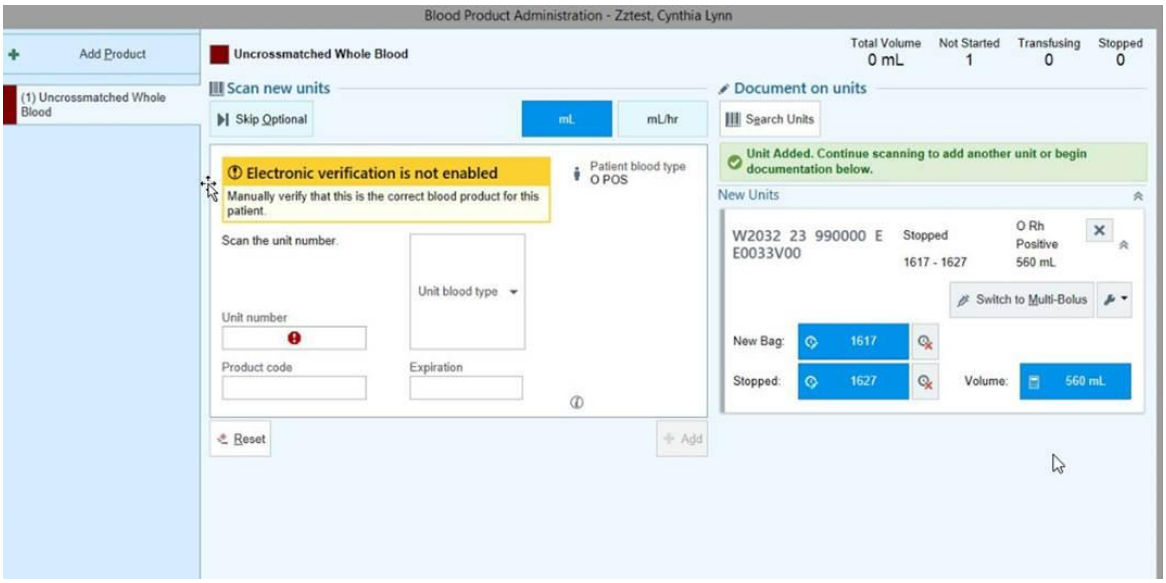
Epic Tip Sheet: OpTime
HPK: BPAM MTP/Emergency Release Blood Products

Summary

An issue has been noted based off of BPAM not flagging or preventing incompatible transfusions during MTP/emergency release blood products.

Scenario

1. When using the emergency add function in BPAM, any blood product type can be added under ***any blood product tab*** (i.e. RBC can be added as a plasma, plasma as an RBC, plasma as a cryo).



2. It is **critical** Anesthesia/Perfusion service that MTP/emergency release blood products should ONLY be given when the attached blood label is either

    a. Blank

    b. Contains the correct patient identifiers

3. Inappropriately using blood products with a different patient's identifying information will not be flagged by BPAM, and could lead to a life-threatening hemolytic reaction.

4. **Please note**: Not all MTP coolers contain group O products. If MTP coolers are inappropriately used for different patients, BPAM will not catch this error and a life-threatening hemolytic reaction could occur.

5. Please ensure that the bedside blood check is completed with a second identifier (RN, CRNA, MD, Perfusionist, Perfusion Assistant)

Epic Tip Sheet: OpTime
HPK: BPAM MTP/Emergency Release Blood Products

Date	Summary of Revisions	User
4/17/2023	Created tip sheet	Caroline Herrera
4/18/2023	Edited Tip sheet	Shamara Jones

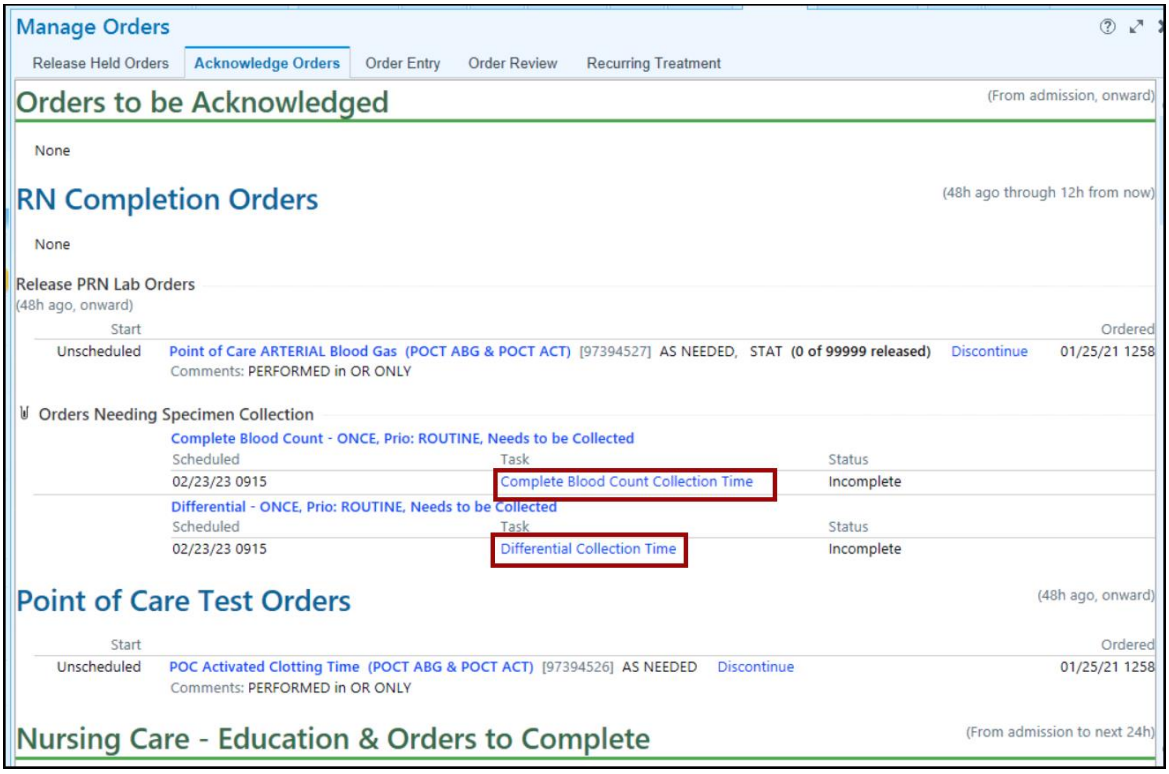
Epic Tip Sheet: OpTime
HPK: Document Lab Collection

Summary

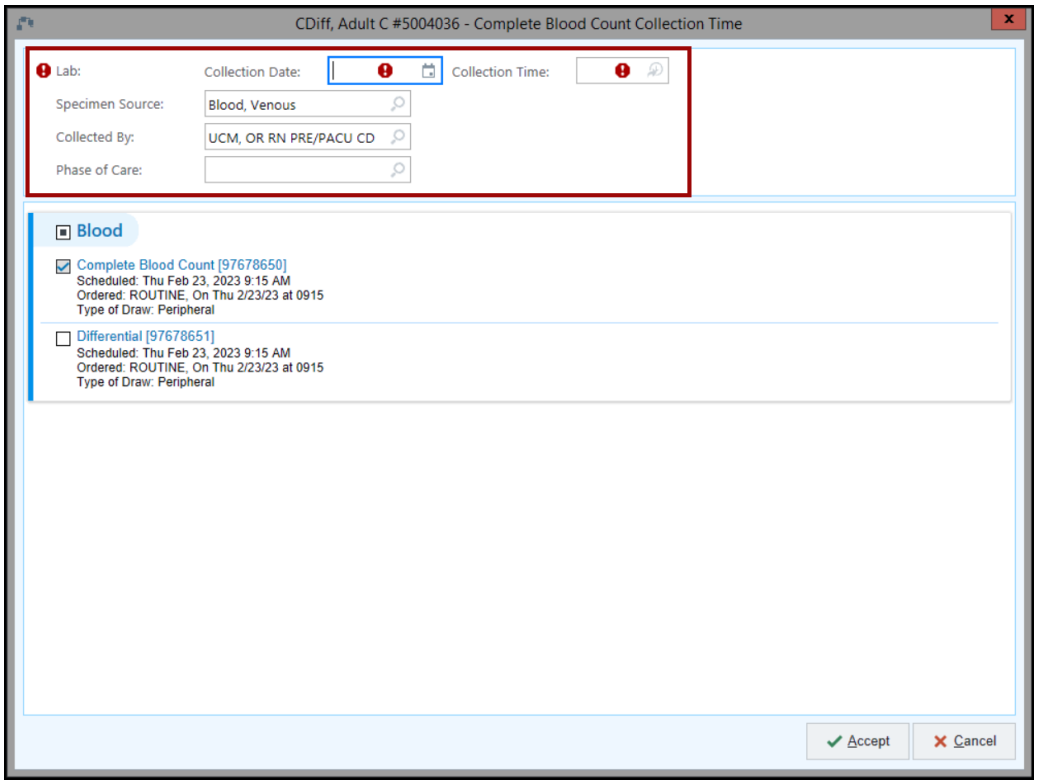
When a new lab order is placed in Epic, you will acknowledge the order and document the collection details. Completing these steps will generate and print a lab label for you.

Step by Step

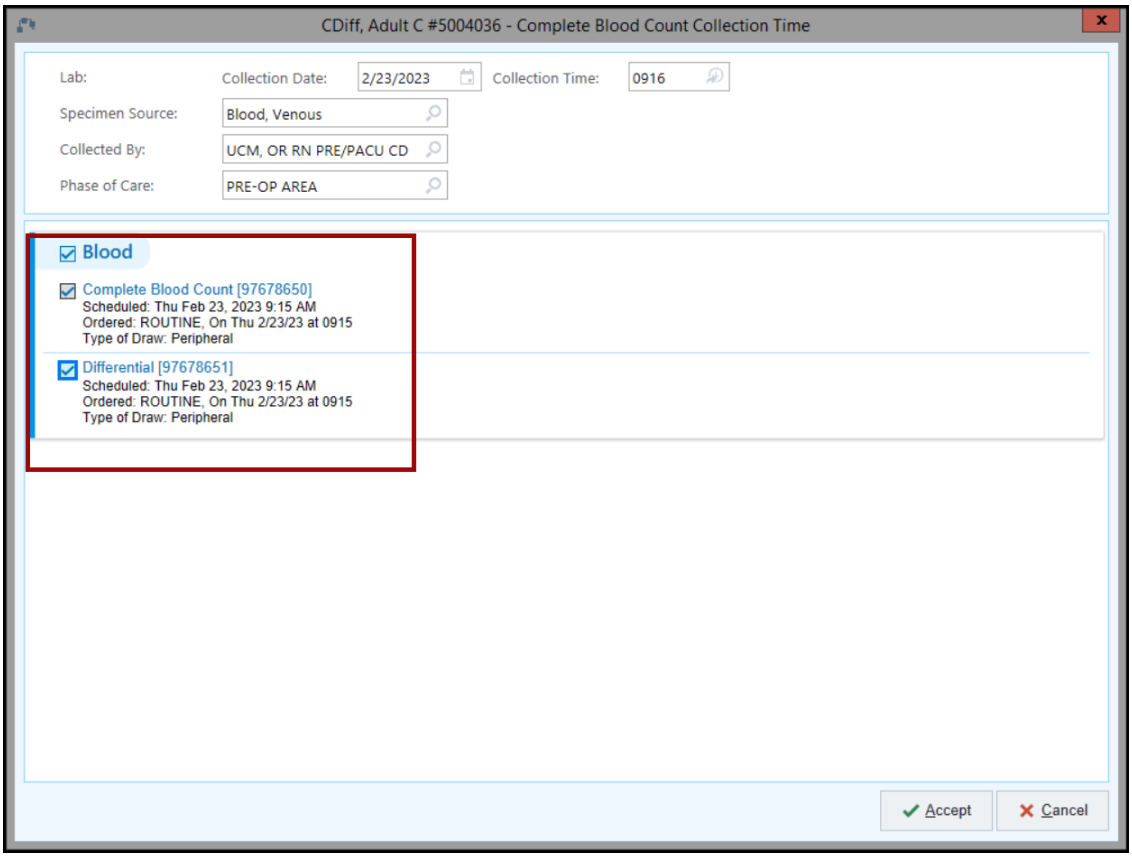
1. Go to Manage Orders
2. Click on the Acknowledge Orders tab
3. Acknowledge any new orders
4. To document that you have collected a lab specimen, click on the Complete Collection Time hyperlink



5. Update the specimen details such as collection date, collection time, and phase of care



6. Select the appropriate lab(s)



7. Click Accept. This will print out a label for you to affix to the lab specimen.

Date	Summary of Revisions	User
02/23/23	Tip sheet created	Kaitlyn Kucia

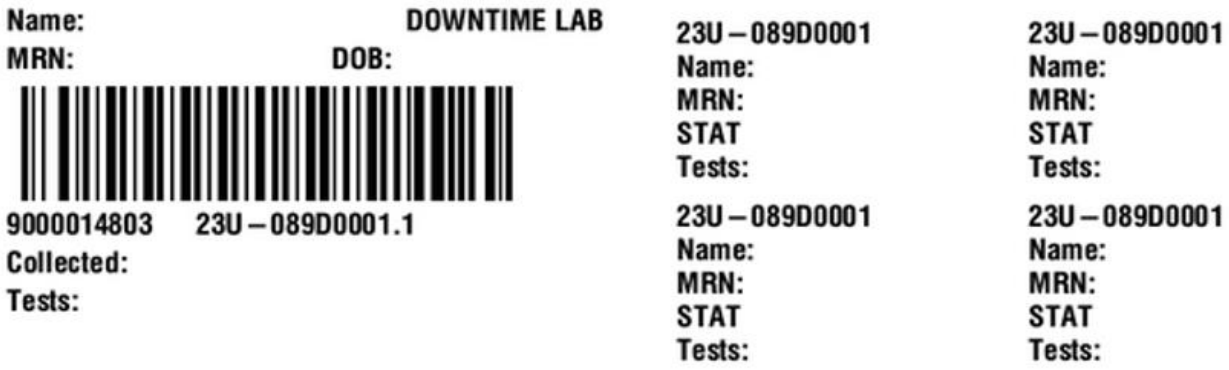
Epic Tip Sheet: ClinDoc
ALL: Lab Specimen Collection during Downtime

