medical Staff and its designated committees and is confidential and privileged. No member of the Medical Staff shall participate in the review process of any case in which he/she was professionally involved unless specifically requested to participate in the review. All information related to performance improvement activities performed in accordance with this plan is confidential and are protected by disclosure and discover-ability through California Evidence Code 1156 and 1157.

ANNUAL ASSESSMENT:

The evaluation includes a review of patient care and patient related services, infection control, medication administration, medical care, and the Medical Staff.

The purpose of the evaluation is to determine whether the utilization of services is appropriate, policies are followed, and needed changes are identified. The findings of the evaluation and corrective actions, if necessary, are reviewed. The QAPI program evaluates the quality and appropriateness of diagnoses, treatments furnished, and treatment outcomes.

An annual report summarizing the improvement activities and the assessment will be submitted to the Medical Staff, MEQC and Board of Managers.

Related Policies/Forms:

Infection Control Plan, IC 1914

Occurrence/Notification Reports, QA-1903

Risk Management, QA-1905

Sentinel Event/Error or Unanticipated Outcome, QA-2001

References:

ACHC, the Joint Commission, CMS COPs, HCQC NRS/NAC

Attachments

QAPI IP Schedule.docx

Approval Signatures

Step Description	Approver	Date

Status Draft PolicyStat ID 20208797

TRUCKEE SURGERY CENTER

Origination	N/A
Last Approved	N/A
Last Revised	N/A
Next Review	N/A
Owner	Heidi Fedorchak: Nurse Manager
Department	Environment of Care
Applicabilities	Truckee Surgery Center

Temperature, Humidity & Air Exchanges, EOC-1937

PURPOSE:

To carefully monitor and control the quality of air entering Truckee Surgery Center.

POLICY:

Temperature and ventilation for sensitive areas or rooms are maintained according to recognized state and national standards. These standards include California Code of Regulations (Title 24, Part 4, California Mechanical Code), Centers for Disease Control (CDC), and Association for the Advancement of Medical Instrumentation (AAMI). The relative humidity standard is based from revised ASHRAE 170-2008 standards. State regulations are followed when discrepancies are noted.

PROCEDURE:

A. Designated staff will record daily temperatures along with the relative humidity (see policy on maintaining relative humidity in the operating suites). Variations from ranges will be reported to the Administrator or Nurse Manager for corrective action. Any corrective action taken will be recorded on the temperature logs or a progress note attached to the temperature and humidity log.

B.

Room	Temperature Range (degrees F)	Relative Humidity
Operating Room	68 - 75	20 - 60%
Sterile Processing	68 - 75	20 - 60%
Decontamination	60 - 73	n/a
Recovery Area	70 - 75	20 - 60%
Sterile Storage	Maximum 75	Maximum 60%

C. Specifications for ventilation will be checked Monthly, Quarterly, and Annually by TFH and/or the HVAC Contrator.

1. Operating Suites (OR #1 & #2): positive air pressure with at least 20 air changes per hour; including at least 4 outdoor air exchanges.
2. Decontamination Room: Sterile Processing has negative air pressure with at least 6 air changes per hour; including at least 2 outdoor air exchanges.
3. Recovery Area: A minimum of 6 air changes per hour; with at least 2 outdoor air exchanges.
4. Sterile Storage: APositive air pressure with a minimum of 4 air changes per hour; with at least 2 outdoor air exchanges.
5. Soiled Utility Room: Negative pressure with a total of 10 air exchanges per hour; including a least 2 outdoor air exchanges.

D. Temperature & humidity logs from OR#1 and OR#2, sterile processing, recovery area (PACU) & sterile storage areas are maintained by TSC.

E. HVAC PM and Contractor Reports on accuracy of air exchanges are maintained in the Preventative Maintenance binder.

CMS Categorical 13-25 Waiver Adoption:

A. Per April 19, 2013 CMS communication Memorandum Summary:

1. Relative Humidity greater or equal to 20% is permitted in anesthetizing locations instead of the greater or equal to 35% RH. The ASC must elect to use the categorical waiver and have written documentation that they have elected to use the waiver.
2. At the entrance of the conference for any survey assessing LSC compliance, a facility that has elected to use the waiver must notify the survey team.

