

Greater New Orleans Surgery Center

ADMITTING A PATIENT TO THE OPERATING ROOM

Page 1 of 2

Reviewed: August 1, 2001

8/01/03, 05/01/2009

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SUBJECT: Admitting a patient to the operating room.

PURPOSE: To ensure a safe surgical environment for each patient.

SCOPE: All perioperative nurses.

POLICY: It is the responsibility of the perioperative nurse to determine if the chart and perioperative checklist have been completed before moving the patient into the operating room.

PROCEDURE:

- A. Greet the patient with understanding and confidence. Introduce yourself.
- B. Check the patient's general condition and notify doctor and anesthesiologist if any irregularity is noted.
- C. Check the patient's name and date of birth verbally and against the patient's arm band. Check against operative schedule for proper identification.
- D. Check patient's allergy and status of NPO.
- E. Check the patient's chart for the following:
 - 1. Operative permit is signed correctly. Verify this verbally with the patient and double check correct side for surgery.
 - 2. Blood work, EKG, chest x-ray per policy or doctor's order. If hemoglobin is below 10 grams, notify the surgeon and anesthesiologist.
 - 3. Urine for pregnancy when required. If other than negative, notify surgeon and anesthesiologist.
 - 4. For all procedures, History and Physical done by surgeon or, if surgeon is a general dentist or podiatrist, History and Physical done by primary medical doctor.
 - 5. Preop orders carried out (i.e., medication, preparation, etc.).

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6. Check with patient re: allergies, NPO, physical limitations, contact lenses, and dentures.
- F. Make sure patient has O/R cap on head and bath blanket if on stretcher.
- G. See if there is anything that you can do to enhance the patient's comfort.
- H. Until above criteria are met, the patient is not transported into the operating room. Nursing personnel familiar with the patient's condition will transport the patient to the OR.

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ASEPTIC TECHNIQUE

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Reviewed: August 1, 2001
08/01/03, 03/05/09
Implemented: August 1, 2001
03/05/09

- SUBJECT:** Aseptic technique.
- PURPOSE:** Eliminate or minimize all modes and sources of contamination to prevent infections.
- SCOPE:** All perioperative nurses and O/R staff.
- POLICY:** Members of the operating team and perioperative nurses are to follow strict aseptic technique in order to prevent contamination and infection.

PROCEDURE:

- A. General principles.
1. Articles used at operative site must be sterile.
 2. Articles are either sterile or unsterile. No compromise. Items of doubtful sterility must be considered unsterile. Consider unsterile if:
 - a. Uncertain about actual timing or accurate functioning of sterilizer.
 - b. Sterilized articles dropped on floor.
 - c. Any article found opened or in allotted area for unsterile goods.
 - d. Holes in wrappers of sterile articles.
 - e. Sterile packages that become or feel damp or wet after proper cooling after sterilization has occurred.
- Instruments sterilized with locks open.

Deleted: except towel clips and tenaculums. These are closed to first lock.¶

- B. Sterile packages.
1. Package integrity by expiration, if applicable, and appearance of sterilizer indicator tape or strip to be checked before opening on sterile field.
 2. After sterile package is opened, edges are considered unsterile.
- C. Solutions.
1. Intravenous and irrigating solutions must be sterile.

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2. Lip of sterile bottle or ampule is non-sterile unless packaged with sterile cap at manufacturer.
3. Avoid splattering solutions when pouring onto sterile surfaces.
4. Avoid contaminating rims of sterile bottles when opening.
5. When pouring sterile solutions into sterile basin, only lip of bottle should be over sterile field.
6. Entire contents of bottle should be poured or remainder discarded.
7. If ampule or vial top is contaminated, wipe edge or stopper with alcohol wipe before pouring.
8. To break ampule, wipe with alcohol sponge and break into sponge. Edge is contaminated and needle used to remove contents to be discarded.

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D. Operating room environment.

1. Drapes handled gently to avoid scattering lint and disturb air around sterile areas.
2. Only top surface of a draped table is considered sterile. Any item that extends beyond the sterile boundary is considered contaminated and not brought back on sterile field.
3. Whenever sterile barrier is permeated, it must be considered contaminated.
 - a. Contamination from direct contact between sterile and unsterile items.
 - b. Less apparent modes (strike-through) passage of liquids through materials and undetected perforations in materials.
4. Dusting in operating rooms must be damp dusted. Lights over operating table, flat surfaces and O/R table are done at least 1/2 hour before first case of the day. Flat surfaces are done between cases including O/R table and any soiled furniture or equipment.
5. Floors are considered contaminated and cross-contaminated and must be mopped with disinfectant solution between procedures and cleaned thoroughly at end of day.

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E. Operating room personnel.

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1. Persons who have scrubbed, gowned and gloved touch only sterile articles.
Persons, who have not, touch only unsterile items.
2. Scrub personnel:
 - a. Do not touch below table level or bring items up that are below table level.
 - b. Consider sterile gowns sterile in front from chest to table level; sleeves sterile to 2 inches above elbow; neckline, shoulders, underarms and back are not considered sterile.
 - c. Drapes table first toward self, then away and protects gown and gloves by cuffing drape.
 - d. Guards sterile field to prevent contamination from unsterile item.
 - e. Stands at safe distance from operating table when draping patient.
 - f. When passing another, pass sterile to sterile, un-sterile to unsterile. (Front to front; back to back.)
3. Circulating nurse.
 - a. Keeps hands below or under sterile table drapes.
 - b. Faces sterile objects, maintaining at least 2 feet distance.
 - c. Does not reach over sterile field. Asks scrub personnel to remove items as necessary to accomplish this.
 - d. Knows shaking packages over sterile field is an unacceptable technique.
 - e. Does not touch sterile field or item or allow any unsterile item to contaminate sterile field.
 - f. Approaches sterile areas facing them and never walks between two sterile fields.
4. Operating team - personal hygiene.
 - a. Fingernails should be short and clean
 - b. Persons with respiratory ailments or skin conditions must not scrub or circulate in operating room.
 - c. Axillary area is considered unsterile; arms are never folded because of perspiration.
 - d. Infectious personnel will be sent off duty or assigned to different areas not involving direct patient care.
 - e. Personnel are to wash hands thoroughly when first reporting on duty and before every procedure.
 - f. Only authorized personnel can enter operating room suite and must be attired properly in scrub clothes, cap, mask, and shoe covers, as needed.