Summary

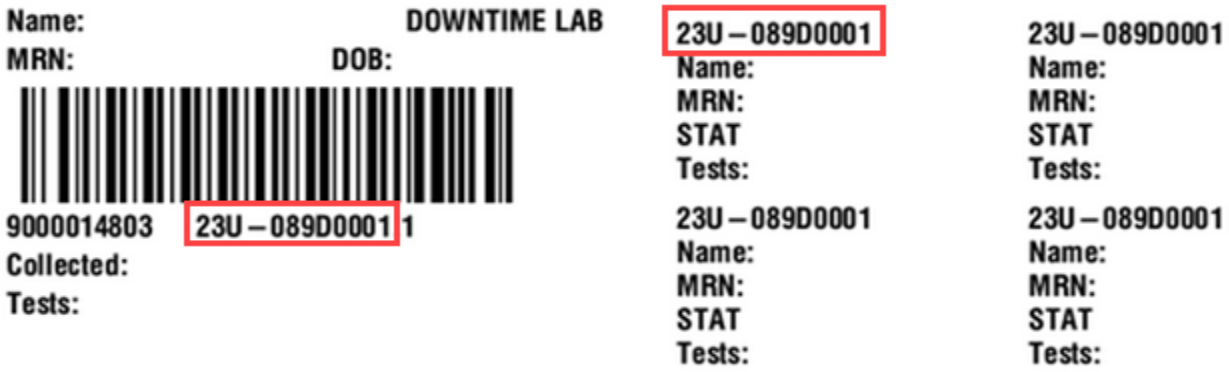
During an Epic Downtime, Lab Specimens will now require special Downtime labels. There will be 2 labels needed for each specimen. Only Lab staff have access to print a downtime label.

Step-by-Step

1. Nursing staff must place a patient chart label on the Lab requisition form and one of the completed specimen downtime labels. The second label should be affixed to the specimen and tubed to the lab.



2. The number 23U-089D0001 as seen below, is for example, the number that will match on both the requisition and specimen tube. Nurses must then complete Name, MRN, DOB, Collected (initials, date, time), and tests collected.



3. During a downtime ONLY STAT orders should be sent to lab.

4. After downtime, the Lab Service Center will entering ALL orders received during the downtime for nursing staff.

Date	Summary of Revisions	User
4/17/2023	Tip sheet created	Caroline Herrera
4/21/2023	Tip sheet updated	Caroline Herrera

Epic Tip Sheet:
Label Placement

Summary

The tip sheet below will outline how to correctly place labels on specimen tubes.

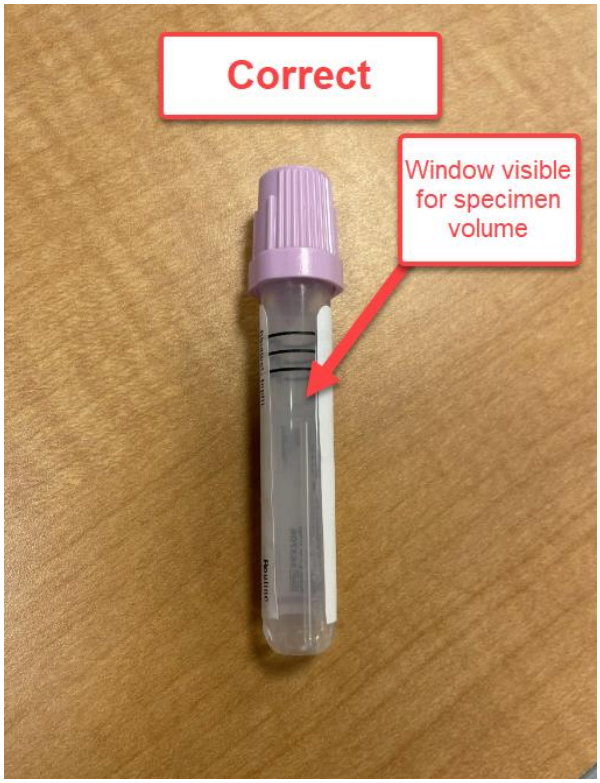
Steps

1. The label should be placed over the manufacture label.
2. The name of the patient should be placed at the top of the tube under the colored cap and should be read from left to right.
3. The vertical barcode should be wrinkle free for scanning purposes.

Epic Tip Sheet:
Label Placement

4. Each tube should have its own label.

5. Leave a window for the specimen volume to be visible.



Epic Tip Sheet:
Label Placement

6. The label should not overlap itself or wrap around the tube horizontally. Please make sure that the label is not too low where it is folding at the bottom of the tube. The label should have no wrinkles.

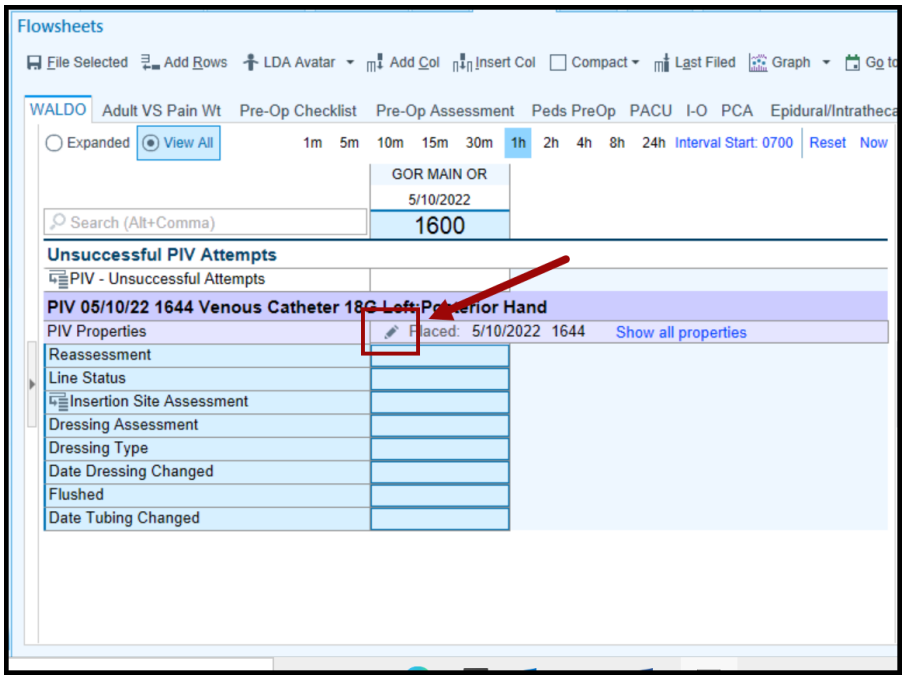
Epic Tip Sheet: OpTime
HPK: Edit or Remove Existing LDA from Flowsheets

Summary

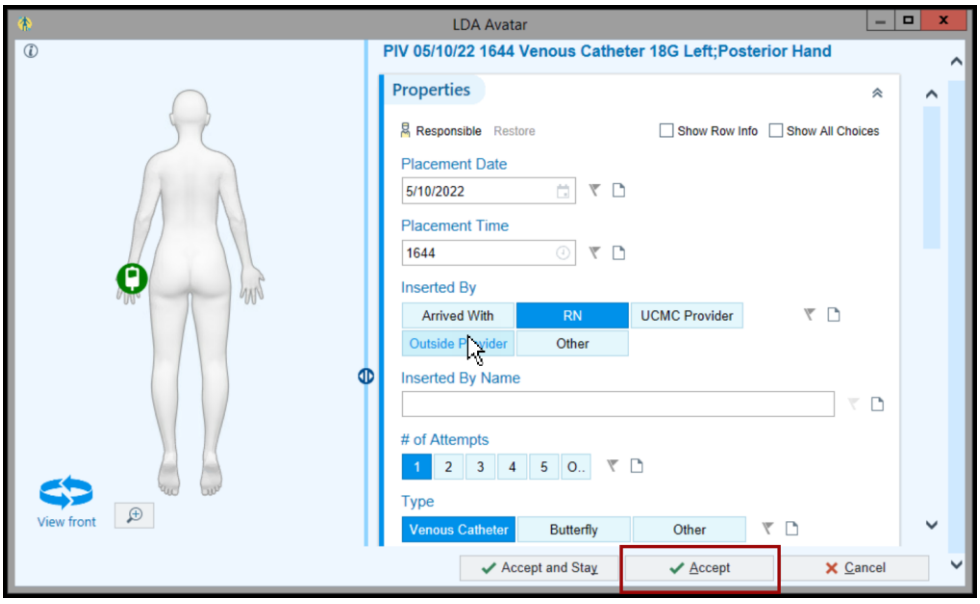
Edit or remove an existing LDA in your Flowsheets activity.

Step-by-Step

1. Click the pencil icon to access the LDAs properties report in your Flowsheets



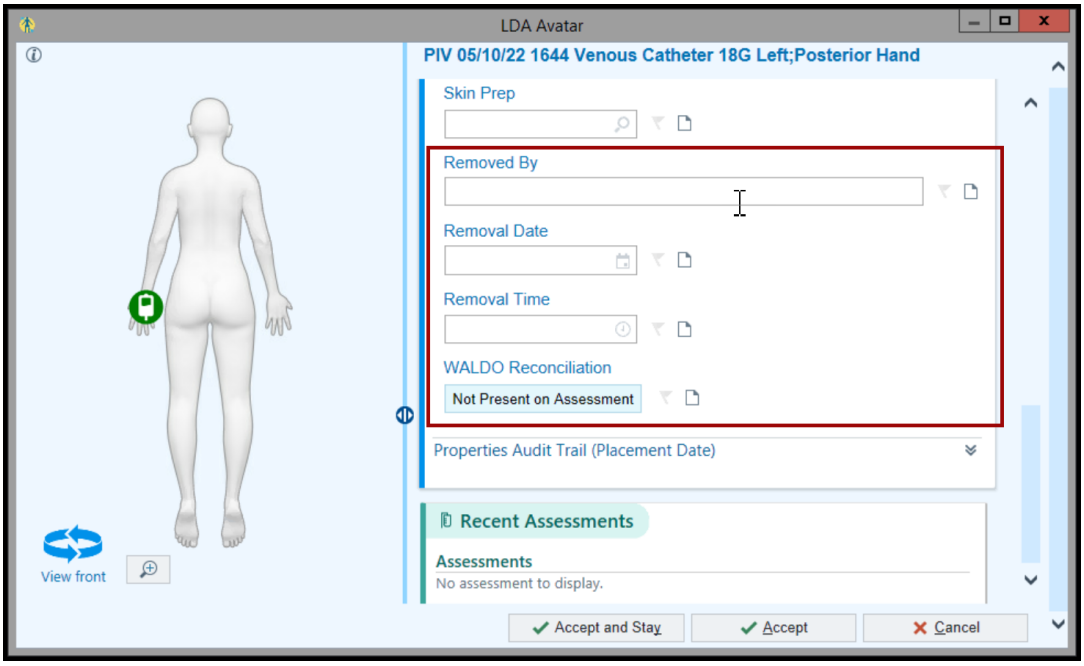
2. The LDA Avatar will open. Edit any documentation as needed & click Accept to save your documentation



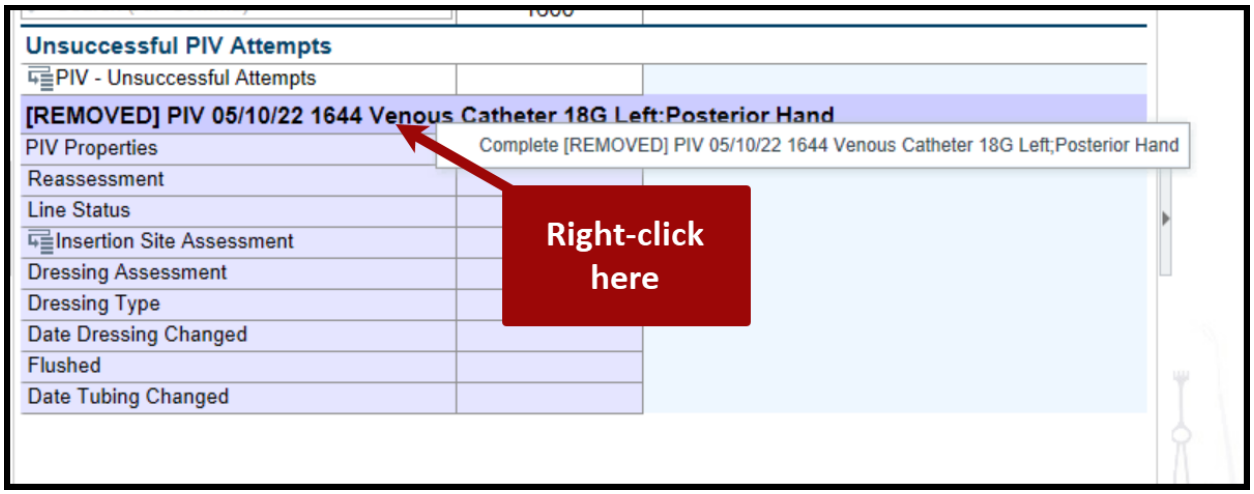
Epic Tip Sheet: OpTime
HPK: Edit or Remove Existing LDA from Flowsheets