B. This P&P is the written documentation to demonstrate the election to use the categorical CMS waiver that permits a RH of greater than or equal to 20% not to exceed 60%.

References:

Guidelines for Perioperative Practice. Denver, CO: AORN, Inc; Perioperative Standards and Recommended Practices

Facility Guidelines Institute, US Department of Health and Human Services, American Society for Healthcare Engineering. Guidelines for Design and Construction of Hospitals and Outpatient Facilities. Chicago, IL: American Society for Healthcare Engineering of the American Hospital Association

Centers for Medicare & Medicaid Services. State Operations Manual Appendix A- Survey Protocol, Regulations and Interpretive Guidelines for Hospitals. Rev. 78

ANSI/ASHRAE/ASHE Addendum h to ANSI/ASHRAE/ASHE Standard 170-2013: Ventilation of Health Care Facilities. Atlanta, GA: American Society of Heating, Refrigerating and Air-Conditioning Engineers, Inc

ACHC: 15.01.02

Approval Signatures

Step Description	Approver	Date

Status **Active** PolicyStat ID **20066004**

Origination	07/2019
Last Approved	03/2026
Last Revised	03/2026
Next Review	03/2027
Owner	Heidi Fedorchak: Nurse Manager
Department	Environment of Care
Applicabilities	Truckee Surgery Center

Fire Drills, EOC-1909

POLICY:

A. In order to assure that fire safety systems are working properly and that the staff is properly trained, Truckee Surgery Center will perform quarterly fire drills.

B. During each quarter a full fire drill will be performed with the "start" of each fire in a different area of the surgery center. One fire drill per year will simulate a patient fire in the operating room. The staff will not be told ahead of time, but it will be announced as a fire drill at the time of the drill.

C. Staff should ensure all doors are closed and observe fire notification devices are functional.

D. Staff should work as a team to follow fire response protocols as described in the Truckee Surgery Center Fire Safety Policy.

E. The Fire Drill Evaluation Form will be completed with each drill and kept on file.

F. Annually, the off-~~premis~~premise monitoring transmission equipment must be tested to ensure the local fire-responding agency receives and alarm signal.

PROCEDURE:

A. The Administrator or Nursing Manager will decide which day and time the drills will be performed.

B. He/she will notify the alarm company, AAA Smart Business/California Security, at 587-6278 prior to the drill to place the monitoring system in test which will bypass the alarm call to Truckee Fire Dispatch. He/She will also notify Tim Sawyer at CAMCO (building maintenance company) 530-308-1079.

C. Annually, during the same month each year, the signal must be transmitted to the fire response

agency. To accomplish this task, AAA Smart Business/California Security will not place the monitoring system in test and Truckee Fire Dispatch, at (530) 477-0641 option #7, will be notified and asked not to dispatch. After the fire alarm signal is initiated, Truckee Fire Dispatch will confirm receipt of notification from AAA Smart Business/California Security. Written verification of this notification must be obtained and keep it on file.

D. Notify surrounding businesses that we will be having a fire drill.

E. Make sure the fire alarm panel key is in the panel.

F. A fire pull and or smoke detector will be activated and an announcement will be made as to the location of the fire. The announcement is performed using the "All Call Page".

G. In a real situation 9-1-1 would be called noting the location of the fire, extent of the fire and how many people are in the building at the time.

H. The alarm panel will be reset and silenced and California Security will be notified when the system is back on line and the drill is complete.

I. A Fire Evaluation Form will be completed and kept on file. The quarterly fire drills are a part of Truckee Surgery Center's quarterly check-list.

J. Device Controls:

1. To activate fire pull, use small screwdriver to open pull and hold down switch until alarm activates.
2. To activate smoke detectors, use "Smoke Detector Test Can" (can of smoke) located in fire panel.
3. To re-set the fire alarm panel, use "square" key located in fire panel and hit the re-set panel, or follow instructions noted inside fire panel..