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g. _____ Jump suits over street clothes may be worn by non-O/R personnel. Cap, mask, and shoe covers are still to be worn.

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ASEPTIC TECHNIQUE¶
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Bacteria cannot always be eliminated from field but must be kept to an irreducible minimum. All possible means are to be used to keep bacteria to minimum and prevent gaining entrance to wound.

- a. Each patient considered potentially capable of contaminating operating room. Items used for one patient must be decontaminated and sterilized before reuse.
- b. Skin cannot be sterilized, only rendered surgically clean. Patient's skin is a source of potential contamination in every surgical procedure.
 - 1) Patients should be encouraged to take shower or bath prior to admission.
 - 2) Patient shaved, scrubbed in holding area according to surgeon's routine orders (see Pre-op shave, scrub procedure).
 - 3) Patient scrubbed and prepped in O/R. (See operative scrub and prep procedure.)
 - 4) After antiseptic prep in O/R, all skin except site of operation covered with sterile drapes.
 - 5) Knife used to skin incision is considered contaminated and is used only for other skin incisions, lengthening initial incision and/or stab wounds.
- c. Some areas cannot be scrubbed; however, an endeavor must be made to reduce bacteria by cleansing as much of the operative area as possible and scrubbing the surrounding skin thoroughly.

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DETERMINATION OF PRIOR OCCUPATIONAL DOSE

Page 1 of 1

Reviewed: August 1, 2001

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Implemented: August 1, 2001

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SUBJECT: Determination of prior occupational dose.

POLICY: All occupational workers prior to initiating work will provide the Administrator with a cumulative history of prior occupational exposure.

STATEMENT: Prior to permitting an individual to work, an exhaustive effort must be made to obtain the current year exposure records and the lifetime cumulative occupational radiation dose.

A. The Administrator will accept a written statement from the individual or from the individual's most recent employer for work involving radiation exposure that discloses the nature and the amount of any occupational dose that the individual received during the current year as a record of the occupational dose that the individual received during the current year.

B. Accepted written statements disclosing individual's prior occupational dose.

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1. HRS Form 1623.
2. Film badge company's monthly report of exposure.
3. Equivalent signed letter by the individual's current employer is acceptable.

C. The form or record shall:

1. Show each period in which the individual received occupational exposure to radiation.
2. Shall be signed by the individual who received the exposure.

If the individual is unable to obtain a complete record of an individual's current and previously accumulated occupational dose, the license or registration shall assume:

The allowable dose limit for the individual is reduced by 1.25 REM for each quarter for which records were unavailable and the individual was engaged in activities that could have resulted in occupational radiation exposure in order to establish administrative controls for the current year.

Records will be retained until this facility removes all radiation machines and terminates use of such.

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RADIATION PROTECTIVE PROGRAM

REQUEST FOR PRIOR CUMULATIVE OCCUPATIONAL DOSE

TO: Human Resources _____

FROM: -----

I was/am employed at your facility from _____ through _____ .

Please submit a complete copy of my cumulative occupational records to the
above named Administrator.

Employee Signature _____ Date _____

Employee Name (Print) _____ Employee Number _____

Please mail prior occupational to:

_____ Administrator

If you have any questions about this request, please call the Administrator at ----
Thank you for your assistance.

Facility Administrator

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DRESSING CHANGES

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Reviewed: August 1, 2001

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SUBJECT: Dressing changes.

PURPOSE: A dressing change is needed when the material put directly over the wound is soiled.

SCOPE: All nursing personnel.

POLICY: The registered nurse is responsible for carrying out the order for a dressing change and for observing the patient for the needed dressing changes and acquiring the order to do it.

GENERAL INFORMATION:

- A. Dressing provides protection, hemostasis and absorbs drainage. Dressing helps to prevent contamination or infection which is enhanced by a soiled dressing and it provides physical and psychological comfort for the patient.
- B. Equipment:
 - 1. Types of dressings.
 - 2. Cotton, gauze or fluff dressing.
 - 3. Tape - regular or non-allergic.
 - 4. Telfa.
 - 5. Antibiotic ointments.
 - 6. Elastoplast.
 - 7. Steri-Strips.
 - 8. Dressing aids.
 - 9. Binders.
 - 11. Bandages
 - 12. Sterile gloves.
- C. Maintain sterile technique.
- D. Anything that comes into direct contact with the wound should be sterile.
- E. Proper hand washing techniques must be employed before changing the dressing.
- F. Supplies must be sterilized or pre-packaged for sterile use.

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DRESSING CHANGES

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- G. Keep exposure of the wound to a minimum.
- H. Medications are applied with sterile applicators. Tongue blades and irrigation tips are never to touch the wound surface.
- I. Proper ventilation and control of air currents must be maintained to avoid moving bacteria about and contaminating wound site.
- J. Minimum handling of the contaminated dressing should be followed, and soiled dressing should be placed in biohazard bag, which is located in the PACU.

PROCEDURE:

- A. Explain procedure to the patient and answer any questions he/she may have.
- B. Gather all necessary equipment.
- C. Check order for dressing change.
- D. Remove soiled dressing, placing contaminated dressing in biohazard bag. Use gloves to remove dressing.
- E. Re-glove with sterile gloves to apply clean dressing to maintain sterility.
- F. If ordered, use an antibacterial agent to clean wound.
- G. Place clean dressing over wound using choice of dressing, such as Telfa, Collodion, Steri-Strips and/or dressing sponges.
- H. After new dressing has been applied, secure dressing firmly with tape.
- I. Chart on the records what you have done and any observations you have noted.

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DUTIES OF O/R PERSONNEL

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Reviewed: August 1, 2001
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Implemented: August 1, 2001
03/05/09

SUBJECT: Duties of O/R personnel.

PURPOSE: Standards of practice provide quality patient care.

SCOPE: All operating room personnel.