Removing the LDA

1. To document the removal of an LDA, click the pencil icon (as shown above)
2. Enter the removal details & click Accept

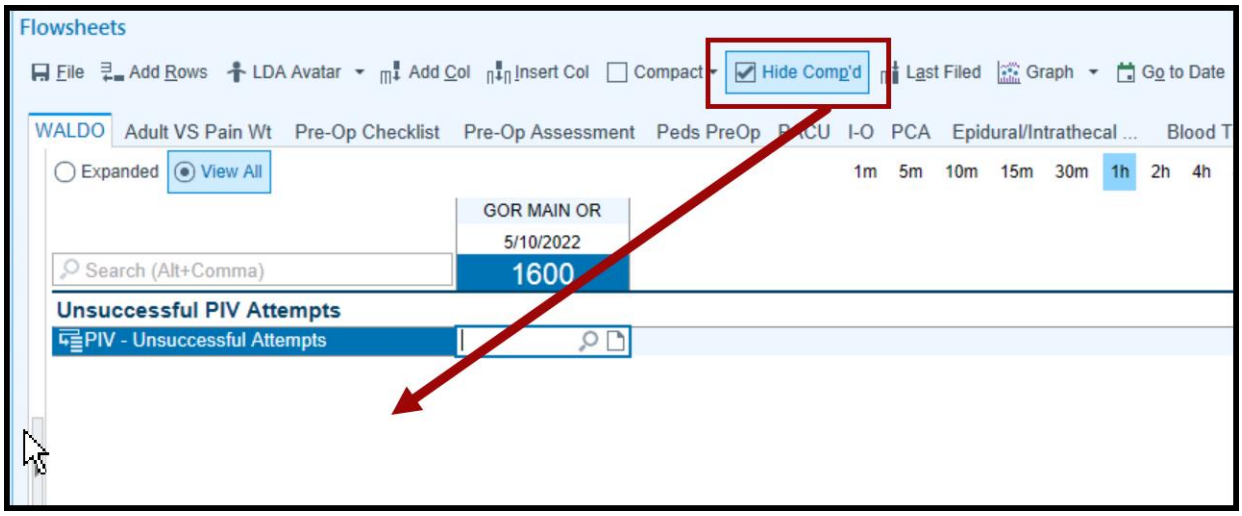


3. Once a date/time are entered for Removal, to "complete" from the flowsheet, Right-click on the LDA header and click Complete. This will actually complete it (i.e., hide it) in the flowsheet.

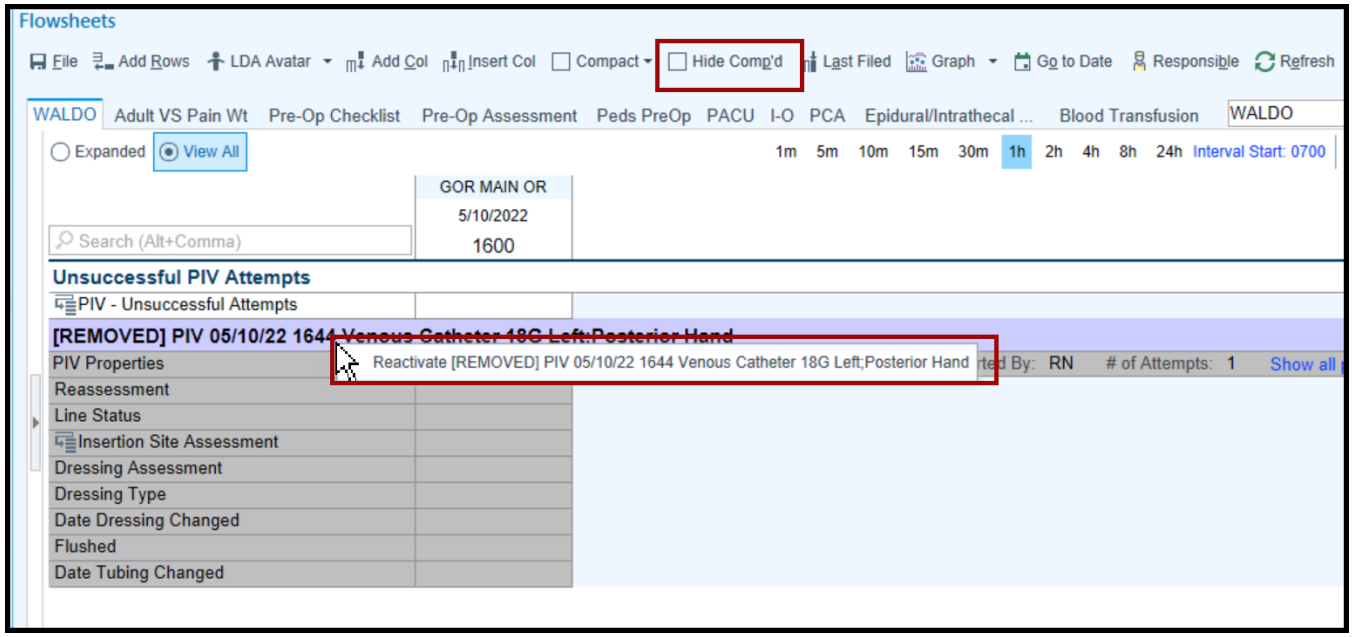


4. If Hide Comp'd is selected, this LDA's rows will now be Hidden in the flowsheet containing all the LDA property rows.

Epic Tip Sheet: OpTime
HPK: Edit or Remove Existing LDA from Flowsheets



5. Deselecting the "hide Comp'd" will still show all the rows but they are dark gray and read only until reactivated. To reactivate, right-click and select "Reactivate"



Date	Summary of Revisions	User
05/10/22	Tipsheet updated & converted to new format	Kaitlyn Burns

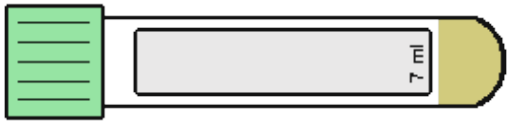
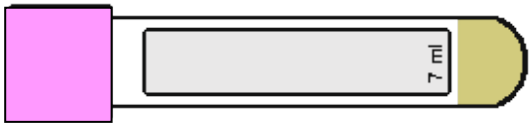
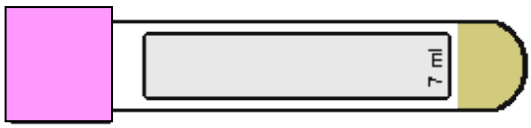
LAB TESTS / TUBE TYPES

Purple Top	
LAB	**CBC / PLATELETS**
USES	requires **full draw** - invert 8 times to prevent clotting and platelet clumping

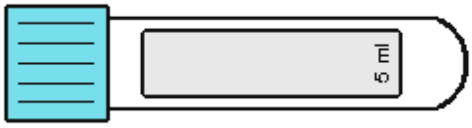
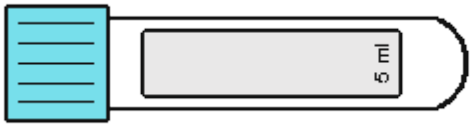
Purple Top **Blue Top**	
LAB	**DIC Panel**
USES	requires **full draw**

Light Blue Top	
LAB	**PT / PTT**
USES	**full draw** required
Light Blue Top	
LAB	**TEG**
USES	**full draw** required – invert sample tube 5 times

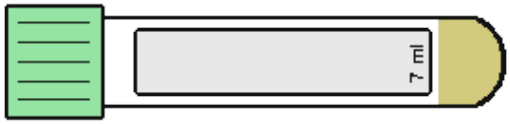
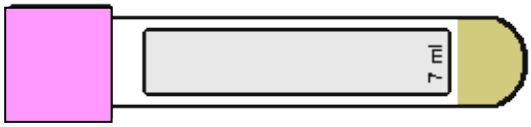
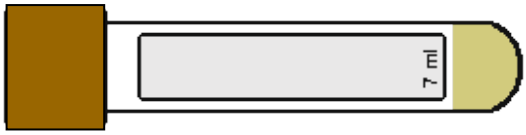
LAB TESTS / TUBE TYPES

Gold or Mint Top	 **OR** 
LAB	**BMP (Basic Metabolic Panel)**
Pink Top	
LAB	**Type and Screen**
Pink Top	
LAB	**ABO Verification**

LAB TESTS / TUBE TYPES

Purple Top	
LAB	**CBC / PLATELETS**
USES	requires **full draw** - invert 8 times to prevent clotting and platelet clumping
Purple Top **Blue Top**	
LAB	**DIC Panel**
USES	requires **full draw**
Light Blue Top	
LAB	**PT / PTT**
USES	**full draw** required
Light Blue Top	
LAB	**TEG**
USES	**full draw** required – invert sample tube 5 times

LAB TESTS / TUBE TYPES

Gold or Mint Top	 **OR** 
LAB	**BMP (Basic Metabolic Panel)**
Pink Top	
LAB	**Type and Screen**
Tan Top	
LAB	**ABO Verification**

University of Chicago Medical Center

Policy: Informed Consent for Procedures and Treatment
Policy Number: PC13
Issued: April 1989
Revised: February 2023

Policy
It is the policy of The University of Chicago Medical Center (UCMC) to provide sufficient information to patients to enable them to exercise their right to make informed decisions regarding their health care.

UCMC personnel have a legal and ethical duty to refrain from treating a patient unless treatment has been authorized by the patient or patient representative, or unless an exception to consent pursuant to this policy exists.

The patient's consent is obtained to protect the patient from unauthorized treatment and to assure that the patient is informed of the risks and benefits of treatment and reasonable alternatives. The consent process presents an opportunity for the patient and the licensed independent practitioner to establish a mutual understanding about the care, treatment, and services the patient will receive.

The information presented in the informed consent process will be provided orally using words, phrases and language which can be understood by the patient or person giving consent. The information may include written, graphic, or videotaped materials, but by itself written material alone is not sufficient. Attention should be given to assessing that the person giving consent appears to understand.

I. Definition

Informed consent shall mean that the patient has been given sufficient information by physicians involved in their procedure and treatment to make an informed decision. The following elements may be included in the informed consent process:

- Patient/legal guardian's preferred language for medical decision making is determined
- When needed the patient/legal guardian is given access to a qualified medical interpreter

- Inform the patient of the name of the physician or other practitioner who has primary responsibility for and/or will perform the patient's care, treatment, or services.
- The name(s) of the LIP(s) who will conduct the surgical/procedural intervention and administer the anesthesia
- Whether physicians other than the operating practitioner, including but not limited residents, will be performing important tasks related to the surgery
- Material risks and benefits for the patient related to the procedure and anesthesia including common side effects or complications

- The likelihood of the patient achieving his/her goals and any treatment alternatives, including the risks and benefits
- The probable consequences of declining recommended or alternative therapies
-
- Explanation of expected difficulties, recovery time, pain management and restrictions post-operatively during admission and after discharge when applicable
- Time and opportunity for the patient/parent/guardian/POA to ask questions
-

Decisional capacity means the ability to understand and appreciate the nature and consequences of a decision regarding medical treatment or forgoing life-sustaining treatment, and the ability to reach and communicate an informed decision in the matter, as determined by the attending physician.

Minor: Individual under the age of 18.

Emancipated Minor is a person who is at least 16 years of age but under 18 years of age who has been adjudicated by a Court pursuant to the Illinois Emancipation of Minors Act to be a mature minor who has demonstrated the ability and capacity to manage his own affairs and to live wholly or partially independent of his parents or guardian and who has obtained the legal status of an emancipated person with power to enter into valid legal contracts. Any Court Order that adjudicates a minor to be emancipated must be reviewed by Legal Affairs.

II. Responsibility

While the physician who will be the attending for the procedure or the treatment is responsible for assuring that the patient has been fully informed and the patient has consented to the procedure or treatment, any of the following licensed clinical professionals may inform the patient, respond to the patient's questions, and obtain the patient's consent:

- The physician or Advanced Practice Nurse or Physician Assistant who will be performing the procedure or treatment;
- Another licensed physician (including a resident)
- Another licensed APN who, pursuant to his/her collaborative nurse agreement, is qualified and permitted to perform the type of procedure or treatment;
- Another PA who, pursuant to his/her written guidelines, is qualified and permitted to perform the type of procedure or treatment.

Educational materials may be provided to the patient by a registered nurse.

The physician(s) who will be the attending(s) for the procedure or the treatment is responsible for assuring that the patient is fully informed and the patient consents to the procedure or treatment. The attending physician for the procedure or treatment continues to be responsible for assuring the patient is fully informed even if he/she is not actually performing the procedure himself/herself.

If a member of the nursing staff discovers that the patient is not fully informed, the nurse notifies the attending physician or his/her designee.

III. Consent Procedures
The physician or designee will obtain an informed consent, as defined above, from the patient or the patient's representative.

Informed consent is required:

a) For all procedures performed in the operating room
b) For all procedures and all imaging diagnostic tests performed under moderate or deep sedation, general, spinal or epidural anesthesia.
c) For all procedures with significant potential for or actual cosmetic effects;
d) For all surgical procedures;
e) For all treatments or procedures where a Medical Center's policy requires informed consent)
f) For a procedure or treatment that has more than minimal risk to a patient. What constitutes minimal risk may vary from circumstance to circumstance and is an informed decision made by the physician.

IV. Exceptions
Circumstances when informed consent is not required appear below:

A. Medical Emergency: A medical emergency is a situation where delay for the purpose of obtaining consent would increase the risk of harm to the patient. Consent in a medical emergency is implied if the patient is unable to consent. The physician must document in the medical record the nature of the emergency and the patient's inability to consent.

The following criteria must be met for the exception to apply:
- There was a medical emergency
- Treatment was required in order to protect the patient's health
- It was impossible or impractical to obtain consent from either the patient or someone
- authorized to consent for the patient
- There was no reason to believe that the patient would decline the treatment, given the
- opportunity to consent.

B. Common and Ordinary Procedures: Written informed consent is not required when the nature and probable risks of the procedure or treatment are of such a common and ordinary nature as to be within the patient's understanding and knowledge (e.g., routine phlebotomy, medication injection, x-rays etc.)