Related Policies/Forms:

Fire Safety, EOC-1910

Effective: August 2003 Revised: May 2011, June 2013, August 2013, June 2019

Approval Signatures

Step Description	Approver	Date
	Heidi Fedorchak: Nurse Manager	03/2026

Status Draft PolicyStat ID 20099026

Origination	N/A	Owner	Heidi Fedorchak: Nurse Manager
Last Approved	N/A	Department	Pharmacy
Last Revised	N/A	Applicabilities	Truckee Surgery Center
Next Review	N/A		

Medication Management and Administration PH-1908

RISK:

Medication management and administration are pivotal components of patient care that present significant risks, including potential for medication errors and adverse drug reactions. Risks may arise from factors such as miscommunication, inadequate patient assessment, improper storage and failure to follow established protocols.

Policy:

Truckee Surgery Center (TSC) will develop, implement and maintain policies and procedures to support the prescribing/ordering and administration of medications. The Medical Executive Quality Committee will develop a system whereby medications are evaluated, appraised, and selected such that drugs considered most useful for patient care are stocked within the facility.

Procedure:

Prescribing / Ordering General Practice

1. Medications are prescribed by a licensed physician (M.D.), a licensed Doctor of Podiatric Medicine (D.P.M.), or D.D.S. or a licensed physician assistant based on individual patient needs and intent for a specific therapeutic response.
2. All orders for medication and treatment must be legible. The prescribing practitioner will be contacted for clarification of any orders staff members feel are not legible, clear or complete.
3. **Abbreviations:** Medication orders shall contain only facility approved abbreviations. Refer to policy GOV-2201 "Approved Abbreviations" and policy PH-2101 "Use of Abbreviations."
4. **Metric:** Medication orders shall be written using the metric system of weights and measures.

The apothecary system of weights should be avoided.

5. **PRN:** Orders for "as needed" or "PRN" medications shall specify the indication(s) for use and be specific for dose, frequency, route, and limit of dosage.
6. **Range dosing and frequency:** Orders containing a range of doses are not acceptable and nursing will clarify order with the prescriber.
7. **Time/Date:** All medication orders shall include the time and date written.
8. There must be evidence of a diagnosis, condition or indication for use on the patient's medical record for each medication ordered by the patient's physician.
9. To be considered complete, all medication orders shall include the name of the drug, the dosage and/or strength, the route, frequency of administration, and indication for use.
10. **Verbal Orders:** Verbal orders will only be allowed in an urgent situation or when the physician is in a physical location that prohibits writing the orders. Verbal (direct or telephone) orders received must be transcribed to a medication order form then read back and verified with the prescriber. Orders must be written in the standard professional language. The order must be signed by the prescriber within 48 hours.
11. **Controlled Medications**: Only licensed independent practitioners duly registered with the federal Drug Enforcement Administration (DEA) and holding a valid and current DEA registration number may prescribe controlled drugs. Current DEA registration numbers are available on file.
12. **Pre-printed orders** will be used instead of standing orders. Preprinted physician orders will be reviewed annually by the Medical Executive Quality Committee and reported as information only to the Governing board. All pre-printed orders will be individualized (checked off), signed, and dated by the ordering physician.
13. In the event of a patient transfer, a complete list of their medications will be copied & transferred with the patient.
14. No medications are dispensed in or by this facility.
15. Only authorized personnel such as Licensed Physicians and Nurses can obtain and administer medications at TSC.

Drug Formulary Selection Criteria

The criteria for selecting medications included in the formulary will be based on population, need, efficacy, risk, potential for error and cost.

1. Generic drugs shall be selected based upon the recommendations of the pharmacy Purchasing vendor or the Consultant Pharmacist.
2. In the case of medication shortages or outages, the appropriate prescriber, staff, and Medical Director will be notified and substitutions will be made if possible.

Requests for Medications Not in Stock

1. Any requests for adding medications that are not on the formulary must be reviewed and approved by the Medical Director. All new medications added to inventory will be approved at the next quarterly meeting of the Medical Executive Quality Committee. The formulary will be updated, as needed, with approved medication.
2. The formulary will be reviewed and approved by the Medical Executive Quality Committee and Governing Board annually.
3. Responsibility for the acquisition and control of medications within this Surgery Center rests with the Nurse Manager or designee. Policies and procedures are designed to ensure the safe and accurate prescribing and control of medications throughout the facility. The Medical Executive Committee will approve these policies.
4. The Nurse Manager or designee is responsible for specification as to quality, quantity and source of supply of all medications used in the facility. The Consultant Pharmacist can provide assistance as needed.
5. In the event a medication order is received which cannot be obtained from normal stock, a substitute drug will be used and attempts will be made to procure through alternate distributors.