POLICY: CIRCULATING NURSE:

- A. To make sure patient receives good nursing care while in the Operating Room.
- B. To be able to coordinate the activities in the Operating Room to ensure safe patient care.
- C. To recognize emergency situations and institute established procedures for specific situations.
- D. To know and carry out Good Principles of Aseptic Technique.
- E. To know the limits of his/her capabilities and ask for assistance when necessary; be alert, calm and courteous at all times.
- F. To be able to assist the Anesthesiologist and Surgeon.
- G. To position patient properly, with approval of Anesthesiologist and/or Surgeon.
- H. To be able to identify and select instruments and equipment necessary for surgical procedures and to know the sterilization method of choice for each.
- I. To know and be able to direct the Scrub Nurse's objectives and duties.

PROCEDURE:

DUTIES OF CIRCULATING NURSE: Follow work assignment in logical sequence.

The circulating nurse is the professional nurse who supervises the activities within an Operating Room, acts as coordinator and teacher. He/she is the key person in coordinating all activities in the room. He/she is the watchdog for aseptic technique and must insist on strict adherence to principles of asepsis at all times.

- A. Receive assignment and ask questions about procedures unfamiliar to you.

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REQUEST FOR PRIOR CUMULATIVE OCCUPATIONAL DOSE¶
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TO: Human Resources . . .¶
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FROM: -----¶
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I was/am employed at your facility from through _____.¶
¶
Please submit a complete copy of my cumulative occupational records to the ¶
¶
above named Administrator.¶
¶
¶
Employee Signature . . . Date¶
¶
¶
Employee Name (Print) . Employee Number¶
¶
_____.¶
¶
Please mail prior occupational to:¶
¶
Administrator¶
¶
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¶
If you have any questions about this request, please call the Administrator at --.¶
¶
Thank you for your assistance.¶
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¶
Facility Administrator¶
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DUTIES OF O/R PERSONNEL

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1. Know procedure, check doctor's preference card and other written procedures. Obtain help if needed.

B. Prepare room for surgery:

1. Go to room assigned and check equipment, suction and instruments for case. Make sure everything is in working order and replace as needed.
2. Check initial cleaning of room and wipe down surfaces of equipment, lights, bed, table, etc., with cleaner before case begins.
3. Have correct set-up in room and open sterile supplies needed for case, no longer than 1 hour before scheduled time.
4. Know time of scheduled case and be ready.
5. Set up surgical prep tray with Surgeon's choice of solutions.
6. Have available in room any bed attachments needed for positioning patient, i.e., stirrups, head brace, arm board, pillow, etc.
7. Check and count needles, blades, instruments, sponges and laps, where applicable.
8. Give scrub personnel saline, water and medications, as necessary.

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C. Prepare patient for surgery:

1. Introduce yourself, check patient's chart against wrist band; ask patient's name and date of birth. Inquire about allergies, procedure, and the last time patient had anything to eat or drink. Check to be sure permit has been properly filled out and signed.
2. Check chart and patient for appropriate Pre-Op preparation.
3. Bring patient into room with Anesthesiologist's approval. Transfer patient to O/R table after verifying stretcher and bed are locked.
4. Position patient on OR bed, securing strap in proper placement (usually above the knees).
5. Assist Anesthesiologist, as requested. Be available at patient's side during induction of anesthesia. Never leave the room at this time.

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DUTIES OF O/R PERSONNEL

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6. Assist with any changes in positioning, making sure of patient's safety and comfort.
7. Adjust light to position.
8. Prepare operative area with Surgeon's choice of scrub and solution.

D. After patient is draped:

1. Assist scrub nurse in positioning tables.
2. Provide stools, if needed.
3. Place kick-buckets in convenient place to receive discarded sponges.
4. Connect suction, cautery, and other equipment, if used.
5. Provide saline, water and supplies, as needed.
6. Ask Surgeon for Pre-Op diagnosis.

E During Case:

1. Remain in room at all times unless properly relieved or absolutely necessary. Ask Anesthesiologist's permission to leave, if necessary.
2. If local anesthesia is being administered, explain procedure and reassure patient continually of procedures performed, always keeping in mind patient's modesty.
3. If anesthetizing medication is to be injected, show bottle of medication to scrub person. Check for correct solution dose and be sure drug is not outdated.
4. Guard safety of patient. Watch for and correct any factor that could mean harm to the patient.
5. Control traffic and noises in room. Avoid unnecessary movement and conversation. Try to relieve tension and do not cause tension in room.
6. Keep room in order. Collect equipment used and put in one area, ready to be removed at one time.
7. Keep sponges ready for count according to procedure; remove dropped items from floor.

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8. Constantly observe surgical field and replenish items used, contaminated, or needed for procedure.
9. Observe sterile technique at all times. If there is a break in technique, it must be corrected immediately and properly.
10. Maintain safe environment in OR at all times.
11. Keep accurate and legible records. Records are important, but do not neglect patient or team to tend to them.
12. Fill out operating record and tissue request forms if applicable.
13. Specimens are the circulator's responsibility as soon as they are handed from the field. Label correctly, immediately.
14. Wash hands thoroughly as needed and between cases.

F. While wound is being closed:

1. Do first applicable counts as first tissue layer is being closed; do second count as subcutaneous layer is closed.
2. Have dressing supplies ready and PACU stretcher available.
3. Give scrub personnel dressings.

G. At end of case:

1. Assist with dressings.
2. Assist in transferring patient to stretcher.
3. Escort patient with Anesthesiologist to PACU and give report.
4. Make sure closing times are on Operating Room Record and that it is filled out correctly.
5. Assist with cleaning, preparation and set-up for the next procedure.
6. Take dirty linen and trash to appropriate areas.

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- H. Put away unused supplies. Restock supplies in room and prep table. Assist in preparing supplies and instruments and in setting up rooms for the next day.

POLICY: SCRUB PERSONNEL:

- A. To know Principles of Aseptic Technique.
- B. To be able to identify and select instruments and equipment necessary for surgical procedures.
- C. To know all of the sterilization methods of choice for special equipment and instruments necessary for surgical procedures.
- D. To be able to competently assist the Surgeon during the operative procedure by anticipating the Surgeon's needs and placing the necessary sterile equipment, supplies and sutures into his/her hands.
 - 1. By anticipating Surgeon's needs you expedite the procedure, thereby minimizing the patient' exposure to trauma and unnecessary time under anesthesia.
 - 2. Know various types of sutures and needles and where they are used.
- E. Recognize emergency situations and institute established procedure for a specific situation.