C. HIV Testing: The Admission and Outpatient treatment Authorization and Consent forms used by the Medical Center and the clinics will include the statement that HIV tests may be done on the patient, unless the patient opts out of testing. The patient's signature on this Authorization will be documentation of consent to the test. There are certain limited circumstances when HIV testing does not require informed consent. Please refer to policy A-08-13B, Consent and Result

Reporting for HIV Testing of patients and A-08-13D Consent and Result Reporting for HIV-Hepatitis Testing in Event of Accidental Exposure to Non-UCMC Employees.

V. Documentation

It is the responsibility of the attending physician who is accountable for administering the treatment or performing the procedure to ensure that informed consent is appropriately documented and placed in the patient's medical record. Consents must be placed in the medical record prior to the procedure, regardless of whether consent was obtained in an inpatient or outpatient setting.

Consent form

The Hospitals utilize a consent form to document the fact that the informed consent process occurred. It is not a substitute for the informed consent process, only evidence that the process took place.

The Consent form must contain:

- Name of the patient, and when appropriate, patient's legal guardian
- Name of the Hospital
- The name(s) of the LIP(s) who will conduct the surgical/procedural intervention physicians other than the operating practitioner, including but not limited to residents, will be performing important tasks related to the surgery
- A discussion about the proposed care, treatment and services, including a description of the proposed procedure and the anesthesia to be used if applicable.
- Indications for the proposed procedure
- Material risks and benefits for the patient related to the procedure including common side effects or complications likelihood of the patient achieving his/her goals and any treatment alternatives, including the risks and benefits
- The probable consequences of declining recommended or alternative therapies
- Common problems that might occur during recuperation
- Signature of patient or legal guardian
- Date and time consent is obtained
- Statement that procedure was explained to patient or guardian
- Name/signature of person who explained the procedure to the patient or guardian.

Progress note

A progress note describing the informational exchange between the physician and patient should be placed in the medical record.

VI. Telephone Consent

In all cases, reasonable efforts should be made to obtain consent in person from the patient or the patient's legally authorized representative. Telephone consent is permitted only when such direct consent cannot be obtained from the patient or the patient's legally authorized representative.

The physician must inform the patient of all criteria listed under Informed Consent above. Telephone consent must be witnessed by at least one person from the medical staff other than the physician. The witness should sign the consent form. To witness telephone consent, the witness must listen to the oral consent:

(1) Either at the same time; or
(2) Immediately after the physician obtaining the consent.

VII. Adult Patients

Persons 18 years of age or older with decisional capacity must consent (or refuse to consent) and sign for treatment on their own behalf. This policy applies to the following exceptions.

A. Exceptions

1. Health Care or Mental Health Agent: If a patient lacks decisional capacity to make an informed decision, the agent under a Durable Power of Attorney for Health Care or Mental Health Treatment Preference Declaration may consent to and refuse treatment on behalf of the patient, and execute any documents needed.
2. Living Will: If a patient lacks decisional capacity and is in a terminal condition, a living will is sufficient to consent to or refuse treatment. However, if a patient has both, a Durable Power of Attorney for Health Care may trump the living will.
3. Health Care Surrogate: If an agent does not exist, a surrogate, determined under the provisions of the Illinois Health Care Surrogate Act, may consent to or refuse medical and/or life-sustaining treatment.
4. Guardian of the Person: If the patient lacks decisional capacity, a court appointed guardian of the person may consent to or refuse medical treatment for their ward. For patients under the age of 18, see Section VIII below.

Ongoing, repetitive procedures (adult and pediatric) require written informed consent only at the start of the course of therapy, unless the patient's condition has significantly changed to alter the risks and benefits.

VIII. Minor Patients

Unless an exception applies, the consent of at least one of a minor’s parents or the legally appointed guardian is necessary before the minor may be treated. A non-custodial parent has the right to make decisions about health care unless a court has specifically ordered otherwise. Any such court order should be reviewed by the Office of Legal Affairs. A child, who is in the custody of or in a placement approved by the Department of Children and Family Service, requires the consent of the DCFS or its designee.

A parent may designate, in writing, that someone else may consent to the minor's treatment in their absence (e.g., a grandparent, custodial relative, babysitter). Legal Affairs should be consulted if there are any questions about such designations.

Situations in which parental consent is not required appear below:

Minors (Individuals < 18 years of age) Who May Consent to All Medical Care

Minors who fit one of the following categories may consent to ALL medical care to the same extent as a person of legal age without the consent of a parent or guardian:

- The minor is legally married.
- The minor is a parent.
- The minor is pregnant.*
- The minor has been legally emancipated by a court.

*Pregnant minors may consent to abortion services. No notification of a parent or adult family member is required.

Specific Circumstances in Which Minors May Consent to Medical Care

Minor Not Living with Parent or Guardian
A minor who is at least 14 years old, living separate and apart from his or her parents or legal guardian, managing his or her own personal affairs, and unable or unwilling to return to the residence of his or her parent or legal guardian ("minor seeking care") can give consent for primary care services if: (1) the health care professional providing such care reasonably believes the minor understands the benefits and risks of the services, and (2) the minor is identified in writing as a "minor seeking care" by an adult relative, an attorney, a school social worker or homelessness liaison, a representative of a homelessness services agency, a representative of a religious organization, or a social service agency that provides services to at risk, homeless or runaway youth.

Contraceptives and Pregnancy Testing
Health care personnel may provide confidential contraceptives and pregnancy tests to minors without parental consent if the minor is married, a parent or pregnant, referred by a physician, clergyman or planned parenthood agency, or where a serious health hazard would be created by the failure to provide these services.

Emergency Contraception (EC)
EC (the morning-after pill) is a form of contraception that women can take up to 120 hours after intercourse to stop a pregnancy before it starts. Most EC can be sold without a prescription to women and men 17 years and older. Some forms of EC are also available to those 16 and younger without a prescription or proof of age. Minors do not need parental consent to obtain EC, and confidential services may be provided.

Sexually Transmitted Infections
Minors aged 12 and over may consent to confidential testing, treatment, and counseling for and vaccination against sexually transmitted infections (STIs). Providers must report incidents of STIs to departments of health in accordance with applicable statutes and ordinances; such reports are to remain confidential. Providers are encouraged, where appropriate, to involve a minor's family in the minor's treatment for STIs, but must first obtain the minor's consent.

HIV
Minors aged 12 and older may consent to testing, treatment and counseling for HIV. Minors aged 12 and older may also consent to anonymous HIV testing. Providers must report incidents of HIV to departments of health in accordance with applicable statutes and ordinances; such reports are to remain confidential. In addition, providers are encouraged, but not obligated, to

notify a minor's parent of a positive test result if the provider has been unsuccessful in persuading the minor to do so and believes that notification is in the minor's best interest.

Sexual Assault
A minor may consent to health services associated with criminal sexual assault or abuse. Such services include emergency contraception, pregnancy tests, counseling and treatment for STIs. A minor who presents for care within seven days of the assault may consent to the use of a sexual assault evidence collection kit. Minors aged 13 and older may give written consent to a hospital to release evidence and information from the kit to law enforcement officials. If medical personnel have reasonable cause to believe that the minor is an abused child under the Abused and Neglected Child Reporting Act, the abuse may need to be reported to the Department of Children and Family Services.

Emergency Care
A minor may receive health services without the prior consent of a parent or guardian when obtaining such consent is not reasonably feasible without adversely affecting the minor's health.

Substance Abuse Care
Minors aged 12 and older may consent to confidential outpatient counseling and treatment if they or a family member abuses drugs or alcohol. Providers are encouraged, where appropriate, to involve a minor's family in the minor's treatment for substance abuse, but must first obtain the minor's consent. However, if a provider is providing counseling to such minor and believes that parental notification is necessary to protect the safety of the minor or others, the provider may inform the parent of the minor's substance abuse counseling or treatment without the minor's consent.

Mental Health
Minors aged 12 and over may consent to confidential counseling or psychotherapy on an outpatient basis. Providers of such treatment may not notify parents of the minor's treatment services without the minor's consent unless the provider believes such notification is necessary; however, in such a case, the minor must be informed of the provider's intention to disclose. If the minor is under 17, counseling or psychotherapy sessions are limited to five in number until parental consent is obtained. In addition, parents can obtain psychological records if the provider does not find compelling reasons for denying access.

XI. Documentation of Deviation from Policy
The reason(s) for any deviation from this policy must be documented by a physician in the patient's medical record.

XII. Duration of Consent
A consent does not expire within any specific time period. It may be obtained in a clinical setting prior to admission and/or surgery/procedure and be valid as long as the risk/benefit assessment has not changed since the consent was obtained. However, a patient's situation must be considered to determine if a previously executed consent is valid or whether a new consent is required. The factors to consider include (a) a change in the patient's condition or prognosis

since the time of consent, (b) a significant passage of time, especially if there has been no or limited contact between the patient and the provider, and (c) the availability of a new alternative or information about risks and benefits. Contact the Office of Legal Affairs (2-1057) for advice concerning the validity of any consent.

Please note there are specific rules concerning sterilization procedures performed on patients whose care is paid for by the Illinois Public Aid Program.

Education
All faculty, trainees, staff, administrators, interpretive services and leaders receive training and education on the processes outlined in PC 13 Informed Consent upon hire and as needed with changes in policy and procedure minimally, every 5 years. This can be done through a variety of methodology incuding but not limited to the following:

- Staff Meetings & Huddles
- Email
- CBT (Computer Based Training) Modules

Any questions and/or concerns can be directed to the Office of Legal Affairs, Patient Safety/Risk Management, Regulatory Compliance and/or the Health Informatics Team

Interpretation, Implementation and Revision
The Office of Legal Affairs (2-1057) is responsible for the interpretation and revision of this policy. Health care providers are responsible for the implementation of this policy.

Cross- References:
05-05 Patient Rights and Responsibilities
A02-11 Photographs and other Images in the Hospital
PC 12 Human Subject Research
A02-07 Child Abuse Neglect Reporting
A-08-13B, Consent and Result Reporting for HIV Testing of Patients
A-08-13D Consent and Result Reporting for HIV-Hepatitis Testing in Event of Accidental Exposure to Non-UCMC Employees

The University of Chicago Medical Center
Policy and Procedure Manual

Policy Name: Universal Protocol/Time Out
Policy: PC 38
Issued: 1998
Revised: June 2020

Policy

University of Chicago Medicine assures patient safety by employing the Universal Protocol to prevent the wrong site, the wrong procedure and the wrong patient. The Universal Protocol applies to all surgical and non-surgical invasive procedures that expose the patient to more than minimal risk. This includes procedures performed in settings other than the operating room and procedure areas (e.g. at clinics and the bedside) (Attachment A).

Prior to initiation of a surgical or nonsurgical invasive procedure, each of the components of the Universal Protocol must be followed and documented as appropriate.

Certain routine and minor procedures (e.g., placing a peripheral intravenous catheter or naso-gastric tube placement) are not within the scope of this protocol. In such cases, the proceduralist will determine whether the Universal Protocol is applicable.

Non-neuraxial regional anesthesia must perform a Time Out for each subsequent site (in the case of multiple peripheral nerve blocks) in a pre-procedural area (i.e. preoperative holding) and/or operating room and include the attending physician.

Definitions

1.Pre-procedure Verification: An ongoing process of information gathering and verification beginning with the decision to perform a procedure and continuing through all encounters in the pre-procedural preparation of the patient up to and including the time-out just before the start of the procedure.

2.Time-Out: A final assessment conducted immediately before starting a a surgical or non-surgical invasive procedure verifying that the correct patient, site and procedure have been identified. During the time out, activities are suspended to the extent possible so that team members can focus on active confirmation of the patient, site and procedure.

3.Non-neuraxial Regional Anesthesia: The administration of regional anesthesia other than subarachnoid or epidural nerve block.

4.Invasive Procedure: Generally involves a break in the skin and/or entry into tissues, body cavities, or vascular space except for insertion of peripheral intravenous catheters (PIVs).

5.Debrief: An interactive form of communication involving the immediate members

(attending physicians, fellows, residents, nurse, and anesthesia team (i.e. attending, resident or certified registered nurse anesthetist) of the procedural team which is completed at the end of an operating room case.

Required Elements of the Universal Protocol

I. Pre-procedure Verification Process

A. The purpose of the pre-procedure verification process is to ensure that all relevant documents and related information or equipment are:

1. Available prior to the start of the procedure
2. Correctly identified, labeled, and matched to the patient's identifiers
3. Reviewed and consistent with the patient's expectations and with the team's understanding of the intended patient, procedure, and site.

B. Verification and Time Out documentation of the proper patient, procedure, and site (the site includes but is not limited to laterality, digit and/or level) prior to the patient entering the-procedure/ surgical room:

1. At the time the procedure is scheduled
2. At the time of preadmission assessment
3. At the time of admission into the pre-procedure area
4. Any time the responsibility for care of the patient is transferred to another member of the procedural care team at the time of, and during, the procedure.
5. At the time of regional anesthesia administration

This step should include ensuring that the medical procedure ordered is the correct medical procedure scheduled and consented.

C. Prior to moving to the procedure room or operating suite a checklist will be utilized to confirm that the following are available, complete and accurately correspond to the patient and the procedure:

1. Relevant documentation (e.g., current history and physical examination, pre-procedure note, nursing assessment, pre-anesthesia assessment, screen for retained foreign object preventions).
2. Accurately completed and signed procedure consent form.
   Note: The consent form must include laterality, digit, level, etc.
3. Correct and properly labeled diagnostic results
   Example: Radiology images, scans, or pathology and/or biopsy reports.
4. Any required blood products, implants, devices, and/or special or critical equipment for the procedure
5. Correct prophylactic medications (if applicable for procedures)

For patients undergoing a procedure in areas that have a pre-op area, this will be done by the circulating RN at the time of arrival to the procedural suite/room.

