

UNIVERSITY OF OKLAHOMA HEALTH SCIENCES CENTER OU PHYSICIANS FAMILY MEDICINE CENTER POLICY AND PROCEDURES			
Policy Name:	Exam Room Items		
Subsection:	17 – Medical Equipment & Supplies		
Page:	1 of 1	Source:	FMC
Effective Date:	06-01-2005	Revision Date:	03-01-2014
		Next Review Date:	

STATEMENT OF PURPOSE: The purpose of this policy is to establish proper placement of exam room items throughout the clinic.

POLICY & PROCEDURES:

The following items are to be kept in Exam Room Cabinets:

1. Cabinet directly above the sink:
 - a. Top shelf – drinking cups, emesis basin, pink bags, nun's hat
 - b. Bottom shelf – thin prep vials, brooms/brushes, wet prep tubes, GC/Chlamydia cultures, OB swabs, aerobic/anaerobic cultures, saline dropper
2. Cabinet directly above the countertop:
 - a. Top shelf – 1 box of gloves (each size), 2 boxes of Kleenex
 - b. Bottom shelf – 1 box of sterile 4x4's, 1 bag of non-sterile 4x4's, 1 box of sterile 2x2's, 1 box of Telfa (non-adherent), 1 roll of 1 inch paper/nylon tape, 1 roll of 1/2 inch paper/nylon tape, saline, sterile water
3. Cabinet drawers:
 - a. Top drawer – Band-Aids (all sizes), tape measures, drawer liner, small red bio bags
 - b. Second drawer – stool occult cards and developer, 2 anosscopes, sterile K-Y Jelly, clear lab bio bags
 - c. Third drawer – sterile gloves (2 each of all sizes), 3 sterile fields, 3 fenestrated sterile fields, 5 Betadine swab packets
 - d. Bottom drawer – sterile urine cups, 1 box of sanitary wipes

The following items are to be kept in each Exam Room Table:

1. Heated drawer:
 - a. speculums
 - b. sterile K-Y Jelly
2. Second drawer:
 - a. Q-Tip swabs
3. Side drawers:
 - a. Top side drawer – gowns (stock both if you use paper)
 - b. Second side drawer – drapes
 - c. Third side drawer – 1 roll table paper, 10 blue pads, 5 pillow cases, 4 sanitary napkins, 3 straight cath kits, 2 pedi cath kits, and 2 pedi urine collection bags

Ring forceps are to be kept in the procedure clinic due to limited quantity.

The following items are to be kept on Exam Room Countertops:

1. cotton balls
2. tongue blades
3. alcohol preps
4. sterile cotton tip applicator
5. Kleenex
6. antimicrobial hand soap
7. antibacterial hand sanitizer

UNIVERSITY OF OKLAHOMA HEALTH SCIENCES CENTER OU PHYSICIANS FAMILY MEDICINE CENTER POLICY AND PROCEDURES			
Policy Name:	Cleaning of Surgical Instruments PRIOR to Sterilization/Autoclaving		
Subsection:	17 – Medical Equipment & Supplies		
Page:	1 of 2	Source:	FMC
Effective Date:	11-18-2004	Revision Date:	03-01-2014
		Next Review Date:	

STATEMENT OF PURPOSE: The purpose of the policy is to ensure that the appropriate steps are being taken in cleaning and maintenance of surgical instruments prior to sterilization/autoclaving.

DEFINITIONS:

Sterile – an absolute term (no living organism survives)

Disinfected – Basically clean. Disinfected instruments are NOT STERILE. Some organisms may survive. Always use the proper sterilization/ cleaning technique to render the instrument in the required condition.

CAUTION: Never expose stainless steel instruments to bleach or other corrosive chemicals. Exposure to bleach may result in instrument surface pitting and will void all manufacturer guarantees.

OPERATING PROTOCOL:

1. Holding/Presoak

- Never hold instruments in a dry container. This allows blood and debris to dry onto instrument surfaces, making cleaning difficult.
- If rinsing and decontamination processes are not immediately available, pre-treat instruments or hold them in a neutral pH holding/presoak enzymatic solution after patient use but before actual cleaning.
- As soon as possible, rinse, disinfect, and clean instruments.

2. Rinsing

- Immediately after surgery, remove organic materials by rinsing instruments under warm (not hot) running water. Rinsing should remove most blood, fluids and tissue.
- Do not process dissimilar metals (stainless, copper, chrome plated, etc.) together.
- Always wear safety protection gear.

3. Disinfecting

- To protect medical staff from contamination during cleaning, immerse instruments completely in an EPA approved disinfectant for approximately 10-20 minutes. Always follow exact manufacturer recommended disinfecting time and solution preparation instructions.
- Rinse again.