PROCEDURE: DUTIES OF SCRUB PERSONNEL:

- A. Receive assignment and ask questions about operations unfamiliar to you.

Know procedure; check doctor's preference card and other written procedures. Obtain help, if needed.
- B. Prepare room for surgery.
 - 1. Go to room assigned and help circulating nurse check equipment.
 - 2. Assist with initial cleaning of room.
 - 3. Have correct set-up in assigned room and assist in opening of sterile supplies needed for case.
 - 4. Know time of case scheduled and be ready.

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DUTIES OF O/R PERSONNEL

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5. Open gown and gloves before scrubbing.
 6. Scrub according to procedure using proper time recommended by manufacturer of scrub agent being used. Don gown and gloves.
- C. While patient is being prepared by circulating nurse:
- Complete setting up procedure and gown and glove doctors.
- D. After patient is pronounced ready for surgery by Anesthesia and is prepped:
1. Assist Surgeon with draping.
 2. Move mayo stand and instrument tables into place.
 3. Hand suction equipment cords and cautery ends to circulator to attach.
 4. Count needles, blades and sponges, when applicable, with circulating nurse before operation begins and when closure starts.
- E. During Case:
1. Anticipate intelligently and in a timely manner, surgeon's needs and provide necessary equipment, suture and supplies throughout the case. When handling instruments, do so in a firm manner so that they can readily be grasped by Surgeon in position for use.
 2. Constant attention is given to the incision.
 3. Keep sterile field neat, uncluttered and safe.
 4. Guard sterility of field and instruments and try to prevent sterile drapes from becoming wet.
 5. Avoid tension-creating situations. Remember that much criticism is due to tension and strain. Do not answer back or try to make excuses or explanations during the case.
 6. Personally responsible for handing off specimens to the circulating nurse with correct, accurate labeling of specimen.
- F. While wound is being closed:

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DUTIES OF O/R PERSONNEL

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1. Do first applicable counts as doctor starts to close first tissue layer.
2. Do second count as subcutaneous tissue is being closed.
3. Have supplies ready for dressing before they are needed. Have a wet and dry sponge on your mayo stand for use before dressing is applied to clean prep solution from skin.

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G. At completion of case:

1. Assist Surgeon with dressing.
2. Check drapes for instruments and return them to dirty table.
3. Remove dirty drapes, place in plastic bag.
4. Remove knife blades, needles, suture needles and any other sharps and discard in sharps container.
5. Open soiled instruments and place in water basin. Irrigate suction or cannulas.
6. Gather dirty suction canister, heavily soiled sponges and other contaminated materials. Place in red bag and dispose of per procedure in decontamination area.
7. Before leaving room, remove gown and gloves worn during procedure and apply clean gloves for decontamination of instruments and room.
8. Take dirty instruments to decontamination area, manually clean per procedure with disinfectant.
9. Assist with taking dirty linen and trash to appropriate area.
10. Assist with cleaning, preparation and set-up for the next procedure.

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Greater New Orleans Surgery Center

LOGGING IMPLANTS

Page 1 of 1

Reviewed: August 1, 2001
8/01/03, 05/01/2009

Implemented: August 1, 2001

SUBJECT: Logging implants.

PURPOSE: To keep a running record of all-implantable items; i.e., prostheses, as requested by the Federal Government.

SCOPE: All perioperative nurses.

POLICY: The perioperative nurses will follow proper procedure in logging implants as requested by the Federal Government.

PROCEDURE:

A. Charting:

Pertinent information regarding implantable items; i.e., prostheses, will be recorded on the patient's permanent O/R record such as:

1. Description of item.
2. Size.
3. Lot # or Control #.
4. Serial #.
5. Amount used.

B. Logging:

The implant log book will be kept in the financial system, and all pertinent information will be recorded in this log. The log is kept by patient's name, date of visit, and doctor of visit.

- Item Type, ID (from Inventory module) and Description
- Manufacturer
- Size
- Model #
- Lot # or Control #.
- Serial #.
- Expiration date, if applicable.

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Page 1 of 1 Reviewed: August 1, 2001 August 1, 2003¶

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SUBJECT: Intraocular lens implants.¶

¶

PURPOSE: To provide a safe and efficient method for treating lens implant patients while complying with clinical investigation procedure mandates.¶

¶

SCOPE: All operating room personnel.¶

¶

POLICY: Operating room personnel will follow proper procedure for intraocular lens implantation, providing a safe environment for patients undergoing this procedure.¶

¶

PROCEDURE: ¶

¶

<#>Surgeon will book case through surgery scheduler.¶

¶

<#>Intraocular lens model and size requested for that patient may be taken at time of booking by surgery scheduler and entered in lens book or given to nurse in O/R. If unusual lens request is made, surgery scheduler should bring it to the attention of nurse responsible for (... [1]

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Greater New Orleans Surgery Center

SPONGE, SHARPS AND INSTRUMENT COUNTS

Page 1 of 3

Reviewed: August 1, 2001

8/01/03, 05/01/2009

Implemented: August 1, 2001

SUBJECT: Sponge, sharps and instrument counts.

PURPOSE: To ensure high quality patient safety through prevention of loss of countable items during the intra-operative phase of patient care.

SCOPE: All operating room personnel.

POLICY: A sponge, sharps and instrument count will be carried out on any procedure in which a body cavity is entered or where the potential for loss of a sponge, instrument or needle is possible.

PROCEDURE:

- A. Sponges:
1. An initial sponge count should be taken on surgical procedures. (Example - Ray-Tecs, laparotomy pads.)
 2. Subsequent sponge counts taken if deemed necessary.
 - a. Additional sponges added to sterile field.
 - b. Before closure of any deep or large incision or body cavity incision.
 - c. After closure of any body cavity incision.
 - d. Time of permanent relief of scrub or circulating person.
 - e. Immediately before completion of surgical procedure.
 3. Sponges should be counted audibly with scrub and circulating persons concurrently viewing each sponge as it is counted.
 4. Count results are to be documented on the O/R record.
 5. Counted sponges should remain within the operating room until end of procedure.
 6. Sponges used during a surgical procedure should be x-ray detectable.
 7. Only non-x-ray detectable sponges should be used as dressings.
 8. Used saturated sponges should be placed in bio-hazard bag, labeled properly and disposed of in bio-hazard container at end of each procedure.