Medications:

Antibiotics:

1. For those procedures requiring IV antibiotic administration within one hour (two hours for Vancomycin) prior to skin incision, the RN in the preoperative setting will confirm with the procedure team that an antibiotic has been started or will be started at the appropriate time if indicated.
2. Documentation of the pre-surgical antibiotic is recorded by marking the check box on the preoperative checklist. The RN in the preoperative setting should check this box only in those procedures where such administration of an antibiotic is required.

D. If information is missing or discrepancies are found, they must be reconciled with the Attending Surgeon or Proceduralist before transporting the patient to the procedure room.

E. For those patients directly admitted to the Operating Room (e.g., emergency, isolation or ICU patients), the pre-procedure verification process may be completed in the operating room.

II. Site marking

A. Site marking is required where there is more than one possible location for the procedure or when performing the procedure in a different location would compromise patient safety. For spinal procedures, in addition to preoperative skin marking of the general spinal region, special intraoperative imagining should be considered when locating and marking the exact vertebrae.

B. The procedural site must be verified and marked by the attending surgeon or proceduralist, his or her resident-designee or a licensed independent practitioner privileged to perform the intended surgical or invasive procedure.

C. Pre-procedure site marking should involve the patient when possible and should occur in the pre-procedure holding area before the patient is moved to the location where the procedure will be performed. The person marking the procedure site will mark the site with his/her initials.

D. Site marking has the following characteristics:

1. It is made at or near the procedure site or the incision site. Other site(s) should not be marked unless necessary for some other aspect of care.
2. It is made using a marker that is sufficiently permanent to remain visible after completion of the skin preparation and sterile draping. Adhesive site markers may not be used as the sole means of marking the site.
3. It must be visible after the patient has been prepped and draped and is in the final procedural position.
4. For spinal procedures, in addition to preoperative skin marking, special intraoperative radiographic techniques must be used to identify the exact vertebral level.

E. Non-neuraxial Regional Anesthesia

If the patient is to receive non-neuraxial regional anesthesia for the surgery/procedure, the

attendinganesthesiologist or his/her designee must also verify and mark the operative/regional anesthesia site with his/her initials. The nerve block may not be performed until both the anesthesiologist/designee and the proceduralist/designee have verified and marked the patient.

F. Surgical and Non-surgical Invasive Procedures Refusal:
In the event the patient refuses to have his/her surgical/procedural site marked a blue band will be initialed and placed on the wrist or ankle (on the side on which the procedure will be performed, if possible). If a patient refuses both methods, such refusal must be documented in the medical record.

G. Surgical and Non-surgical Invasive Procedures Lacking Laterality:

If the site were the procedure is to be performed does not lend itself to marking/initialing, (e.g., mucosal surfaces, premature infants, genitalia, perineum, anus, tonsils, burns), a blue band will be initialed and placed on the wrist or ankle (on the side on which the procedure will be performed, if possible).

For procedures involving teeth, a blue band will be initialed and placed and the operative tooth name(s) and/or number will be marked on the dental radiographs or dental diagram. The documentation, images, and/or diagrams must be in the procedure room before the start of the procedure.

For certain interventional procedure cases (cardiac catheterization) in which the procedure is predetermined yet the point of entry cannot definitively be determined prior to the start of the procedure or an alternate site may be utilized due to the patient's anatomy or condition, the site or point of entry is not marked. At the conclusion of the procedure the site or point of entry is documented in the medical record by the proceduralist.

For procedures involving mucosal cavities where there is only one possible location for the procedure, correct procedural site will be documented at the time of the final verification. Site marking is not required and a blue band does not need to be placed on the patient.

Due to the risk of permanently tattooing premature infants a blue band is used in lieu of marking the site.

H. Invasive Procedure Site Marking Exceptions

Site marking is not required when the individual doing the procedure is continuously with the patient from the time of the decision to do the procedure through to the performance of the procedure. However, the requirement for final time-out verification still applies. If the person performing the procedure is not in continuous attendance, site marking must occur for all procedures involving right/left distinction, multiple structures such as fingers and toes, or level(s) as in spinal procedures.

Site marking may be waived in emergency situations at the discretion of the attending physician, but this must be documented in the medical record.

III. Patient Check-In

For patients receiving procedures in the DCAM Operating Rooms, Comer Operating Rooms or CCD Operating Rooms, a patient check in/sign in will be completed by the operating room team. This will occur before the patient is transferred from patient cart/bed to the operating room table.

IV. Time Out

A time-out is conducted immediately before the start of a surgical or non-surgical invasive procedure including non-neuraxial regional anesthesia. A designated member of the surgical or procedural team is responsible for leading the Time-Out with the team. The attending surgeon/proceduralist must be present during the time-out process.

Exception: Advanced practice providers with credentials/privileges to perform procedure independently.

Resident/Fellows performing a procedure which has been identified by their training program as a procedure that they may perform independently.

The time-out will involve the immediate members of the procedure team including the proceduralist(s), the anesthesia providers (if applicable), procedural designee, the nurse(s), and other active participants as appropriate for the procedure who will be participating in the procedure at its inception. Please see Attachment A: List of Procedures performed outside of the operating rooms/procedural areas requiring the use of the Universal Protocol/Time Out documentation.

The time-out addresses the following:

- Accurate Procedural Consent
- Correct Patient
- Correct Procedure
- Correct Site- Including visual identification of site marking conducted
- Correct patient position
- Relevant images and results are properly labeled and appropriately displayed
- Availability of correct implants and any critical equipment
- Risk of retained foreign object.
- Safety precautions based on the patient history and medication use
- The need to administer antibiotic/s or fluids for irrigation purposes
- Agreement on the procedure(s) to be done

All discrepancies identified thorough the Time-Out process shall be resolved prior to initiation of the procedure.

B. The Time Out must always be conducted unless it will result in greater risk than benefit. The decision and rationale to proceed without doing so must be documented in the medical record.

C. When two or more procedures are being performed on the same patient by different surgical or procedural teams, a time-out is performed to confirm each subsequent procedure before it is initiated.

D. The site marking of the operative/procedural site should be performed prior to the patient being taken to the procedure room. If the final verification reveals that the site was not marked in the pre-procedural area, the attending surgeon/proceduralist or his/her designee must mark the site in the operating/procedural room prior to skin incision. This should only happen when the patient bypasses the pre-procedure area and goes directly to the procedure room (e.g., isolation or emergency patients).

E. The Attending Anesthesiologist, resident, and nurse must participate in the preoperative verification of the surgical site for non-neuraxial regional anesthesia.

V. Debrief

It is recommended that a surgical debriefing be completed before exiting the operating/procedural room and include the attending surgeon or proceduralist and immediate members of the procedural team (attending physicians, fellows, residents, nurse, and anesthesia team (i.e. attending, resident or certified registered nurse anesthetist).

VI. Documentation Summary

A. It is the responsibility of the physician who will perform the surgical or non-surgical invasive procedure to ensure that the informed consent is appropriately documented, including the site (laterality, digit and/or level).

B. The person scheduling the case must enter "right", "left", "bilateral", "level", "midline" or "not applicable" onto the OR schedule

C. For cases involving non-neuraxial regional anesthesia, the anesthesiologist must document verification of the site.

D. Any inconsistencies discovered during the final verification process must be reconciled and documented in the patient's medical record by the attending proceduralist before starting the procedure.

E. The nurse caring for the patient prior to the surgery will document and verify the completion of the pre-surgical verification process in the electronic medical record (EMR). Just prior to accepting the patient to the procedural or operating room the circulating nurse will review and verify relevant documentation, diagnostic results, supplies and equipment are in place. This may include but not limited to the following:

1. Accurately completed consent form
2. Site Marking
3. Implants devices or special equipment
4. Blood products, diagnostic and/or radiology results required for the procedure are

available.

F. A member of the procedural team should document the time out in the electronic medical record.

G. For those invasive procedures performed at the bedside, a member of the procedural team will facilitate and conduct the time-out. The Time-Out should be documented in the EMR by the RN or a member of the procedural team.

Attachments:

A: List of Procedures performed outside of the operating rooms/procedural areas requiring the use of the Universal Protocol.

Cross-References:

1. PC 80 Sponge, sharp, instrument, and miscellaneous item count.
2. PC 13 Informed Consent
3. A08-19 Patient Identification

Interpretation, Implementation and Revision

The interpretation, implementation and revision of this policy is the responsibility of Peri-operative Services.

ATTACHMENT A:

Procedures performed outside of the operating rooms/procedural areas requiring the use of the Universal Protocol/Time Out documentation includes but is not limited to the following:

Procedure List

- Ablation
- Cardiac Catheterization
- Cardioversion
- Central Venous Line Insertion/PICC Line Insertion
- Chest Tube Insertion
- Circumcision
- Defibrillator Insertions
- Electrophysiology Study
- EVD/ICP
- Invasive Fertility Procedure
- Interventional Radiology Procedure
- Lumbar Puncture
- Needle Localizations in Mammography
- Pacemaker Insertion
- Paracentesis
- PEG Placement
- Peritoneal Lavage
- Therapeutic or Regional Nerve Block
- Thoracentesis
- Tracheostomy

- Transesophageal Echo
- Any procedure in which requires the following:
  - Moderate Sedation
  - Deep Sedation
  - General Anesthesia
  - Regional Anesthesia
- Biopsy including but not limited to the following:
  - CT/Ultrasound Guided
  - Bone/Bone-Marrow Biopsy
  - Liver/Kidney Biopsy
  - Breast/Prostate biopsy
  - Surgical biopsy requiring sedation or anesthesia
- Endoscopy including but not limited to the following:
  - Bronchoscopy
  - Upper GI/Lower GI

University of Chicago Medical Center
Policy & Procedures Manual

PC 80: Sponge, Sharp, Instrument, and Miscellaneous Count Policy
ISSUE Date: May 1986
REVISED Date: August 2020

PURPOSE:
To provide guidance in performing sponge, sharp, instruments, and miscellaneous items counts for surgical and other invasive procedures to lessen the potential of retention of a foreign body.

DEFINITIONS:
Sponges (soft goods): Items, typically soft goods, that are used to absorb fluids, protect tissues, or apply pressure or traction, etc. Items include but are not limited to radiopaque gauze pads, cottonoids, peanuts, dissectors, tonsils and laparotomy sponges.

Sharps: Items with edges or points capable of cutting or puncturing. Items include but are not limited to, suture needles, scalpel blades, hypodermic needles, electrosurgical needles and blades, and safety pins

Instruments: Surgical tools or devices designed to perform a specific function, such as cutting, dissecting, grasping, holding, retracting, or suturing.

Miscellaneous Items: Include, but are not limited to, KOH rings, vessel clips, vessel loops, suture reels, peripheral intravenous catheters and introducers, vascular inserts, cautery scratch pads, trocar sealing caps, catheter sheaths, non-radiopaque items such as umbilical tape, other small items, and altered items. (2)

Altered Items: An altered item is an item that has been cut into two or more pieces

Unintentional Retention of a Foreign Object (RFO): Retention of a foreign object in a patient after surgery or other procedure that is discovered after skin closure is completed.

- Applicable even if the patient is still in the operating or procedure room.
- Other procedures include non-invasive procedures, such as a vaginal delivery

Intentional Retention of a Foreign Object (RFO): Any surgical material or foreign body that is knowingly left in a patient. This includes such things as packing material as well as items for which a clinical decision was made, based on an assessment of the relative risks, to leave the RFO in the patient versus removing it (e.g. a micro suture needle). If a surgical item is

intentionally left in a patient, the rationale must be included in the operative report/procedure note (i.e. packing, mesh, bioabsorbable sponges or intentional retention of broken needles, screws, etc.). Such intentional retention of a foreign body is not considered a Joint Commission Sentinel Event or a hospital acquired condition triggering an AHRQ patient safety indicator code.

Wet Read Interpretation: An immediate review and interpretation of a radiograph image.

Micro-needle: A surgical needle that, for adult procedures, is less than 13 mm in size.

POLICY:

Sponge (Soft Goods), Sharps, Instruments and Miscellaneous Item Counts will be performed to account for all items used during a surgical or other procedure in which the possibility exists for a retained foreign body. The Physician or designated licensed independent practitioner must perform an oral, rectal, or vaginal sweep, except for vaginal deliveries, if during the procedure any object is introduced into that area of the body.

SPONGES (Soft Goods):

1. Soft goods will be counted for all surgical cases and other procedures in which soft goods are used.

2. Soft goods count will be performed:

    a. Before the procedure to establish a baseline
    b. Before closure of a cavity within a cavity.
    c. Before wound closure begins.
    d. Prior to completion of skin closure or end of procedure.
    e. At the time of permanent or temporary relief of either the scrub person or the circulating nurse.

3. Sponges will be separated, counted audibly and concurrently viewed during the count procedure by two individuals. (In the Operating Room setting, one of these individuals must be an RN circulating nurse). Only x-ray detectable sponges will be used during a surgical procedure and **will not be cut or altered**. Sponges used in the Operating Room (including the Labor and Delivery Operating Room), will be bagged in a pocketed sponge counting system for visualization.

4. The bag of sponges must be available to the Anesthesiologist for estimating blood loss. All new prepackaged sterile sponges introduced to the sterile field will be counted. All counted sponges will remain within the OR during the procedure.

5. Counted sponges should not be used as postoperative packing. In circumstances where

counted sponges have been intentionally retained, the number, types, and the reason for the retention will be documented on the intraoperative or procedure note and confirmed by the Surgeon/Proceduralist. An x-ray will be taken to confirm the retained sponges have been removed.

SHARPS:

1. Sharps will be counted for all surgical cases and other procedures in which sharps are used
2. Sharps will be counted in a manner identical to that for sponges.
3. Suture needles will be counted and recorded according to the number marked on the outer package and verified by the scrub person when the package is opened. Suture packages must not be used to rectify a discrepancy in a closing needle count.
4. Sharps should be handed to and taken from the Surgeon/Proceduralist through an exchange approach.
5. All counted sharps will remain within the OR, procedural area and/or sterile field during the procedure and will be contained in an appropriate sharps box after use. One suture needle will be placed in a needle mat for each space provided.