Ordering of Controlled and Non-Controlled Drugs

Ordering of controlled and non-controlled medications will be done in compliance with State and Federal regulations. The ordering, receiving and inventory will be monitored by the Consultant Pharmacist. All medications will be ordered as a single unit dose when possible.

Non-Controlled Medications:

Ordering

1. Pharmacy nurse or designee will place pharmaceutical orders directly to vendor via online platform.
2. Medications ordered must be on the approved medication formulary list.

Delivery and Receiving

1. Medications delivered will be checked in against invoice.
2. Give one copy of the packaging slip to the Administrator and place one copy in the pharmacy binder.
3. When stocking medications place those with more advanced expiration dates to the back of the shelf.

Controlled Medications

Ordering

1. Employees who are authorized CSOS users can order controlled substances.

Receiving

1. Controlled medications are checked in against invoice.
2. Place received items into double locked cabinet for controlled drugs in PACU.
3. Each box/item of controlled substance must be signed in on the Controlled Substance record by two licensed persons.
4. Packing slip will be signed by two licensed persons.
5. A Copy of the packing slip will be given to the administrator and a copy attached to invoice and filed in pharmacy binder.
6. Invoices for C-II should be separately stored from invoices for C III – V. All records pertaining to controlled substances will be retained in the facility, readily available, in a locked area for a minimum of three years. The records will be retained in storage after this for seven years.

Storage of Medications

1. Only approved medications are stocked and stored.
2. The organization stores medication according to manufacturers' recommendations.
3. Medications are stored under proper conditions of temperature to ensure stability.
4. Medications are secured at all times in designated areas in Preop, PACU, OR, and Anesthesiologists' work areas.
5. Lockable medication carts (including anesthesia carts) are used to store unit-of-use medications in the patient care areas. These carts will be locked when not attended.
6. All high-risk drugs and drugs with a higher potential for dispensing error due to look-alike/ sound-alike names, will be stored apart and with a secondary caution label, alerting staff for the necessity of taking additional dispensing precautions.
7. Refrigerators intended for medication storage will have continuous temperature monitoring to ensure temperature is within the recommended range of 36-46°F (or 2-8°C). Daily refrigerator temperature monitoring will be recored on operating days by staff. The monitors will alarm and notify the Nurse Manager and Administrator if the temperature is outside of recommended range. In the event a medication refrigerator malfunctions and cannot maintain its recommended temperature range, its contents will be transferred to an alternate medication refrigerator as soon as possible.

8. Medications are routinely checked by nursing personnel who are responsible for maintenance of stock and surveillance of expired drugs.
9. All expired or damaged non-controlled medications will be removed from stock and disposed of in the pharmaceutical waste bins. For expired controlled medications, these medications these will be packaged with an "expired" note on the medications and segregated from other medications (but still stored in the double locked controlled drug cabinet) until ready to dispose of through a reverse distributor. These medications will still be kept in the daily count with "expired" notation and only to be removed from count on the day they are being sent back through the reverse distributor Inmar for disposal.
10. The Crash Cart will be checked daily for integrity of tamper proof seal and documented. The exact contents inside should match the list of contents on the inventory list.
11. Multi-dose vials are to be opened using strict aseptic technique, and entered with a new needle and a new syringe, even when obtaining additional doses for the same patient.
12. Multi-dose vials are dated by health care personnel when they are first opened and discarded within 28 days unless the manufacturer specifies a different date for that opened vial.
13. Multi-dose vials to be used for more than one patient are kept in a centralized medication area and do not enter the immediate patient treatment area.
14. If multi-dose vials enter the immediate treatment area, they should be dedicated for single-patient use and discarded immediately after use.
15. Succinylcholine will be discarded 14 days after removal from the refrigerator.
16. Rocuronium vials will be discarded 60 days after removal from the refrigerator, or 28 days after the vial is opened, whichever occurs first.

Medication Recall and FDA Reporting

Truckee Surgery Center will be notified of manufacturer's recall proceedings through direct mail or through the wholesaler's notification. A chronological file of such notifications shall be maintained in the "Recall Binder".