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RADIAL KERATOTOMY AND ENHANCEMENT¶

Page 1 of 2 Reviewed:
August 1, 2001¶
. August 1, 2003¶
. Implemented: August
1, 2001¶

¶
SUBJECT: Radial keratotomy and enhancement.¶

¶
PURPOSE: To be used as an outpatient treatment for myopia and/or astigmatism.¶

¶
SCOPE: All perioperative nurses.¶

¶
POLICY: Perioperative nurses will follow the procedure for radial keratotomy and enhancement, providing a safe environment for patients undergoing this procedure. . . .¶

¶
PROCEDURE: ¶

- ¶
A. Preop:¶
- ¶
1. Admit one hour prior to procedure.¶
 - ¶
2. Fill out Admission Questionnaire for local patients.¶
 - ¶
3. H&P to be completed by physician.¶
 - ¶
4. No lab work required.¶
 - ¶
5. Have patient sign Consent Form.¶
 - ¶
6. Take vital signs.¶
 - ¶
7. Note allergy history.¶
 - ¶
8. Apply name band; apply allergy band, if applicable.¶
 - ¶
9. Administer pre-op sedation per physician's orders between 30 minutes and 1 hour pre-op.¶
 - ¶
10. Instill topical anesthetic to operative eye per physician's order.¶
 - ¶
11. Patient will put on hat, booties and cover garment over their clothing.¶
 - ¶
12. Patient will remain in pre-op area until time of surgery.¶

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SPONGE, SHARPS AND INSTRUMENT COUNTS

Page 2 of 3

9. If the count is correct or incorrect, the surgeon is always notified. The surgeon is to acknowledge the count.

B. Sharps:

1. Sharps (Example - needles, blades.) should be counted on surgical procedures.
2. Subsequent sharps counts taken if deemed necessary.
 - a. Additional sharps added to sterile field.
 - b. Before closure of any deep or large incision or body cavity incision.
 - c. After closure of any body cavity incision.
 - d. Time of permanent relief of scrub or circulating person.
 - e. Immediately before completion of surgical procedure.
3. Sharps should be counted audibly with scrub and circulating persons concurrently viewing each sharp as it is counted.
4. Count results are to be documented on the O/R record.
5. Counted sharps should remain within the operating room until end of procedure.
6. Sharps broken during a procedure should be accounted for in their entirety.
7. Sharps should be contained in puncture resistant impervious containers and confined to ensure proper safe disposal.
8. At end of surgical procedure, sharps will be disposed of in bio-hazard sharps container.

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C. Instruments:

1. Instruments should be counted on procedures in which a body cavity is entered and a potential for loss of an instrument is possible.
2. Subsequent instrument counts taken if deemed necessary.
 - a. Additional instruments added to sterile field.
 - b. Before closure of any deep or large incision or body cavity incision.
 - c. After closure of any body cavity incision.
 - d. Time of permanent relief of scrub or circulating person.
 - e. Immediately before completion of surgical procedure.

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SPONGE, SHARPS AND INSTRUMENT COUNTS

Page 3 of 3

3. Instruments should be counted audibly with scrub and circulating persons concurrently viewing each instrument as it is counted.
4. Count results are to be documented on the O/R record.
5. Counted instruments should remain within the operating room until end of procedure.
6. At the end of the surgical procedure, instruments are carried to the soiled utility room for immediate decontamination.

D. Incorrect counts:

1. Incorrect or incomplete counts are to be reported to the surgeon immediately.
2. A reasonable search for the missing item is to be made.
3. An x-ray of the operative site is to be performed prior to the patient's leaving the Center if the count remains incorrect.
4. Incorrect or incomplete counts are to be reported to the Clinical Manager or Administrator immediately.
5. An incident report is to be completed.
6. The incorrect count will be documented on the O/R record as well as the steps taken to locate the missing item.

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Greater New Orleans Surgery Center

SURGICAL POSITIONING

Page 1 of 7

Reviewed: August 1, 2001

8/01/03, 05/01/2009

Implemented: August 1, 2001

Deleted: August 1, 2003

SUBJECT: Surgical positioning.

PURPOSE: To position the patient in proper body alignment with ample padding to ensure comfort and protection of nerves, tissues and bony prominences.

SCOPE: Surgeon, anesthesiologist, perioperative nurse.

POLICY: Perioperative nurses working with the anesthesiologist and surgeon will position the patient to provide access to the surgical site, airway, intravenous lines and monitoring devices. The position should not compromise patient's comfort, circulatory, respiratory, musculoskeletal, neurological or integumentary structures.

PRELIMINARY CONSIDERATIONS:

A. RESPONSIBILITY FOR POSITIONING:

1. The physician and or anesthesiologist will choose the position of the patient.
2. Circulating nurse is responsible for placing patient in correct position under the direction of the anesthesiologist and surgeon.
3. Circulating nurse assesses positioning needs before positioning devices are placed on the operative bed, making sure they are readily available, clean and in working order.
 - a. Stirrups
 - b. Arm supports
 - c. Kidney rest
 - d. Padding
 - e. Securing devices
4. In difficult cases or where more detailed positioning is needed or where patient is extremely obese, surgeon himself will position patient with help of circulating nurse, anesthesiologist and other O/R personnel.

B. FACTORS AFFECTING TYPE OF POSITIONING:

1. Site of patient's operation
2. Weight and height
3. Physical limitations

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SURGICAL POSITIONING

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4. Type of anesthetic agent and anesthesia used.
5. Nutritional status
6. Skin condition
7. Pre-existing disease
8. Type and length of procedure

C. QUALIFICATIONS OF A GOOD POSITION:

1. The most important factor is maximum safety for patient by maintaining patient's body alignment and tissue integrity.
2. Free respiration:
 - a. to prevent hypoxia
 - b. to aid induction of inhalation anesthesia
3. Free circulation:
 - a. to prevent post-operative circulatory disturbances. It is an established fact that sludging of blood, which occurs when the circulation is poor, disposes thrombus formation.
 - b. to permit free flow of intravenous solution
 - c. to help maintain blood pressure.
4. To prevent pressure on any nerves. Pressure on any nerve may cause paralysis or serious injury to patient.
5. Hand and feet supported to prevent wrist or foot drop.
6. No undue postoperative discomfort:
 - a. If patient's procedure is extended for a long time, he may suffer more discomfort from resulting "stiff neck" than from actual surgery.
 - b. Avoid strain on muscles of limbs and body.
7. Accessible operative area:
 - a. Permits surgeon to reach affected area as conveniently as possible.
 - b. Patient must be stabilized so he maintains position throughout operation.