INSTRUMENTS:

1. Instrument counts will be performed for all surgical cases and other procedures in which the possibility exists that an instrument could be retained, unless a departmental safety measure or alternative has been implemented to mitigate the risk of a RFO.
    a) Procedures in which accurately accounting for instruments is not achievable (e.g. spinal procedures) should include an intra-operative x-ray prior to skin closure.
    b) Fluoroscopy is not an acceptable verification process.
2. All individual pieces of assembled instruments (such as wing nuts or sheathes) will be accounted for on the count/instrument sheet.
3. Instruments must be counted on all blind body cavity procedures e.g. vaginal procedures
4. When additional instruments are added to the field, they will be counted when added and recorded as part of the count documentation.
5. Instruments will be counted in Central Sterile Processing when sets are assembled for sterilization. This assembly count provides a basic reference for the instrument set and is **not** to be considered the initial count before the surgical procedure.
6. Instrument counts will be performed:
    a. Before the procedure to establish a baseline
    b. Before closure of a cavity within a cavity.

c. Before wound closure begins.
d. Prior to completion of skin closure or end of procedure.
e. At the time of permanent or temporary relief of either the scrub person or the circulating nurse.

7. The final instrument count should not be considered complete until all instruments are removed from the wound and returned to the scrub person.

MISCELLANEOUS ITEMS:

1. Miscellaneous items will be counted for all surgical cases and other procedures in which miscellaneous items are used.
2. Miscellaneous items will be counted in a manner identical to that for sponges.
3. All counted miscellaneous items will remain within the OR, procedural area, and/or sterile field during the procedure and will be contained in an appropriate receptacle after use.
4. Where applicable, miscellaneous items will be counted and recorded according to the number marked on the outer package and verified by the scrub person when the package is opened.
5. Altered Items: An altered item is an item that has been cut into two or more pieces. Altered items must be included in the count process and the circulating nurse must record the altered items on the white board. A Patient Safety Report must be completed by the circulating nurse, or a member of the procedure team for any items altered. This Patient Safety Report can be submitted via the electronic Event Reporting System.

DOCUMENTATION:

1. The results of the counts will be documented in the medical record. For areas with electronic medical record documentation, the paper intra-op/ procedure record will be utilized if DOWNTIME PROCEDURES must be initiated.
2. Rationale of counts not taken will be documented in the electronic medical record. For areas with electronic medical record documentation, the paper intra-op/ procedure record will be utilized if DOWNTIME PROCEDURES must be initiated.
3. All actions taken to resolve counts should be documented in the intra-operative record.
4. The results of the X-ray must be documented in the intra-operative record.

EMERGENCY PROCEDURES:

In the event an instrument, sponge, sharp and/or miscellaneous items **count** cannot be performed prior to a surgical or other procedure, the following must be done at the end of the procedure.

1. If the patient's condition is deemed stable, a STAT RFO x-ray and "Wet Read Interpretation" should be ordered by the Surgeon/ Proceduralist. The circulating OR

nurse or a member of the procedure team, if outside of the OR, will notify Radiology. The RFO x-ray order must specify the following five elements:

- The clinical question to be answered (e.g. 'incorrect count, surgery length greater than 8 hours, BMI over 40, etc.')
- The suspected location of the RFO
- The name of the suspected foreign body
- The patient's BMI to allow for better diagnostic imaging
- The specific contact information (OR extension and OR room number) where the Surgeon/ Proceduralist can be contacted.

a. A STAT interpretation of the radiograph will be done by a Radiology Resident (or Radiology Attending).

b. The Radiology Resident (or Radiology Attending) will immediately contact the Surgeon/ Proceduralist, at the extension provided to communicate the radiograph findings, or make a recommendation for additional imaging. If the Surgeon/Proceduralist Attending is not present, the Surgeon/Proceduralist Resident, APN, Fellow or PA will notify the Attending.

c. At the Surgeon/Proceduralist Attending discretion, a STAT Radiology Attending read may be requested. Otherwise, the Radiology Attending will review the case within 24 hours.

d. At the Radiology Resident's discretion, a STAT Radiology Attending read may be requested. Otherwise, the Radiology Attending will review the case within 24 hours.

2. If the patient's condition is deemed <u>unstable</u> by the Attending Surgeon/Proceduralist or Anesthesiologist and must be moved out of the operating/procedure room, a STAT RFO x-ray and "Wet Read Interpretation" should be obtained as soon as possible upon arrival to next phase of care. The Surgeon/Proceduralist retains responsibility for ensuring the x-ray is conducted and for confirming no retained foreign object(s) exists. The RFO x-ray order must specify the following five elements:

   - The clinical question to be answered (e.g. 'incorrect count, surgery length greater than 8 hours, BMI over 40, etc.')

- The suspected location of the RFO
- The name of the suspected foreign body
- The patient's BMI to allow for better diagnostic imaging
- The specific contact information (OR extension and OR room number) where the Surgeon/ Proceduralist can be contacted.

a. A preliminary interpretation of the radiograph may be done by the Attending Surgeon/ Attending Proceduralist in the operating/ procedure room. The Attending Surgeon/ Attending Proceduralist may make the determination to proceed with wound closure and discharge of the patient to the PACU, or wait for a STAT radiograph interpretation by a Radiology Resident.
b. The Radiology Resident (or Radiology Attending) will immediately contact the Surgeon/ Proceduralist at the extension provided to communicate the radiograph findings, or make a recommendation for additional imaging. If the Surgeon/Proceduralist Attending is not present, the Surgeon/Proceduralist Resident APN, or PA will notify the Attending.

c. At the Surgeon/Proceduralist Attending discretion, a STAT Radiology Attending read may be requested. Otherwise, the Radiology Attending will review the case within 24 hours.

d. This process must be completed as soon as possible if the patient's condition is unstable.
e. At the Radiology Resident's discretion, a STAT Radiology Attending read may be requested. Otherwise, the Radiology Attending will review the case within 24 hours.

3. Documentation of an inability to perform counts should be done in the medical record.

DISCREPANCY: Any count discrepancy must be reported to the Surgeon/Proceduralist and the procedure team immediately with verbal acknowledgement from surgeon.

If the patient's condition is deemed unstable by the Attending Surgeon/Attending Proceduralist or Anesthesiologist and must be moved out of the operating/procedure room, a STAT RFO x-ray and "Wet Read Interpretation" should be obtained as soon as possible upon arrival to next phase of care.

If the patient's condition permits, the following should occur:

1. Manually inspect the operative site and sterile surgical field for the missing item(s).
2. All areas surrounding the surgical field should be visually inspected, including the floor, kick bucket, linen and trash receptacles.
3. A STAT RFO x-ray and "Wet Read Interpretation" should be ordered by the Surgeon/Proceduralist. The circulating OR nurse or a member of the procedure team, if outside of the OR, will notify Radiology. The RFO x-ray order must specify the following five elements:
    - The clinical question to be answered (e.g., incorrect count, surgery length greater than 8 hours, BMI over 40, etc.')
    - The suspected location of the RFO,
    - The name of the suspected foreign body
    - The patient's BMI to allow for better diagnostic imaging
    - The specific extension to OR and OR room number where a Surgeon/Physician of the Surgery/Proceduralist team can be contacted.
4. A preliminary interpretation of the radiograph may be done by the Attending Surgeon/ Proceduralist in the operating/ procedure room. The Attending Surgeon/ Attending Proceduralist may make the determination to proceed with wound closure and discharge of the patient to the PACU, or wait for a STAT radiograph interpretation by a Radiology Resident.
5. A STAT interpretation of the radiograph will be done by a Radiology Resident (or Radiology Attending).
6. The Radiology Resident (or Radiology Attending) will immediately contact the Surgeon/ Proceduralist, at the extension provided to communicate the radiograph findings, or make a recommendation for additional imaging. If the Surgeon/Proceduralist Attending is not present, the Surgeon/Proceduralist Resident APN, Fellow or PA will notify the Attending.
7. This process should be completed before the patient leaves the OR/procedure area, or, as soon as possible if the patient's condition is unstable.
8. At the Surgeon/Proceduralist Attending discretion, a STAT Radiology Attending read may be requested. Otherwise, the Radiology Attending will review the case within 24 hours.
9. At the Radiology Resident's discretion, a STAT Radiology Attending interpretation may be requested. Otherwise, the Radiology Attending will review the case within 24 hours.
10. The Surgeon/Proceduralist retain responsibility for ensuring the x-ray is conducted and for confirming no retained foreign object(s) exists. The STAT

RFO x-ray order must specify the following five elements:

- The clinical question to be answered (e.g. incorrect count, surgery length greater than 8 hours, BMI over 40, etc.'),
- The suspected location of the RFO,
- The name of the suspected foreign body
- The patient's BMI to allow for better diagnostic imaging
- The specific contact information (OR extension and OR room number) where the Surgeon/ Proceduralist can be contacted.

11. Document all remedial actions and outcomes in the medical record. The Attending Surgeon/Attending Proceduralist will document the count discrepancy and outcome in the dictated operative or procedure note. The OR/procedure room staff will document the count discrepancy in the medical record.

12. Complete a Patient Safety Report. This Patient Safety Report can be submitted via the electronic Event Reporting System,

13. Report the discrepancy to a departmental manager.

14. Review of the incident or near miss for cause, effect and prevention will be conducted by departmental manager and Risk Management.

PREVENTION OF RETAINED OBJECTS:

To mitigate the risk of a RFO, an intra-operative RFO X-ray must be taken and results communicated to Surgeon/Proceduralist prior to skin closure if one of the following factors is present and the possibility exists for a RFO:

1. An instrument, sponge, sharp and/or miscellaneous item count cannot be performed prior to a surgical or other procedure.

2. Incorrect final count for any reason, with the exception of micro needles measuring <13 mm which cannot be visualized on x-ray.

3. Change in planned procedure such as **urgent** conversion from laparoscopy to open procedure, or when an additional surgical team is unexpectedly needed.

4. Patients undergoing an open procedure (abdominal, pelvic or thoracic cavity) with a BMI of greater than 40, or patients undergoing a C-section with a BMI of greater than 50.

5. Any patient experiencing a significant unanticipated physiologic event (cardiac arrest, massive hemorrhage, etc.)

6. When multiple surgical teams operate on a patient and close at different times. The RFO x-ray must be performed prior to skin closure of each site and/or cavity.

7. When an intentionally retained sponge(s) or instrument(s) from a prior surgery/procedure are removed.

8. Cases length greater than 8 hours

9. Live donor organ procurement and organ transplant recipient cases with the exception of routine single kidney transplant cases.

10. When the OR nursing staff involved in the case have worked a total of 18 hours or more within a 24 hour time period.

11. When there is an incorrect count, the patient will not be charged for x-rays obtained.

12. If the patient's condition permits, a STAT RFO x-ray and "Wet Read Interpretation" should be ordered by the Surgeon/ Proceduralist. The circulating OR nurse or a member of the procedure team, if outside of the OR, will notify Radiology. The RFO x-ray order must specify the following five elements:

- The clinical question to be answered (e.g. incorrect count, surgery length greater than 8 hours, BMI over 40, etc.'),
- The suspected location of the RFO
- The name of the suspected foreign body
- The patient's BMI to allow for better diagnostic imaging
- The specific contact information (OR extension and OR room number) where the Surgeon/Proceduralist can be contacted.

13. A preliminary interpretation of the radiograph may be done by the Attending Surgeon/ Proceduralist in the operating/ procedure room. The Attending Surgeon/ Proceduralist may make the determination to proceed with wound closure and discharge of the patient to the PACU, or wait for a STAT radiograph interpretation by a Radiology Resident.

14. A STAT interpretation of the radiograph will be done by a Radiology Resident (or Radiology Attending).

15. The Radiology Resident (or Radiology Attending) will immediately contact the Surgeon/Proceduralist at the extension provided to communicate the radiograph findings, or make a recommendation for additional imaging. If the Surgeon/Proceduralist Attending is not present, the Surgeon/Proceduralist Fellow, Resident, APN or PA will notify the Attending.

16. This process should be completed before the patient leaves the OR/procedure area, or, as soon as possible if the patient's condition is unstable.

17. At the Radiology Resident's discretion, a STAT Radiology Attending read maybe requested. Otherwise, the Radiology Attending will review the case within 24 hours.

18. If the patient's condition is deemed unstable by the Attending Surgeon/Proceduralist or Anesthesiologist and must be moved out of the operating/procedure room, a STAT RFO x-ray and "Wet Read" interpretation should be obtained as soon as possible upon arrival to next phase of care. The Surgeon/Proceduralist retains responsibility for ensuring the x- ray is conducted and confirming no retained foreign object(s) exists. The RFO x-ray order must specify the following five elements:

    - The clinical question to be answered (e.g. incorrect count, surgery length greater than 8 hours, BMI over 40, etc.'),
    - The suspected location of the RFO
    - The name of the suspected foreign body
    - The patient's BMI to allow for better diagnostic imaging
    - The specific contact information (OR extension and OR room number) where the Surgeon/ Proceduralist can be contacted.

19. A STAT interpretation of the radiograph will be done bya Radiology Resident (or Radiology Attending).

20. The Radiology Resident (or Radiology Attending) will immediately contact the Surgeon/ Proceduralist at the extension provided to communicate the radiograph findings, or make recommendation for additional imaging. If the Surgeon/Proceduralist Attending is not present, the Surgeon/Proceduralist Resident APN, or PA will notify the Attending.

21. At the Surgeon/Proceduralist Attending discretion, a STAT Radiology Attending read maybe requested. Otherwise, the Radiology Attending will review the case within 24 hours.