4. Cleaning

All blood, dried body fluids, and tissue should be completely removed from the instruments prior to sterilization.

- Soak:** An enzymatic cleaner bath (soak) or a solution of distilled (demineralized) water and neutral pH (7) detergent is effective in removing organic material from instruments. Instruments should be fully submerged for at least 10 minutes. Do not let "sharps" (scissors, knives, osteotomy's, etc.) touch each other. Separate dissimilar metal instruments. Rinse instruments under running water to remove solutions. Change solutions frequently.
- Manual Cleaning:** If ultrasonic cleaning is not available, observe the following steps:
 - Use stiff nylon cleaning brushes. Do not use steel wool or wire brushes except specially recommended stainless steel wire brushes for instruments with serrated areas, bone files, burs or on stained areas of knurled handles.
 - Use only a neutral pH (7) detergent. If not rinsed properly, low pH (acidic – less than 6 pH) detergents break down the stainless protective surface resulting in pitting and/or black staining. High pH detergents (alkaline – more than 8 pH) can cause brown stains (phosphate surface deposit) which can interfere with smooth instrument operation. Most brown stains are not rust and are easily removed with a surgical instrument stain remover.
 - Brush delicate instruments carefully, and if possible, separate them from general instruments.
 - Make sure instrument surfaces are visibly clean and free from stains and tissue. This is a good time to inspect each instrument for proper function and condition.
 - After scrubbing, rinse instruments thoroughly under running water. While rinsing, open and close scissors, hemostats, needle holders, and other hinged instruments to make sure hinge areas are thoroughly rinsed and no debris remains.

5. After Cleaning

- Separate dissimilar metals prior to sterilizing/autoclaving.
- If instruments are to be stored, let them air-dry and store them in a clean and dry environment.
- Check scissor blades to ensure proper function. Blades should open and close smoothly. Scissors should cut all the way to the tips. Test cutting performance at $\frac{1}{4}$ length of the blade with the following recommended materials:
 - Fine/Delicate scissors: Surgical glove
 - Medium scissors: Single layer of stocking/cast netting
 - Large/Utility scissors: Double layer of stocking/cast netting
- Check forceps (pickups) for proper jaw alignment. Teeth must meet properly – without catching.
- Check hemostats and needle holders to ensure jaw tips close in first ratchet position and entire jaw should close in third ratchet position. Check instruments for loose hinges and verify that they lock and unlock easily. Check instruments for wear on jaw surfaces.
- Suction tubes should be clean inside.
- Test biopsy punches by punching a clean hole in 306 mil thick poly-bag material. If poly-bag material is not available, use tissue paper.
- Retractors should function properly.
- Cutting edge instruments and knives should be sharp and free of damage.

<p style="text-align: center;">UNIVERSITY OF OKLAHOMA HEALTH SCIENCES CENTER OU PHYSICIANS FAMILY MEDICINE CENTER POLICY AND PROCEDURES</p>			
Policy Name:	Sterilization & Autoclave Procedures		
Subsection:	17 – Medical Equipment & Supplies		
Page:	1 of 2	Source:	OU Physicians Intranet Online Policies CP39
Effective Date:	09-22-2014	Revision Date:	08-05-2016
		Next Review Date:	08-05-2019

STATEMENT OF PURPOSE: The purpose of the policy is to establish guidelines to assure autoclaves and sterilization processes are maintained in accordance with manufacturer's recommendations and CDC recommendations for effective sterilization and disinfection of clinic instruments used in patient care.

STATEMENT OF OBJECTIVE: To provide safe, efficient patient care, the staff will follow standard infection control measures for sterilization process in OU Physician Clinics.

SCOPE: The scope of this policy includes OU Physicians, the clinical practice of the University Of Oklahoma College Of Medicine and includes all clinics under the auspices of University of Oklahoma College of Medicine.

OPERATING PROTOCOL:

1. OU Physicians will follow University, state and federal rules and regulations.
2. All staff who use the autoclave must receive training prior to use and annually. The required training is available on the Training & Development website. All staff that use an autoclave must have this process included in their annual competency evaluations.
3. All OUP Clinics will utilize the Midmark Ritter autoclave equipment for their instrument sterilization process.
4. Each clinic that has an autoclave in use will have an assigned team lead and a designated back up responsible for the cleaning, maintenance and spore testing of the autoclave.
5. The manufacturer's manual should be stored near the autoclave for ease of review of recommendations for use and maintenance. The staff will follow the manufacturer's recommendation regarding monitoring of temperature and humidity in the room where the autoclave is located
6. If an autoclave exists in a clinic and is not being used, then the autoclave needs to be removed from the clinic and placed in storage.
7. All autoclaves in use will be cleaned according to the manufacturer's recommendations and using recommended cleaning solution. Cleaning will be documented in the clinic's autoclave cleaning log. Sample autoclave cleaning log [attachment B](#).
8. At the completion of a cycle each package will be assessed that appropriate temperature for sterility has been reached per manufacturer's recommendation and supplies utilized. For additional assurance of sterility, it is required that each packaged or unpackaged item (s) include an additional chemical/biologic indicator to assure that the contents of each reached sterility temperature inside the tray or package where the instruments are placed. When unpackaged instruments are sterilized, place the indicator on the tray to ensure sterilization temperature was reached. Record the results on the Spore testing log or Run Log. Sample log is [attachment C](#).
9. Spore testing should be performed weekly following OU Physicians designated process which is described in [attachment A](#). Review Procedure in [attachment A](#) for exceptions. Instruments sterilized during the spore test run or after the run will not be utilized until the spore test results are reported and the testing was successful at 24 hours. Final read out is 48 hours.
 - A. Spore testing should also be performed
 - 1) when a new type of packaging material or tray is used,
 - 2) after training new sterilization personnel,
 - 3) after a sterilizer has been repaired and
 - 4) after any change in the sterilizer loading procedures.

Spore testing kits can be obtained from the medical supply vendor. Spore testing packets are to be processed according to the package inserts. Results of spore testing will be recorded in the clinic's autoclave spore testing log. (Sample log [attachment D](#)) Report each failed test to the clinic manager immediately. Any failed spore test will result in immediate discontinuation of the autoclave. This will require that all items sterilized since the last passing spore test be re-packaged and re-sterilized using a different autoclave.
10. Staff must follow manufacturer's recommendations specific to the equipment regarding solutions used and the process for cleaning items before they are autoclaved. Instruments such as clamps and scissors should be opened to clean and to sterilize. The instruments must be allowed to dry before sterilizing. The staff conducts a visual inspection of the instruments and instruments are discarded if rust or damage is noted.
11. The Clinic will maintain an Autoclave Run Log and record each time the autoclave is run by documenting the following information: Date, Items (brief description of item) # of packages, Duration (in minutes) Indicate sterilization success yes or no and staff signature. For clinics that have a high volume of sterilization, the staff may instead document each run on the Autoclave Run Log (Sample log [attachment E](#)) and after the run is complete, write the date and run # of the load on the outside of the

package. By doing this, every load can still be tracked and packages for each run can be identified. Run Logs should be retained up to three years.

- A. Each package that is sterilized is initialed and dated with the date of sterilization. According to CDC guidelines, intact packages of sterilized instruments are considered sterile as long as the package remains intact and no discoloration is seen.
- 12. Sterilized instruments should be stored in a manner that preserves the integrity of the packaging material by storing in an enclosed storage area such as a cabinet or drawer. Before use the package should be inspected to verify barrier integrity and dryness. Any package that is wet, discolored as has been wet, torn, dropped on the floor, or damaged in any way should not be used. The instruments should be re-cleaned, packaged in new wrap, and sterilized again. If multiple autoclaves are used in one clinic, the autoclave used, should be indicated on the outside of the packaging material. Sterilized items should remain wrapped until they are needed for use. Unwrapped items are susceptible to contamination. Items should not be stored loose in drawers or cabinets because unwrapped items cannot be kept sterile. Items for patient use should never be stored under sink.
- 13. The autoclave will be inspected by a licensed biomedical service technician once per year. The inspection will include electrical functioning and calibration.
- 14. All logs maintained during the autoclave sterilization, cleaning, and maintenance process must be retained a minimum of three (3) year per CDC recommendation.

ATTACHMENTS A-D: see next 4 pages

OU Physicians (OUP) Autoclave Sterilization and Maintenance Procedures

OBJECTIVE: To assure that each clinic that uses an autoclave will follow manufacturer's recommendations for cleaning and maintenance and that OU Physicians will follow a standardized process to assure effective sterilization of clinic instruments. For all future purchases, the autoclave of choice for OU Physicians is the Midmark Ritter M9 or M11.

1. Training must occur prior to using an autoclave and annually. This training is available on the Training & Development website using the following link:
<http://training.ouphysicians.com/TPOnline.dll/TP2005/TPOnline.dll/TP2005>
2. Spore testing will be performed using the following supplies: Use 3M Biological Indicator vials that provide 24 hour results in either a Steam Pack (preferred for areas that sterilize steam packs regularly) or Spore test biological indicator vials for clinics that do not sterilize steam packs. If you order the 3M Starter Kit #115 the incubator is included.