EQUIPMENT FOR POSITIONING:

A. OPERATING ROOM TABLE:

1. Table consists of rectangular metal top which rests upon hydraulic wheeled base.

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SURGICAL POSITIONING

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2. Table top is divided into three hinged sections, each of which can be manipulated by means of a lever. Individual sections of table can be flexed or extended so that any desired position can be obtained. There is a cross-bar between two upper sections of table which is used as kidney elevator and is manipulated by crank at head of table.
3. Fourth section is head of table which can be lowered or raised by lever under it.
4. Each table has metal clamps along sides for insertion of different table attachments, such as screen, footboard, stirrups or arm-boards.
5. Entire table can be tilted from side to side or raised and lowered or Trendelenburg and reverse Trendelenburg. It has a lock for stabilization and also level for degree of tilt.

B. TABLE ATTACHMENTS:

Table attachments must be adequately padded to prevent trauma.

PROCEDURE - OPERATIVE POSITIONS:

A. DORSAL POSITION: Basic position with no table manipulation unless surgeon requests table raised. Used for abdominal, vein ligation, breast procedures, etc.

1. Description: Patient flat on back with head in line with body, arms and hands alongside of body with fingers extended along the buttocks unless one or both are extended on arm-board for IV therapy. If arms secured, use lift sheet tucked well under patient and table pad. Legs straight, not crossed, and secured with knee strap two inches above knees. May position pillow under knees to relieve any undue pressure to patient's back.
2. Equipment:
 - a. Lift sheet
 - b. Leg strap
 - c. Arm-boards

B. DORSAL RECUMBENT POSITION: Used for vaginal exams or catheterizations.

1. Description: Patient flat on back with arms at sides. Knees are flexed and thighs externally rotated with soles of feet resting on table.

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SURGICAL POSITIONING

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2. Equipment: Bath blanket for draping.

C. MODIFIED DORSAL POSITION: Used for hand operations.

1. Description: Patient flat on back, affected side even with edge of table. Arm of affected side on arm-board at right angle to body. If axilla involved, arm is even with lower edge of board to render it as accessible as possible. Legs straight with knee strap. Note: Avoid hyper-extending arm to prevent nerve damage.
2. Equipment:
 - a. Knee strap
 - b. Lift sheet
 - c. Clamp on arm-board if IV
 - d. Over-size arm-board

D. LITHOTOMY POSITION: Used for urological, vaginal and rectal procedures.

1. Description: If general anesthesia used, patient anesthetized in dorsal position.
 - a. Buttocks placed on pad and even with break in table.
 - b. Arms protected with padded armboards with Velcro straps to secure arms in place.
 - c. Feet put up in stirrups. If possible, both feet should be put in stirrups at the same time to prevent undue muscle strain and hip dislocation.
 - d. Foot of table dropped and patient checked to be sure buttocks even with table edge. If knee crutches are used, thighs are placed in padded crutches, making sure no undue pressure occurs.
 - e. After procedure, foot is elevated and both feet removed from crutches or stirrups at same time. Both legs should be adducted first then lowered to table slowly to prevent hip dislocation.
2. Equipment:
 - a. Stirrups
 - b. Head extension placed at foot of table and pad placed accordingly.

E. TRENDELENBURG POSITION: Used for laparoscopy, pelvic examination or any operation in which it is desirable to tilt abdominal viscera away from pelvic area for better exposure. This position is used also for shock.

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SURGICAL POSITIONING

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1. Description: Same as dorsal position until exposure is needed. Knees over lower break in table.

After patient is asleep and exposure is needed, table is adjusted at an angle of 30-45 degrees so that head is lower than feet.

At times to help keep Mayo tray low enough for scrub nurse, legs may be lowered. Knees at break in table so there will be no pressure on small area of legs which might cause phlebitis or pressure on nerves of lower legs.

2. Equipment: Same as dorsal position.

F. REVERSE TRENDELENBURG POSITION: To decrease blood supply to operative area and to facilitate breathing. Also allows abdominal viscera to slide away from epigastric region.

1. Description: Dorsal position with feet lower than head and feet placed against padded foot board.

Thyroid position: Same as above with small sand-bag or rolled towel under shoulders and headpiece broken so head drops slightly back, making a straight line from chin to shoulder. Arms straight at sides.

2. Equipment:

- a. Footboard
- b. Sandbag or small pillow for neck procedures.
- c. IV stands (2) to use as screen if needed instead of anesthesia screen.

G. PRONE POSITION: Used for skin grafts on back and excision of tumor of back, etc. Patient is anesthetized on stretcher in dorsal position and then turned onto abdomen after tubes, IV lines; monitoring devices etc. are anchored in place.

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1. Description: Patient lying face down with head turned to one side or in padded head rest with arms at side or out on arm-boards. Pillows may be placed under legs to protect bony prominences.

2. Equipment:

- a. Lift sheet
- b. Pillow rolls or frame

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SURGICAL POSITIONING

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- c. Small pillow or roll under ankles
 - d. Leg strap above back of posterior thighs
 - e. Arm-boards
 - f. Head rest (optional)
- H. JACK-KNIFE POSITION: Used for pilonidal cystectomy and rectal procedures.
- 1. Description: Modified prone position. Table adjusts to that buttocks are elevated and head and feet lowered. Sides of buttocks may be retracted by adhesive strips fastened to sides of table.
 - 2. Equipment: Same as prone plus 2" adhesive tape.
- I. LATERAL POSITION: Used for excision of cysts, etc. in areas that can only be exposed by this position.
- 1. Description: Patient on either right or left side with table slightly broken in center. Kidney rest elevated if necessary. Body of patient near edge of table with lower leg flexed, upper leg straight with pillow between legs. Arms out at angle with body with lower arm supported by arm-board. Folded sheet or pillow between arms. Knee strap above knees and 2" adhesive tape strip over hip and shoulders and attached to table on either side to stabilize patient.
 - 2. Equipment:
 - a. Knee strap
 - b. 2" adhesive tape
 - c. 2 pillows
 - d. Arm-board
- J. SIMS' POSITION: Used for rectal exams, sometimes for sigmoidoscopy.
- 1. Description: Anesthetized in dorsal position and turned on left side with buttocks and shoulder close to edge. Knees flexed, right knee more than left.
 - 2. Equipment: Same as above.
- K. LIFTING UNCONSCIOUS PATIENTS:
- 1. Anesthesiologist guards head and neck from injury.
 - 2. Secure all tubes, IV lines and monitoring devices.