22. At the Radiology Resident's discretion, a STAT Radiology Attending read may be requested. Otherwise, the Radiology Attending will review the case within 24 hours.

23. For procedures on counts for vaginal delivery see FBC-16

INTERPRETATION, IMPLEMENTATION, AND REVISION:

The Chief Nursing Officer, Peri-Operative Services, and Radiology are responsible for the interpretation and implementation of this policy.

CROSS-REFERENCE:

FBC-16 Prevention of RFO during Vaginal Delivery

REFERENCES

1. AORN. (2011). Perioperative Standards and Recommended Practices, pgs. 263-282

2. Institute for Clinical Systems Improvement. (2007, September). Health care protocol: Prevention of unintentionally retained foreign objects in surgery. 1st Ed (pg. 12).

The University of Chicago Medical Center
Policy and Procedure Manual

Policy: PC 92 History & Physical Examination
Issued: June 2004
Revised: October 2018

PURPOSE: To define the required components of and documentation requirements for the history and physical examination (H&P).

DEFINITION:

1. Licensed Independent Practitioner (LIP) – Medical Doctor, Doctor of Osteopathy, Physician Assistant and Advanced Practice Nurse credentialed and/or privileged by the Medical Center to perform an H&P.

2. For all outpatients undergoing anesthesia, inpatients and observation patients, the H&P shall at a minimum include these components:

    a. Chief complaint
    b. History of present illness
    c. Relevant past medical and surgical histories
    d. Relevant family and psychosocial histories, as appropriate to the patient's age.
    e. Allergies, medication and status of applicable immunizations
    f. Review of systems, as appropriate to the patient's condition
    g. Physical examination, as appropriate to the patient's condition or procedure being performed. At a minimum, the following elements are required:
        i. Constitutional (to include pertinent vital signs and general appearance)
        ii. Respiratory/Pulmonary
        iii. Cardiovascular
        iv. Mental Status/Neurological
        v. Impression or provisional diagnosis
        vi. Planned course of action
        vii. Date and time completed

3. For all outpatients undergoing moderate or deep sedation for an invasive procedure, the H&P shall be appropriate for the patient's condition and type of procedure in accordance with PC 16 – Sedation and shall at minimum include these components:
    a. A baseline health evaluation that includes a brief health history reflecting:
        i. Allergies and previous adverse drug reactions
        ii. Current medications
        iii. Diseases, disorders, and abnormalities
        iv. Prior hospitalizations
        v. Pertinent family history of diseases and disorders
        vi. Review of systems
        vii. Pertinent lab or other test results
        viii. Previous anesthesia/sedation problems

ix. Reason for procedure relating to the diagnosis
x. Planned course/procedure

b. A physical examination specific to the procedure being performed, including
i. Constitutional ((to include pertinent vitals and general appearance)
ii. Baseline oxygen saturation
iii. Airway assessment
iv. Chest and cardiac examination
v. State of consciousness

c. Update/addendum to the H&P: A statement that indicates that the medical record was reviewed, the patient was examined, and documents changes in the patient's condition or that "no changes" have occurred.

POLICY:

1. An H&P shall be completed and documented in a timely manner for all inpatients and observation patients and for those outpatients undergoing a procedure with moderate sedation, deep sedation, monitored anesthesia care, regional anesthesia or general anesthesia.

2. The H&P and any update/addendum shall be completed and documented in the medical record for each patient by an LIP or, for a patient admitted only for oral maxillofacial surgery, by an oral maxillofacial surgeon.

3. In addition to the standard H&P, the H&P may take the form of a referral letter, consultation, or clinic note if the required components are included.

4. An update to the H&P may be documented in the electronic H&P update template, or take the form of a paper or electronic progress or clinic note.

5. In an emergency, when there is no time to record a complete H&P, a progress note or admission note including a brief history, appropriate physical findings and the pre-procedure diagnosis shall be record in the medical record prior to the procedure.

6. Valid documentation of an H&P and any updates or addenda must contain all the necessary information, utilize approved form/formats and are signed, dated and timed by the LIP when completed.

PROCEDURE:

1. The LIP completed and documents an H&P and any updates or addenda in the medical record within the following timeframes:

2. Within 24 hours **after** admission but prior to a surgery or a procedure requiring anesthesia.

3. If the H&P was completed more than 30 days prior to admission, a new H&P must be completed within 24 hours after admission but prior to a surgery or a procedure requiring anesthesia. For example, if an H&P is completed on January 1, 2011 in the clinic or previous hospital encounter and the patient is admitted on February 1, 2011, then a new H&P must be completed.
4. Outpatients and same day admit (SDA) patients must have an H&P in the medical record prior to the start of the procedure. The patient may not leave the pre-op/pre-procedure without an H&P.

5. Inpatients should not leave the patient care area for the operating room or procedure area unless there is an H&P in the medical record. The care nurse is responsible for reviewing the medical record prior to sending the patient to the operating room or procedure area. If the H&P is missing or invalid, the nurse must page the service. If the service requests to meet the patient in the pre-op holding area to complete the H&P, the nurse must note the name, credentials, and pager number of the LIP making the request and indicate the service is aware that the H&P is not in the medical record. The LIP shall meet the patient in the pre-op/pre-procedure area to complete the H&P. The patient may not leave the pre-op/pre- procedure area without an H&P.

Interpretation, Implementation and Revision:
The Health Information Management Committee is responsible for the interpretation and revision of this policy.

UCMC Policy & Procedure Manual

Surgical/Procedural Attire Requirements

Policy: **PC 242**
Issued: **September 2018 (Replaces PC 106 Scrub Wear)**
Revised: **N/A**

PURPOSE:
The purpose of this policy is as follows:

- To define mechanisms of providing barriers to contamination.
- To promote high-level cleanliness and hygiene.
- To minimize transmission of infectious microorganisms to patients.

SCOPE: All Surgical/Procedural Personnel/staff, Physicians, Licensed Independent Practitioners (LIP), Allied Health Personnel, Vendors and Visitors.

DEFINITIONS:

Hospital Laundered Scrubs: All hospital-laundered scrubs are misty green in color. Misty green scrubs are available through an automated dispensing system (e.g. auto-valet) or Linen Services in the event the automated system is down.

Semi-restricted Areas: Pharmacy and instrument rooms, clean supply rooms, clean utility core, the sub command desks and command center, administrative offices, designated elevators from locker room to operating room suite, and the corridors connecting the operating theaters are considered semi-restricted areas. Any area behind the "red line" is considered semi-restricted. Dress code requires that misty green, hospital-laundered scrub and a clean surgical head cover or hood that confines all hair and completely covers the ears, scalp skin, sideburns, and nape of the neck should be worn *in* the semi-restricted areas.

Restricted Areas: The operating theaters are designated restricted areas. Dress code requires that misty green, hospital-laundered scrubs, long-sleeved jackets and a clean surgical head cover or hood that confines all hair and completely covers the ears, scalp skin, sideburns, and nape of the neck should be worn in the restricted areas and masks be worn during cases or if open sterile items or equipment are present or scrubbed person are located. Surgical mask with eye protection or goggles should be worn whenever contact with blood, body fluids or other potentially infectious material is anticipated. Additional garments shall be completely contained or covered within the scrub attire. Patients shall wear attire appropriate for their surgical procedure and shall wear hair covering. Traffic should be restricted to authorized personnel and patients.

Transition areas
Locker rooms and connecting spaces to the operating suite are considered transition areas. Traffic should be permitted to allow movement of personnel between unrestricted areas and semi restricted areas. Personnel may enter in street clothing and shall exit into the semi-restricted areas in surgical attire.

Monitored unrestricted area

The **Preoperative/PACU** areas are monitored unrestricted areas. Permitted traffic includes authorized personnel and patients and their families who have been screened by hospital personnel. Health care workers in scrub attire may use this area for the purpose of patient management and hospital business. Dress code requires that misty green, hospital laundered scrubs be worn by personnel routinely assigned to **Preoperative/PACU.**

Unrestricted areas: Includes the entrance areas for patients, personnel and materials. Street clothes are permitted in these areas, and traffic is not limited.

PROCEDURE:

All Surgical/Procedural personnel, Physicians, Licensed Independent Practitioners (LIP), Allied Health Personnel, Vendors and Visitors are required to wear the appropriate attire when in restricted and semi-restricted areas of the hospital as defined in this protocol. They are as follows:

- Staff /Faulty assigned to work in restricted and unrestricted areas must wear hospital laundered misty green scrubs. They cannot wear scrubs into the hospital from home or other institutions nor out of the hospital after finishing their shift. Hospital staff will wear street clothes to work, change into misty green hospital laundered scrubs and change back to street clothes before leaving work.
- Scrub uniforms will be worn for only one day and will be changed if they become visibly soiled or wet.
- Hospital-laundered misty green scrubs do not need to be covered when leaving a semi-restricted or restricted area. A laboratory coat or cover-up is highly recommended when leaving a restricted or semi-restricted area, especially when the intent is to return to a restricted area. Persons exiting the hospital shall don hospital laundered scrub attire on return to the surgical/procedural area (IL Hospital Licensing Section 250.1300).
- Coverall (Bunny) suits may only be used for temporary access to semi-restricted areas. They but may not be worn into any procedure room or O.R. suite when sterile equipment or supplies are open. Persons and visitors to these areas are required to cover all head and facial hair.
- Disposable masks will be worn in the restricted areas during procedures or when there are open sterile items and equipment present such as sterilizers.
- Masks will cover the mouth and nose, and will be secured in a manner to prevent venting.
- Masks will be changed between cases, and as they become wet or soiled.
- Masks should be removed carefully by handling only the ties, and they should be discarded immediately. Masks should not be worn hanging down from the neck. Masks that have been worn should not be tucked into a pocket for future use.
- Disposable clean surgical head coverings will entirely cover hair. Those with beards will wear surgical hood hair covers.
- Persons in the surgical suite will not wear artificial nails of any kind. Chipped fingernail polish will be removed prior to entering the semi restricted area. For those staff working in CSP (central Sterile Processing), jewelry, and artificial nails cannot be work AND they CAN NOT wear any nail polish.
- All jewelry shall be removed prior to the surgical scrub. Jewelry shall not be worn in the operating room, except that anesthesia personnel may wear a watch.(Section 250.1300).
- Personal Protective Equipment (PPE) such as goggles, face shields, glasses with side shields, gloves, etc. will be used appropriately to reduce the risk of exposure to blood and body fluids.

- Fleece material clothing may never be worn in the operating/procedure rooms.
- Fabric stethoscope tubing covers will not be used.

Additional Information:

If required to bring in a backpack or briefcase, they must be of a material that can be washed down and dried prior to bringing into the restricted area. Other fanny packs, backpacks and briefcases are not allowed into the semi- restricted or restricted areas of the surgical/procedural suites.

Any wheeled backpacks or briefcases are not permitted in the semi-restricted or restricted areas.

INTERPRETATION, IMPLEMENTATION AND REVISION

The Infection Control Department in collaboration with Peri-operative Services and Supply Chain are responsible for the interpretation, implementation and revision of this document.

It is the responsibility of leadership (managers, directors, executive directors, attending physicians, residency program directors, fellowship program directors, chiefs' et al) to hold their staff accountable to the requirements of surgical attire outlined in this document.

Employees who fail to comply with this may be subject to discipline, up to and including termination.

Cross-References:

IC-03-19 Operating and Recovery Room Suites
IC-03-02 Anesthesia and Critical Care
IC-03-05 Central Sterile Processing

References:

AORN Guidelines for surgical Attire. May 30, 2017.
https://www.aorn.org/about-aorn/aorn-newsroom/health-policy-news/2017-health-policy-news/aorn-guideline-for-surgical-attire

IDPH/IL Hospital Licensing Requirements, Section 250.1300

Beaker Label Printer Troubleshooting (Zebra ZD410 & ZD411)

How to Load Label Roll on the Zebra Printer

1. Pull the yellow **latches** on both sides of the printer towards you and lift the printer's **lid** open.

2. Pull the yellow **roll guides** apart and insert the **label roll** with the labels facing upwards.

3. Release the **roll guides** and push them together. Make sure the **label roll** is secure and turning freely.

4. Pull the **labels** out past the cutter at the front of the printer. ***NOTE: Make sure to pull out enough labels so that any adhesive that is dried to hold the roll together is pulled out because if left it can potentially scratch the printer lenses that prints information on the label***

5. Push the labels **under** the roll guides.

6. Push the **lid** closed until both yellow latches snap shut.

7. ***Recalibrate the label printer by pressing the pause "\|\|" button and "X" button <u>at the same time (hold for ~5 seconds).</u>*** A few blank labels will print out during recalibration.

Beaker Label Printer Troubleshooting (Zebra ZD410 & ZD411)

Please attempt the following troubleshooting steps prior to submitting a Help Desk ticket.

Please summarize troubleshooting attempts made in the Help Desk ticket details.

Printer Troubleshooting Steps

1. ***If the printer is not printing, make sure it's not paused***

2. ***If the labels are printing faded***, you will need to adjust the darkness on the printer.
    a. Press and hold the pause button until the box with the diamond is solid. 
    b. Next press the feed button to move the light so that the label/arrow light is on. 
    c. Then press the pause button to start adjusting the tone, the printer will auto print labels from faded to darker. Once the printer gets to **20.0** press the feed button twice and that completes setting the darkness on the label.

3. ***If the printer starts to print out a bunch of blank labels***
    a. Make sure to open the lid roll the labels back and closed the lid.
    b. Next calibrate the printer by pressing the pause"||" button and "x" button at the same time (hold for ~5 seconds). A few blank labels will print out during recalibration.
    c. Reboot the workstation to clear any jobs stuck in the ZDesigner queue that may have corrupted the printer.
    d. ***Un-pause the printer*** and test Print.
    e. If the printer is still printing blank labels try to print from windows, if that does not work the printer will need to be replaced.