1. Recalled medications will be removed from shelf immediately and dealt with according to the manufacturers recommendations.
2. The staff member responsible for ordering pharmaceuticals for the facility will have the responsibility of addressing the recall notice and following the instructions provided. These responsibilities will include pulling the affected medications from stock and notifying the Nurse Manager and if recommended on the notice, the manufacturer, physician(s) of patients who have received these medications and appropriate regulating agencies, such as the FDA.
3. FDA Problem Reporting: Significant problems noted or suspected with any drug product shall be reported to the FDA via the FDA "Drug Quality Reporting System" form. Examples for filing this report include: labeling problems, vial contamination, product discoloration, etc. All reports

shall be kept on file in the pharmacy binder. The Problem Report can be obtained at www.fda.gov/medwatch.

Preparation of Medications

1. Proper medication preparation and aseptic technique is to be used to assure sterility of end product.
2. Perform visual inspection of the integrity of the medications.
3. Maintain clean and uncluttered medication preparation areas.
4. Staff preparing medications should not be interrupted or distracted during preparation and administration of medications.
5. Exception to USP 797 and California State Compounding Law sterile product preparation applies to compounded sterile products (CSPs) that are intended for immediate use in emergency situation or as directed by FDA approved labeling. Immediate use must meet all of the following criteria to be exempt:
    1. Preparation involves low-risk level of compounding only (e.g., reconstitution).
    2. Drug is reconstituted by a health care professional licensed to administer drugs by injection.
    3. Aseptic technique is followed and sterile product is under continuous supervision of the preparer.
    4. Medication is administered no later than **1 hour after preparation.**
    5. Unless medication is immediately administered, the medication shall bear a label listing patient identification, medication name and amount, initials of preparer and the time and date it was prepared.

Medication Labeling

1. Anytime one or more medications are prepared, but are not administered immediately, the medication container must be appropriately labeled with with the following: Drug name, strength, amount (if not apparent from the container, expiration date, if product has less than 24 hours stability.
2. All prepared medications should be for immediate use, within 1 hour of preparation.
3. Any pre-drawn medications must be properly labeled with medication name and dose, the initials of the person preparing the medication and date and time of preparation.
4. All medications on the sterile field must be labeled appropriately with medication name and dose with the exception of direct draw medications drawn directly from a labeled container and administered to patient **immediately** after the medication is drawn.

Administration of Medications

1. The patient will be interviewed and the chart reviewed prior to medication prescribing for: age, gender, diagnosis, height, weight, pregnancy status, lab results, and current medications.
2. Medications are administered only by a Physician or RN in compliance with California state law. RNs practice under the direction of a physician.
3. Orders will be read and reviewed by a licensed Registered Nurse and checked for accuracy as follows: Right patient, medication, dosage, correct/proper route, time of administration, indication, effect and documentation. The medication is also checked for stability and expiration date prior to administration.
4. The patient and chart will be assessed for allergies, sensitivities, and/or possible contraindications.
5. The patient will be identified using name and date of birth, and verified by the identification wrist band before the drug is administered.
6. The order will be noted and signed by the Registered Nurse.
7. To confirm the proper drug is being administered, read the label on three different occasions: while removing medication from holding space, while preparing dose, immediately prior to administration.
8. Always confirm the 8 rights of medication administration:
    1. Right Dose
    2. Right Medication
    3. Right Patient
    4. Right Time
    5. Right Route
    6. Right Indication
    7. Right Documentation
    8. Right Effect
9. When appropriate, upon initial dose, educate the patient and/or family about the drug, reason for use, possible side effects, etc.
10. Single dose (single use) medication vials are used for only one patient and should be discarded after single patient use.

Monitoring of Medications

1. Each patient's response to their medication is monitored according to their clinical needs.

Monitoring a medication's effect on a patient includes the following:

1. Gathering the patient's own perceptions about side effects and, when appropriate, the perceived efficacy.
2. Referring to information from the patient's medical record, relevant laboratory results, clinical response, and medication profile.

Documentation

A. All medications will be documented on the patient's record with the following information: Date, time, name of medication, dosage, route, site of administration and signature of person administering. This will be done in accordance with the written order of a physician.

B. The patient's response to the medication will be monitored and documented in the patient record for efficacy, as well as adverse effects.