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SURGICAL POSITIONING

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3. Arms are splinted or supported when intravenous is running.
4. Do not let arms or legs dangle.

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SURGICAL SKIN PREPARATION

Page 1 of 5

Reviewed: August 1, 2001

8/01/03, 05/01/2009

Implemented: August 1, 2001

Deleted: August 1, 2003

SUBJECT: Surgical skin preparation.

PURPOSE: To remove as many bacteria as possible from the operative site and surrounding area before surgery to minimize danger of infection from this source.

SCOPE: The perioperative nurse.

POLICY: Perioperative nurses will follow proper procedure for surgical skin preparation to minimize chance of infection.

PERTINENT FACTS:

- A. **SKIN:** Skin normally has an abundance of organisms, which under ordinary circumstances do not harm because our bodies are endowed with natural barriers against disease and infection. Our skin acts as a barrier to these organisms. As long as we have no cuts or abrasions to provide entry, bacteria normally present cannot penetrate it. Therefore, because the surgeon will be making an incision, we must attempt to cleanse or disinfect the skin before surgery.
- B. **SHAVE PREPS:** Routine shave preps are done in the Holding Area, O/R or by the patient himself prior to surgery.
1. Hair follicles harbor a high concentration of resident bacteria and can be a source of wound infections. Failure to thoroughly shave all hair follicles may well make the difference between a clean wound and a secondarily infected one.
 2. If the skin is shaved more than six hours prior to surgery, extreme care must be used to prevent nicking or abrading the skin, as minor wounds permit rapid proliferation of resident bacteria and often become subsequently infected by the time the surgical incision is made.
- C. **SCRUB AND PAINT PREPS:** Basic principles:
1. Clean, flat surfaces should be scrubbed and/or painted first, beginning at the surgical site and working toward the periphery of the area with ever-widening circular motions.

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Greater New Orleans Surgery Center

SURGICAL SKIN PREPARATION

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2. Several mechanical strokes should be applied over every inch of skin surface as you work out toward the periphery; however, once an area has been scrubbed, it should not be scrubbed again until the sponge is discarded.
3. Separate sponge is used for each wound. Never return to the area of the incision with a sponge used on the periphery.
4. The so-called "dirty" areas, those which harbor bacteria not normally found on the surrounding skin, are cleansed last on each round of the prep. For example, the umbilicus is considered a dirty area in relation to the surface surrounding it because it may harbor bacteria. The general rule to follow is to scrub the dirtiest part of the area last with separate sponges.

SPECIAL AREAS:

A. EXTREMITIES:

1. Foot or hand may be prepped first to avoid solution from an unclean area running over a scrubbed area. The procedure for prepping an extremity must be dictated by the location of the site of the incision.
2. Same above principle applies. You should never scrub the site of the incision with a sponge that has been used at the periphery.

B. VAGINAL VAULT:

Should be scrubbed and wiped clean following preparation of the vulva, pubic area and perineum. The vaginal canal is wiped primarily to prevent the possibility of fluid entering the peritoneal cavity. Like the mouth, the vaginal canal cannot be thoroughly cleansed or disinfected.

C. EYE:

Skin of the face and eyelid should be scrubbed and chemically disinfected. The eye, itself, should then be irrigated with a non-irritating solution at the discretion of the surgeon.

ANTIBACTERIAL CLEANSERS AND ANTISEPTICS AVAILABLE IN THE OR:

1. Betadine Scrub: Mixed with saline. Used routinely on cases except upon special request of surgeon.
2. Betadine solution: Used routinely on cases except upon special request of surgeon.

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Deleted: A. Antibacterial cleansers available in O/R for scrubbing:¶

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Greater New Orleans Surgery Center

SURGICAL SKIN PREPARATION

Page 3 of 5

3. pHisoHex: Used upon request of the doctor. Usually for facial preps or laser procedures.
4. Alcohol 70%: Nontoxic, easy and pleasant to use. Extremely bactericidal even to T.B. but not sporicidal. Used in O/R for nurses to wipe off Betadine before applying 3M plastic drapes. Should not be used as skin preparation for incision, especially when electrocautery is used because of inflammable qualities.
5. Dyna-Hex 4 or Techni-Care: Used upon request of surgeon, usually for facial preps.
6. Duraprep: Used routinely on most orthopedic cases

EQUIPMENT:

- A. Prep solutions of choice and sterile water or saline.
- B. Sterile gloves.
- C. Prep tray.

PROCEDURE:

- A. Before starting Prep:
 1. Verify (before anesthesia begins) the affected site with the patient, chart and doctor.
 2. Check with anesthesia before touching or moving patient.
 3. Position patient utilizing the principles of body mechanics and surgical positioning, under supervision of surgeon.
 4. Adjust lights over incision area.
 5. If patient is awake, explain what you are going to do.
 6. Check for patient's allergies, especially to Iodine.
 7. Be sure all catheters are open and draining.
 8. Be sure adequate skin shave prep has been done.

Deleted: pHisoHex: Used upon request of the doctor. Usually for facial preps or laser procedures. ¶

Deleted: B. Antiseptics for painting the skin:¶

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Deleted: Betadine solution: Used routinely on all cases except upon special request of surgeon.