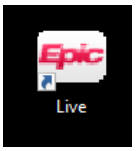
4. ***Labels are not printing clear***
    a. Make sure to clean the print head with alcohol pad to remove any adhesive that may cause the printer from printing clear.
    b. Make sure there is not labels obstructing the print head, rollers, or sensor.
    c. Make sure the sensor is place in the center

Beaker Label Printer Troubleshooting (Zebra ZD410 & ZD411)

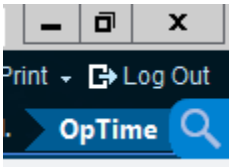
Test Print

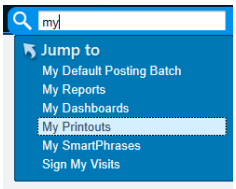
Please always have a clinical end user attempt a test print of a Beaker label when Field Services is still present after attempting to address a printer Help Desk ticket. If the Epic label does not print, Help Desk needs to be notified the original ticket number is an Epic Beaker printer issue, NOT printer hardware, and should be assigned to the correct team. Please send these tickets to Beth Veronesi and Tracy Schrayer for escalation.

1. Log in to Epic by double clicking the *Live* icon on the desktop. If the Live icon is not on the desktop, you can find Epic Live through UCMC Applications on the desktop.

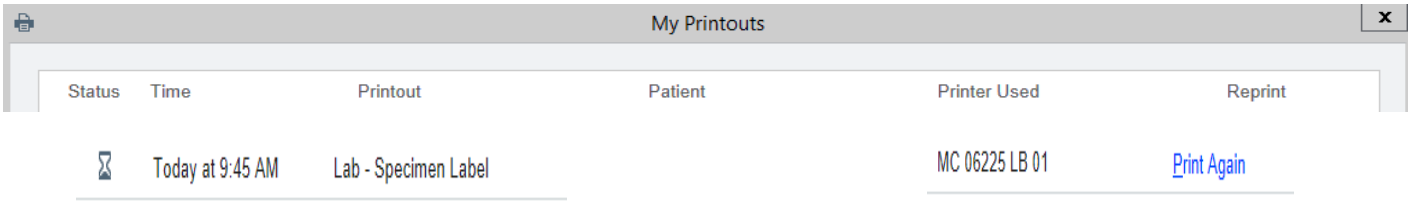


2. Once in Epic, you can search "My Printouts" in the top right hand corner below the Log Out button.





3. Then select "My Printouts" in the Jump to section (the patient name will display in Epic Live). Then click "Print Again"



4. Once you have found the correct printer click the **Print** button

Date	Summary of Revisions	User
06/15/23	Tip sheet created	Beth Veronesi

The University of Chicago Medical Center
Policy and Procedure Manual

Visitors in the Procedural Suites, Operating Rooms and Post Anesthesia Recovery Unit

Policy: A02-24
Issued: January 2001
Revised: March 2016
Reviewed: March 2019, June 2022

Policy:

Access to the Surgical and Procedural Suites is limited to Authorized Personnel. Access to such areas may be granted to a Visitor who has been evaluated and approved pursuant to this policy. Without completion of the approval procedures defined below, a Visitor will be denied access to the Surgical and Procedural Suites. All University of Chicago Medical Center (UCMC) and Biological Sciences Division (BSD) personnel working in these patient care units have responsibility for enforcing this policy.

Definitions:

Authorized Personnel: Includes members of the medical staff, persons employed or engaged by the UCMC/BSD and assigned to work in the Surgical or Procedural Suites or assisting with healthcare operations (e.g., Patient Safety), or persons participating in an applicable residency, medical education, clinical training or allied health educational program approved by the UCMC and assigned to participate in the Surgical or Procedural Suites.

Visitor: Includes all non-Authorized Personnel who fall under one of the following categories:

- Vendor Representatives
- Physicians and other health care professionals who are not participating in a UCMC approved educational program or who have been approved as a Clinical Observer (See Patient Care Policy 52: Clinical Observers)
- Lay Visitors 18 years or older (e.g., Media Representative) whose presence has been requested by the patient's physician

Individuals falling under a Visitor Category described above must be sponsored by an Attending Physician.

A Visitor does not include:

- Parent/Guardian of patients 12 years or younger permitted in the OR or procedure room during induction of anesthesia (See Procedure, Section II).

- Parent/Guardian/Patient Representative permitted in the Post Anesthesia Care Unit (PACU) (See Procedure, Section III).

Procedure:

I. Visitor Approval Process

A. Sponsorship and Supervision

a. Visitors must be sponsored by an Attending Physician who will be responsible for ensuring compliance with the UCMC policies and procedures. Each Visitor to the Procedural Suite/OR must be approved through the following procedures:

i. Request for visitation must be submitted via email by the Sponsoring Attending Physician **5 business days** in advance of the visit to his or her Chairman's Office or designee whereupon a UCMC/BSD Staff person will be assigned. The physician performing the procedure, if different from the sponsoring physician, must also grant approval.

b. The Visitor Validation Packet will be completed by the Sponsoring Attending Physician and UCMC/BSD Staff person, including:

i. Email notification to the Department of Anesthesia and Critical Care (DACC) Vice Chair for Clinical Affairs or designee, and the Perioperative Services Clinical Director, Surgical Director and Medical Director or designees.

ii. Patient Consent Forms: the patient shall be contacted prior to the procedure by the Sponsoring Attending Physician or the UCMC/BSD Staff person and consented to having a visitor in the OR/procedural suite. This must be documented on the OR/Procedural Suite Visitor Consent Form and signed by the patient prior to the Visitor entering the OR/Procedural Suite. The consent conversations may be conducted on the day of the procedure.

1. Visitor Competency Packet & Agreement: The Sponsoring Attending Physician and/or UCMC/BSD Staff person must provide appropriate documentation of orientation for the Visitor including education regarding this policy, the medical procedure, basic infection control practices (safeguards against the introduction of infection, hazards, dress code, traffic patterns, hand washing, basic infection control practices expected of the person, and an explanation of the specifics regarding procedure and recovery and what can be expected), patients' rights and confidentiality, appropriate conduct in the OR/procedural suite environment, aseptic principles and techniques, and fire, electrical and other safety protocols. This orientation shall be conducted prior to entry into the OR/procedural suite and the Visitor must sign the Visitor Agreement prior to entering the OR. (Visitor Agreements should be filed with the Privacy Office.)

c. Medical Record Documentation – the Sponsoring Attending Physician shall record the Visitor's presence and reason for the visit in the patient's medical record.

i. Documentation by the circulating nurse in the patient's intraoperative/intraprocedural record must reflect the presence of the Visitors, identifying the individual by name, institution/employer, if applicable, and the times entering and exiting the operating room suite.

ii. If the Visitor is to verbally assist a proceduralist on the use of equipment, the Sponsoring Attending Proceduralist shall document this in the medical record.

d. While in the surgical or procedural suite, the Visitor must be supervised by the Sponsoring Attending Physician or the UCMC/BSD Staff person at all times to ensure compliance with the UCMC policies and procedures.

B. Patient Care - A Visitor classified as a Vendor Representative or Lay Person shall not participate in any patient care activities, including coming in contact with equipment in the OR, entering the sterile field or touching the patient. A separate agreement, in one or more form(s) approved by the relevant Department (Surgery, OB/GYN, Anesthesia and Critical Care or other) and the Office of Legal Affairs, must be executed in advance with any Visitor who participates in the procedure. Such Visitors must also be approved by the Medical Staff Office and be granted temporary privileges.
   a. If the Visitor is classified as a Clinical Observer, then the Visitor must comply with the Clinical Observers Policy, PC 52, which includes having a signed Clinical Observer Agreement.

C. Visitors whose presence in the OR is necessary for a category of procedures may be evaluated once and approval granted for repeat visits (e.g. a technician from XYZ Corporation may be present during all hip replacement surgeries involving XYZ Corporation's hardware for the purpose of helping the surgeon identify the appropriate implant devices).

D. Visitors classified as Vendor Representatives must be screened pursuant to Administrative Policy A05-08: Vendor Relations prior to being permitted into UCMC and the Clinical Care Unit(s). The Vendor Representative or his/her company must have a Business Associate Agreement on file with the Purchasing Department, unless the requirement is waived by the Office of Legal Affairs.

E. The Visitor shall leave the OR/procedural suite whenever requested to do so by the Attending Surgeon, Attending Anesthesiologist, UCMC/BSD Staff person or other OR/procedural personnel.

F. Patient Privacy: The Visitor shall be provided with only that patient information that is essential to the Visitor's purpose, and he/she shall maintain the privacy and confidentiality of all patient information accessed. A visitor may not photograph, audiotape, videotape, or otherwise record any aspect of the surgical procedure unless permitted by hospital policy. A *Consent to Photograph/Media Consent Form* must be signed by the patient prior to photographs or videotapes being taken.

G. If at any time a staff member determines that the Visitor poses a threat to the safety of the patient or staff, he/she may require the visitor to leave.

H. All Visitors shall be required to wear nametag identification during their visit to the OR/procedural suite and to enter only those areas for which permission has been granted.

II. Parent/Guardians in the Procedural Suite/Operating Room and PACU: With respect to patients 12 years or younger, the Procedural Suite/Operating Rooms and Post Anesthesia Care Unit (PACU) generally shall be limited to Authorized Personnel and parents and guardians of patients 12 years or younger:

a. Procedures for Parents and Guardians in the Procedural Suite/OR: For patients 12 years of age or younger, the patient's parent, guardian, or other individual selected by the child's parent or guardian may be allowed into the procedural suite/OR during the induction of anesthesia if the following procedures are followed:
    i. Written consent shall be obtained from the parent, guardian, or other designated individual, and the attending anesthesiologist and attending physician performing the procedure. Under such consent, the parent, guardian, or other visitor agrees to follow all hospital policies and procedures, agrees to not operate any medical equipment, agrees to remain in the designated areas and agrees to leave) when requested by a member of the OR/procedure team or after the induction of anesthesia is completed.
    ii. The child's medical record shall include documentation in the nursing flow sheet of the additional person in the procedural suite/OR and their relationship to the child.
    iii. At least one additional medical or service staff person (not the circulating nurse) shall be assigned to oversee, supervise, and assist the parent, guardian or other designated individual for the period of time such person is present in the procedural suite/OR. This staff person should have no other designated responsibilities during the time that the parent, guardian, or other visitor is in the procedural suite/OR.
    iv. If at any point during the induction of anesthesia a staff member determines that the parent, guardian or other visitor poses a threat to the safety of the patient or staff, he/she may require the parent, guardian or other visitor to leave.
    v. Parents, guardians, or other visitors granted permission to enter the procedural suite/OR under this policy should be provided a nametag, identifying their name and reason for being there.
b. Procedures for Parents and Guardians in the PACU: For patients 12 years of age or younger, the patient's parent, guardian, or other individual selected by the child's parent or guardian, may be allowed into the PACU (Phase 1 & 2) during the child's recovery from a surgery or procedure if the following procedures are followed:
    i. Written consent shall be obtained from the parent, guardian, or other designated individual, and the attending physician performing the surgery/procedure. Under such consent, the parent, guardian, or other visitor must agree to follow all hospital policies and procedures, agree not to operate any medical equipment, agree to remain in designated areas, agree to leave when requested by a member of the PACU team, and agree to respect the privacy of other patients in the PACU.
    ii. The child's medical record shall include documentation in the nursing flow sheet of the additional person in the PACU and their relationship to the child.
    iii. If at any point during the recovery of the minor patient a staff member determines that the parent, guardian or other visitor poses a threat to the safety of the patient or staff, he/she may require the parent, guardian or other visitor to leave.
    iv. Parents, guardians, or other visitors granted permission to enter the PACU under this policy shall be provided a Perioperative nametag, identifying their name and visitor status.
    v. The PACU personnel shall ensure the privacy of other patients who may be recovering from surgical procedures in the PACU when a parent, guardian, or other visitor is present. This may include use of screens or other types of

separation for recovery of children who have a parent, guardian or other visitor in the PACU.

III. Patient Representative in the PACU: Patient Representatives shall be permitted in the UCMC PACU while the patient is recovering.

a. Written consent should be obtained from the adult patient, the parent, guardian, or legal representative of a minor or a mentally disabled adult, or the physician performing the surgery/procedure. Under such consent, the parent, guardian, or patient representative must agree to follow all hospital policies and procedures, agree not to operate any medical equipment, agree to remain in designated areas, agree to leave when requested by a member of the PACU team, and agree to respect the privacy of other patients in the PACU.
b. The patient's medical record shall include documentation in the nursing flow sheet of the patient representative in the PACU.
c. If at any time during the recovery period a staff member determines that the visitor poses a threat to the safety of the patient, other patients or staff, he/she may require the parent, guardian or other visitor to leave.
d. Patient representatives granted permission to enter the PACU under this policy shall be provided with a name tag, identifying their name and visitor status.
e. The PACU personnel shall ensure the privacy of other patients who may be recovering from surgical procedures in the PACU when a patient representative is present. This may include use of screens or other types of separation for recovery of patients who have a patient representative in the PACU.

IV. Safeguards Against Infection and Other Hazards: In addition to the above procedures, steps shall be taken to minimize the introduction of infection or other hazards in the procedural suites, ORs, and PACU by a Visitor, Parent, Guardian or Patient Representative. All individuals must be free of transmissible infections. Visitors, Parents/Guardians and Patient Representatives shall receive information related to safeguards against the introduction of infection, hazards, dress code, traffic patterns, hand washing, basic infection control practices expected of the person, and an explanation of the specifics regarding procedure and recovery and what can be expected.

Interpretation, Implementation and Revision

The Department of Surgery, the Department of Anesthesia & Critical Care, the Department of Obstetrics and Gynecology and Perioperative Services in collaboration with the Department of Risk Management and Patient Safety are responsible for the interpretation and revision of this policy. The procedural suite/OR personnel are responsible for the implementation of this policy.

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Thomas Jackiewicz
President