C. Refused or held medications shall be documented in the medical record as well as the reason for holding medication.

D. Medication instructions to the patient and family will include purpose and expected effects of the drug and possible significant side effects for those drugs administered at the facility.

E. In the event of an Adverse Drug Reaction, it will be reported to the physician immediately and documented. Intervention and treatment will follow. An Occurrence report will also be completed and forwarded to the Nurse Manager and/or Administrator.

Patients Personal Medications

1. Patient's personal medication(s) in original containers brought into the facility will be administered only upon the direct written order of a physician. A complete order must be prescribed (drug, dose, route, frequency, and indication) with notation of "patient may take own medication". Medications will be visually inspected to evaluate medication's integrity.
2. If a nurse is required to administer the medication, the nurse will inspect the container label for the correct medication as prescribed. The nurse will then utilize a professional medication reference to verify the medication prior to administration and document administration according to policy.
3. Upon patients discharge, patient's personal medication will be returned to the patient or caregiver.

Medication Reconciliation

In compliance with the National Patient Safety Goals, Truckee Surgery Center will reconcile medications by documenting a complete list of patient medications upon admission through patient discharge. This process includes active participation of the patient/caregiver and health care provider.

1. During the Preoperative phone call or upon admission, the preoperative nurse will interview the

patient to include a complete list of all medications, vitamins, herbs and supplements.

2. On the date of surgery, the day and time of the last dose taken will be documented for each medication.
3. Any medications that are added by the organization will be added to the list and will be reviewed with the patient/caregiver upon discharge.
4. A copy of the ~~Patient Home~~ Medication Reconciliation List will be given to the patient/ caregiver ~~upon request~~ at discharge. This list will include any added medications that may have been prescribed on day of surgery to be taken at home.
5. Providing summary (blanket) orders for patient's to resume their previously prescribed medications is prohibited. Each medication to be resumed shall be considered independently. Resumption of High Risk medications (such as blood thinners) shall be at the discretion of the prescribing physician. Patients are advised to contact their providers for instructions regarding resuming these medications.

RISK MANAGEMENT AND REDUCING MEDICATION ERRORS

Voluntarily reporting of medication errors, both actual and potential, are systematic using the clinical management chain of command, the incident report process and medication directed educational in-services provided. Staff members are always encouraged to share medication related incidents, however minor, in an effort to consistently improve patient care safety initiatives within the surgery center.

Tracking, trending and aggregation of data is performed related to all medication error occurrences including actual or potential adverse drug events and significant adverse drug reactions. Any and all variances are deemed significant and play a role in the facility plan to reduce medication errors or "near misses".

Truckee Surgery Center utilizes a Medication Error Reduction Program (MERP) which considers eleven areas within the healthcare environment where medication related errors can occur. The MERP plan elements involve evaluation and assessment of procedures and systems in each of the areas to identify weaknesses or deficiencies that could contribute to errors in the administration of medications. An annual review, or as needed, of the MERP will be performed to assess the effectiveness of the implementation of each of the procedures and systems listed in each area. Modification of procedures/ systems will occur as warranted when weaknesses or deficiencies are noted to achieve the reduction of medication errors. These areas are as follows:

- Prescribing
- Prescription order communication
- Product labeling
- Packaging and nomenclature

- Compounding
- Dispensing
- Distribution
- Administration
- Education
- Monitoring
- Use

Error Reduction Strategies

The following error reduction strategies have been successfully implemented for use within Truckee Surgery Center:

1. Statistical tracking and analysis of all medication errors based on a percentage of patients served.
2. Immediate implementation of policy and procedure development for all "same kind" medication errors discovered in tracking and trending.
3. A complete list of all allergies and reactions are documented on the patient record.
4. Using the eight rights of medication administration prior to medication administration.
5. The double-checking, by two clinicians, of insulin dosages prior to administration.
6. The development and annual review of a facility specific drug formulary.
7. Use of physician specific pre-printed orders which are reviewed at least annually or as needed.
8. Defined dose and dose repetitions for medications on the pre-printed orders.
9. Drug recall tracking.
10. Limiting multiple dosages of the same medication within TSC.
11. Clinical pharmacist consulting on a quarterly basis and more often as dictated by need and/or adverse occurrences.
12. Prohibiting the practice of dispensing medications to patients.
13. Prohibiting the practice of dispensing sample drugs to any patients.
14. Elimination of the storage of chemicals from the pharmaceutical storage areas.
15. Storage of oral medications separate from injectable medications
16. Use of unit dose medications when available
17. Tracking and analysis of all adverse drug reactions separate from medication errors.