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3. Hibiclens: Used upon request of surgeon if patient is allergic to Betadine. Use carefully on face as it can cause blindness.¶
¶
Techni-Care

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Page 4 of 5 . ¶
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Greater New Orleans Surgery Center

SURGICAL SKIN PREPARATION

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9. If prep is not adequate, wet shave prep should be done to prevent contamination by loose hair.
10. Examine patient's skin for abrasions, lesions, drainage, etc. If such is noted, report to surgeon, and note on O/R record.
11. If cautery is to be used, position ground pad appropriately on patient. Place on clean dry skin surface over a large muscle mass and as close to the operative site as possible.

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B. Prep:

1. Using information given before, scrub operative site and a generous adjacent area using light friction. Begin at the incision site and work outward to periphery using a circular motion.
2. Pay special attention to areas where there are folds of skin; i.e., axillae, pubic and umbilical areas. Use a sterile applicator if needed for these areas.
3. The surgical prep should be for 5 minutes. Orthopedic procedures require a 10 minute surgical prep.

C. Approved skin prep agents.

1. pHisoHex.
2. Betadine (Solution and Scrub).
3. Dyna-Hex.
4. Alcohol.

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D. After prep:

1. Remove all prep equipment and place into trash before case starts.
2. Never throw prep sponges in kick buckets as they may confuse sponge count.

E. Key points:

1. Too wide a prep is much better than too small an area.
2. Mechanical friction is most important in destruction of bacteria present.
3. Remember and apply Basic Principles.

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4. No flammables may be used.
5. Do not allow solutions on or under the ground pad.

For laser procedures, all prepped area must be dry. No alcohol is to be used

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USE OF HUMIDIFIER

Page 1 of 1

Reviewed: August 1, 2001

8/01/03, 05/01/2009

Implemented: August 1, 2001

Deleted: August
1, 2003

SUBJECT: Use of humidifier.

PURPOSE: To provide humidified oxygen.

SCOPE: All PACU personnel.

POLICY: Any patient needing humidified oxygen after general anesthesia will have it provided during the recovery phase at the facility.

EQUIPMENT:

- A. Flow meter.
- B. Humidifier.
- C. Sterile water.
- D. Connectors to apply oxygen to the patient.

PROCEDURE:

- A. Fill the plastic holder with water until it reaches the filled mark.
- B. Refill unit if level reaches down to the refill line.
- C. Attach tubing with mask, tent, or ETT connector.
- D. At the request of the anesthesiologist for patient's receiving general anesthesia, or at the discretion of the PACU RN, use oxygen aerosol tubing at 98% humidity, set at 10 liters per minute until they are fully reacted or discontinued by anesthesiologist's request.

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INTRAOCULAR LENS IMPLANTS

Page 1 of 1
1, 2001

Reviewed: August

August 1, 2003
1, 2001

Implemented: August

SUBJECT: Intraocular lens implants.

PURPOSE: To provide a safe and efficient method for treating lens implant patients while complying with clinical investigation procedure mandates.

SCOPE: All operating room personnel.

POLICY: Operating room personnel will follow proper procedure for intraocular lens implantation, providing a safe environment for patients undergoing this procedure.

PROCEDURE:

Surgeon will book case through surgery scheduler.

Intraocular lens model and size requested for that patient may be taken at time of booking by surgery scheduler and entered in lens book or given to nurse in O/R. If unusual lens request is made, surgery scheduler should bring it to the attention of nurse responsible for ordering lens implants.

- C. Medication orders will be taken by a nurse
- D. Patient follows routine procedure for admission to facility including pre-admission interview and preparation for surgery.
- E. The operating room staff will be responsible for completing the package inserts at the time of the surgery which include:
 - 1. A postage paid card to the manufacturer. (Fill in all appropriate data requested and required by the FDA.)
 - 2. The patient identification card.
- F. Apply lens labels to appropriate documents: O/R record, O/R implant log book and back of O/R schedule for that day of surgery.

The PACU staff may be asked to give the patient the identification card or the O/R nurse should give the surgeon the card to give to the patient.

RADIAL KERATOTOMY AND ENHANCEMENT

Page 1 of 2
1, 2001

Reviewed: August

1, 2003

August

1, 2001

Implemented: August

SUBJECT: Radial keratotomy and enhancement.

PURPOSE: To be used as an outpatient treatment for myopia and/or astigmatism.

SCOPE: All perioperative nurses.

POLICY: Perioperative nurses will follow the procedure for radial keratotomy and enhancement, providing a safe environment for patients undergoing this procedure.

PROCEDURE:

A. Preop:

1. Admit one hour prior to procedure.
2. Fill out Admission Questionnaire for local patients.
3. H&P to be completed by physician.
4. No lab work required.
5. Have patient sign Consent Form.
6. Take vital signs.
7. Note allergy history.
8. Apply name band; apply allergy band, if applicable.
9. Administer pre-op sedation per physician's orders between 30 minutes and 1 hour pre-op.
10. Instill topical anesthetic to operative eye per physician's order.
11. Patient will put on hat, booties and cover garment over their clothing.

12. Patient will remain in pre-op area until time of surgery.
13. Heparin lock policy will be waived for radial keratotomy patients.

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RADIAL KERATOTOMY AND ENHANCEMENT

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B. Intraoperative:

1. Nurse to accompany patient to operating room. Patient may be transported in wheelchair or stretcher or may be ambulatory.
2. Patient will be assisted to O/R bed and positioned according to physician's instructions.
3. Apply pulse oximeter, BP cuff and EKG. Record O₂ saturation, and B/P x 10 minutes. (O₂ will be applied 3 l/min for O₂ saturation level less than 92, as necessary.)
4. Circulating nurse to complete appropriate O/R record.
5. Physician and scrub nurse will wear scrubs, mask, hat, booties and sterile gloves during procedure.
6. Eye prep to be completed per physician's instructions.
7. Eye drape may be used if physician requests, but it is not mandatory.

C. Postoperative:

1. Patient will be ambulated with assistance to recovery room lounge. Wheelchair or stretcher may be used, if needed.
2. Vital signs will be taken upon arrival to recovery area and prior to discharge.
3. Instruction sheet given to patient. Nurse will verbally review instructions with patient and person accompanying patient home. Patient will sign copy of instructions, to be placed in patient's chart.

Patient may be discharged 30 minutes after procedure, if stable.

Patients may not drive themselves home. If they do not have someone to drive him or her home, we will provide a taxi.

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