Weekly, a 3M biological indicator spore test vial will be placed in a sealed package and placed on the middle tray. If this package will be sterilized with other packages, place the Spore Test package under other packages to be sterilized in the autoclave to make it more difficult for steam to reach and to sterilize. If using Steam Pack instead of a vial, place the steam pack on the middle tray among other steam packs or packages and run a normal cycle. After the autoclave has finished and cooled to appropriate handling temperature, the spore test vial will be incubated along with a control vial. Results will be available within 24 hours. Final results are read at 48 hours. It is best practice not to use the autoclave until the results of the spore testing is available. However, if instruments are sterilized with the spore test run and again before the results are known, they should not be used until the clinic knows that the spore test passed. Clinics that don't use the autoclave at least weekly may conduct a spore test at the time the autoclave is used as long as the instruments sterilized during this run are not used until there is a negative spore test result at 24 hours. Record on the spore test log that the autoclave was not used for the week there is no spore test results. Even if no spore testing is performed because the autoclave was not used, the Weekly Cleaning must still be performed as good maintenance for the autoclave. Record Weekly Cleaning on the Cleaning Log. Results of each Spore test will be recorded on a log. Sample logs are available or you can use the logs provided by Spore Testing vendor 3M. Logs should be retained for up to 3 years.

In addition, quarterly, each clinic will process a Healthlink Spore test mailer strip and mail to Healthlink. The results from Healthlink Spore test will be retained for up to 3 years. This process is for 3rd party verification of spore testing results.

Additional spore testing should occur for the following reasons: 1) when a new type of packaging material or tray is used, 2) after training new sterilization personnel, 3) after a sterilizer has been repaired and 4) after any change in the sterilizer loading procedures.

If a spore test fails, notify the Clinic/Nurse Manager immediately. Then the autoclave should be drained and cleaned using the monthly cleaning process. After the cleaning has been finished, then an additional spore test should be processed. It is recommended that the clinic use the 3M Comply Bowie-Dick Plus test pack to do spore testing when there has been a failed spore test because this process is more sensitive than other spore tests. The autoclave cannot be used again to sterilize instruments until it passes a new spore test and all instruments sterilized in this autoclave since the last passing spore test, must be re-cleaned, repackaged and re-sterilized in a different autoclave.

To verify that sterilization temperature was reached during the cycle, each package and every unpackaged tray should contain some type of chemical indicator. The steam indicator tape from the packaging or the 3M Comply Class 5 (SteriGage) Chemical Integrator # 1243 should be used. Results of this indicator should be recorded on the Autoclave Run log. Sample log is attached.

3. For Midmark Ritter autoclaves, the manufacturer recommends that the temperature range in the room be maintained in the following range: -22 degrees F. to 140 degrees F. The recommended relative humidity range is 10% to 90%.
4. Each run should be documented on a Run log. Run logs should be maintained and kept up to 3 years. Sample logs are available. Each package should be dated with the run date and the initials of the person who processed the run.
5. Required Cleaning & Maintenance will be performed daily, weekly and monthly according to Midmark manufacturer's requirements. This cleaning will be recorded on the Cleaning log. Sample logs are available.
6. For refresher training the staff can use the following link from Midmark:
http://www.midmark.com/en-us/TechnicalSupport/Training%20Videos/Online%20M9_M11%20Sterilizer%20User%20Training/Start.html

DAILY CLEANING: The exterior of the sterilizer should be wiped down each day. Do not use alcohol or bleach-based cleaners. In addition, the door gasket and door dam gasket should be inspected for damage. When the inspection is complete, wipe both gaskets with a damp cloth.

WEEKLY CLEANING MAINTENANCE: After disconnecting the upper portion of the water level indicator, bend it downwards and let the chamber drain into a suitable container. After draining, refill the chamber with clean DISTILLED WATER until the water level indicator is in the green area. Next, clean trays with Speed Clean or mild soap. Never use bleaching agents and abrasives to clean the sterilizer chamber. This includes steel wool, scouring powder, bleach, or wire brushes.