18. The labeling of all medications in use on the sterile field or non-sterile field by clinical personnel
19. Review of the consulting pharmacist contract and responsibilities on an annual basis
20. All medications within the facility, exclusive of IV solutions, are consistently secured for access by clinicians only.

Drug Samples/Investigational Medications

1. Drug samples are not used in this facility
2. Investigational drugs or clinical trial medications can be used in this facility
3. In rare instances when TSC is unable to procure a medication, a physician may bring in a medication for use on a specific patient with the approval of the Medical Director and Nurse Manager or Administrator. In such instances, the medication that is brought to the facility will be identified and inspected for integrity. Opened or non-intact packaged medications will not be allowed for use in patient care. If a medication is not used by the physician who brought the medication in for the patient, it will be taken back by the physician or discarded at the center.
4. Sample medications from physician offices will not be allowed for use in the facility.

Medications on the OR Sterile Field

1. Medications used during the course of an operative procedure should receive special attention to assure that the correct medication and dosage are administered to the appropriate patient.
2. When preparing medications for the surgical technicain/scrub nurse, the circulating nurse will verify the type of medication and expiration date verbally and by showing the scrub nurse the vial(s) prior to dispensing medication(s) onto the sterile field.
3. If tumescence is to be used, the medications added to the IV solution will be shown to the surgical technician/scrub nurse prior to use.
4. Proper labeling of medications/solutions on the sterile field will be maintained.
5. The surgical technician/scrub nurse will recite the medication being handed to the surgeon prior to injection or infusion.
6. The medication container(s) will be kept until the procedure is completed in the event there are questions regarding the type of medication, strength, and/or dosage.
7. Medications will be mixed and administered for each patient per case.
8. Medications mixtures will be discarded at the end of each case once the patient has been transferred to PACU.

Regulation of Controlled Medications

1. Controlled medications will remain under double locked cabinets at all times.

2. Controlled medications for anesthesiologist use will be removed at the beginning of the day by an RN and placed in a secure lock box. The Controlled Medication Record will reflect medications removed and the provider will document usage on the Daily Narcotic Sheet for each patient.
3. Keys to controlled medication cabinet will be kept in a designated locked area during non-operative hours. Controlled drug keys will be kept in possession of a registered nurse at all times during hours of operation or in designated locked area. Under no circumstances are the controlled drug keys to be removed from the premises. In case of a stolen or missing key, the locks will be replaced or tumblers changed. If the key is broken, it will be replaced and the Administrator's key will be used until another key is obtained.
4. When a controlled medication is administered, it will be recorded on the Controlled Medication Record, including patient name, date & time, name of the medication, dose, route, and signature of the individual who administered the dose.
5. Controlled drugs should be wasted as soon as it is determined that the remaining dose will not be administered. The responsible RN or physician should waste and document with a co-signature of a second licensed practitioner.
6. The Controlled Medication Record will also document the disposition and destruction of any discarded substances by accounting for controlled drugs broken, spilled or wasted.
7. All controlled drug waste/ broken/ spilled has to be witnessed and countersigned by a second licensed personnel (RN or MD).
8. The controlled medications will be counted and tallied on the Controlled Medication Record at the beginning and end of the operating day by two RN's.
9. Any unresolved discrepancy, possible loss or theft must be reported and documented. The Administrator, Nurse Manager and/or PACU Nurse should initiate contact with:

- Chief Nursing Officer of Tahoe Forest Hospital
- Consulting pharmacist
- Risk Management of Tahoe Forest Hospital
- Medical Director
- DEA (Drug Enforcement Administration) as appropriate.

All incoming controlled substances will be inspected and logged into the ledger by two (2) licensed persons. Each entry made into the ledger will include the signatures of these persons, the amount added and the change in total quantity. The packing slip will be attached to the invoice and filed in the Pharmacy Binder. Invoices for C II should be stored separated from invoices for C III-V. These documents must be readily available for 3 yrs.

Disposition of Outdated Medications

For Non-Controlled Medications:

1. Nursing Personnel will be responsible for routinely checking for outdated/ expired medications.
2. Expired medications will be removed from general stock and disposed of in appropriate pharmaceutical waste bin.

For Controlled Medications:

1. Nursing Personnel will be responsible for routinely checking for outdated/ expired medications.
2. If there are expired controlled medications, the designated medication nurse will use the Inmar Med-Turn, Inc method of returning of controlled medications.
3. Document on the Controlled Drug Record the amount of medications expired and disposition.
4. Controlled substances schedule I & II returns require a DEA 222 form from Inmar Med-Turn in addition to the Inmar schedule I & II request form before sending via Fed-Ex. The sender's copy of the Fed-Ex US Airbill, a copy of the return request, and the DEA 222 Purchaser's copy 3 must be attached to the relevant page of the Controlled Substance record. DEA schedule III-V meds to be returned only require an Inmar schedule III-V inventory form. A copy of this inventory form and the sender's copy of the FedEx Airbill should be attached to the relevant page of the Controlled Substance record. Proof of receipt by Inmar Med-Turn should also be attached to the Controlled Substance record.

References:

Current copy of the Nurses' Drug Handbook will be kept in PACU

AORN Perioperative Standards and Recommended Practices.

AAHHS/HFAP www.hfap.org

Approval Signatures

Step Description	Approver	Date

PATIENT HOME MEDICATION LIST

**Home Medication List is as provided by the Patient and therefore may be incomplete*
(Include prescriptions, over the counter medications, herbals supplements, vitamins and birth control)

ALLERGIES:____

____

☐NO MEDICATIONS ☐PATIENT UNABLE TO PROVIDE COMPLETE MED LIST

*******If you have questions regarding below medications, please contact the prescribing physician*******

Medication	Dose	Frequency	Last Taken Date/Time	Continue	Comments
		☐Once Daily ☐Twice Daily ☐PRN ☐Other:		☐Yes ☐No	
		☐Once Daily ☐Twice Daily ☐PRN ☐Other:		☐Yes ☐No	
		☐Once Daily ☐Twice Daily ☐PRN ☐Other:		☐Yes ☐No	
		☐Once Daily ☐Twice Daily ☐PRN ☐Other:		☐Yes ☐No	
		☐Once Daily ☐Twice Daily ☐PRN ☐Other:		☐Yes ☐No	
		☐Once Daily ☐Twice Daily ☐PRN ☐Other:		☐Yes ☐No	
		☐Once Daily ☐Twice Daily ☐PRN ☐Other:		☐Yes ☐No	
		☐Once Daily ☐Twice Daily ☐PRN ☐Other:		☐Yes ☐No	
		☐Once Daily ☐Twice Daily ☐PRN ☐Other:		☐Yes ☐No	
		☐Once Daily ☐Twice Daily ☐PRN ☐Other:		☐Yes ☐No	
		☐Once Daily ☐Twice Daily ☐PRN ☐Other:		☐Yes ☐No	
		☐Once Daily ☐Twice Daily ☐PRN ☐Other:		☐Yes ☐No	
		☐Once Daily ☐Twice Daily ☐PRN ☐Other:		☐Yes ☐No	
		☐Once Daily ☐Twice Daily ☐PRN ☐Other:		☐Yes ☐No	

Preop Nurse Signature: ______________________ **Date/Time:** ______________

New Prescriptions Added	Dose	Route	Frequency	Comments

☐Complete list reviewed with patient and/or caregiver with opportunity to ask questions
☐Copy of medication list given to patient upon discharge

PACU Nurse Signature: ______________________ **Date/Time:** ______________

Truckee Surgery Center Annual Bonus Plan

Objective: The employee bonus plan explains how Truckee Surgery Center will distribute an annual bonus to its employees. We want to reward employees for their contribution to the overall success and satisfaction of the patients they serve.

Scope: This plan applies to all employees of Truckee Surgery Center including full time, part time, per diem and exempt employees.

Plan elements:

Metric: Patient Satisfaction Survey Results

Goal: Maintain a 90% or greater positive patient survey rating on their overall experience at Truckee Surgery Center.

Bonus: Annually

Non-exempt employees: $1/hour worked

Exempt Employees: $2/ hour worked