MONTHLY CLEANING MAINTENANCE: Drain the unit and refill with clean distilled water. Then add one ounce of Speed-Clean Sterilizer Cleaner directly to the cool chamber, not to the reservoir. Run a single "Pouches" cycle, but push the "STOP" button when the drying cycle begins. Then, drain the reservoir again and refill a second time with clean distilled water for the rinse cycle. Place a rolled towel around the sterilizer and then start an "Unwrapped" cycle by pushing the "Unwrapped" button and the "Start" button. Monitor the display and wait for the pressure to reach 20 PSI during the heat up cycle. Now, pull up on the relief valve lever on top of the sterilizer cabinet and hold it open momentarily, just long enough to let a little steam escape. Release the lever quickly and verify that the valve has closed properly by noting that steam release has stopped. If the unit is still releasing steam, pull up on the valve lever again and release it quickly so the valve snaps back into position. Repeat this if necessary to make sure the valve is sealed correctly. After the unit has finished its cycle, drain the reservoir and allow the chamber to cool. After the unit has cooled, remove the trays and tray rack and wipe them down with a damp cloth. If you have difficulty removing the tray rack, consult your manual for assistance or view training on Midmark training website. Remove the filters as shown by pulling upward and twisting slightly. After removal, filters should be cleaned by washing with a mild soap and distilled water solution. DO NOT USE TAP Water to clean filters. Use a small stiff brush or an ultrasonic cleaner to remove stubborn deposits. After cleaning, rinse the filters with clean DISTILLED Water and set them aside. Being careful not to damage the heating element, steam temperature probe or water level sensor; wipe out the inside of the sterilizer chamber. Now re-insert the filters into the appropriate holes by pushing downward while twisting slightly. Re-install the tray rack and trays. Finally refill the unit with clean distilled water and log results on Cleaning Log. Sample log is attached.

Autoclave Cleaning Log - 2018

[illegible]

[illegible]

Autoclave Spore Testing Log – 2018

[illegible]

UNIVERSITY OF OKLAHOMA HEALTH SCIENCES CENTER OU PHYSICIANS FAMILY MEDICINE CENTER POLICY AND PROCEDURES			
Policy Name:	Dirty Utility Closets		
Subsection:	17 – Medical Equipment & Supplies		
Page:	1 of 1	Source:	FMC
Effective Date:	06-01-2005	Revision Date:	03-01-2014
		Next Review Date:	

STATEMENT OF PURPOSE: The purpose of this policy is to establish proper utilization of dirty utility closets.

POLICY & PROCEDURES: Items to be placed in dirty utility closet:

1. Top shelf above sink – Large basins for cleaning instruments (clean instruments not yet autoclaved may be placed in large basin until autoclaving is done).
2. Bottom shelf above sink – Enzyme cleaner, instrument cleaner, instrument lubricant, instrument stain remover, room aerosols, RID, cetylcode spray, cetylcode concentrated solution, gloves.
3. Sink area – large basin for cleaning to be done inside of sink, brushes with 28-day cleaning solution in right hand corner, clean instruments may be spread out on clean blue pad, bio container in left hand corner.

Daily reminders:

1. All instruments are to be cleaned and removed from basin in sink each day. Nothing is to be left soaking overnight. This causes damage to instruments.
2. The noon nurse will clean instruments from the morning session and the late nurse will clean instruments from the afternoon session.
3. There will be a sign-in sheet placed inside the door for the 28-day cleaning solution to be changed at appropriate times. This will be checked every month by the team leaders.
4. Bio containers must be emptied daily.
5. Nothing should be in the dirty utility closet that will come into patient contact at any time.

UNIVERSITY OF OKLAHOMA HEALTH SCIENCES CENTER OU PHYSICIANS FAMILY MEDICINE CENTER POLICY AND PROCEDURES			
Policy Name:	Availability of Suture Repair Kits After Hours		
Subsection:	17 – Medical Equipment & Supplies		
Page:	1 of 1	Source:	FMC
Effective Date:	05-23-2006	Revision Date:	09-16-2011
		Next Review Date:	

STATEMENT OF PURPOSE: The purpose of this policy is to establish proper procedures regarding the availability of supplies for clinicians after normal business hours, and to ensure proper billing of supplies.

POLICY & PROCEDURES:

1. Any clinician may procure needed supplies, including suture kits, after normal business hours.
2. Disposable (one time use only) suture repair kits are located in the procedure clinic on the west wall counter.
3. Other supplies, such as suture, xylocaine, bandages, gloves, tape, etc., can be found in either of the procedure clinic rooms. The doors will remain unlocked.
4. If a suture kit or other supplies are procured after hours, the clinician will leave their name, the patient's name, patient's date of birth, and list of supplies needed for care of the patient either:
 - on the physician call-in line (extension 32000) or
 - will write the information and leave it on the procedure clinic desk
 This is to be done so that the items used can be replaced for the next clinician who needs them and for item #6 below.
5. The services rendered will be documented in the patient's electronic medical record (EMR) chart.
6. The information from #4 will be given to the nurse manager the following day so that an Encounter Form can be made and given to the billing staff for processing.

UNIVERSITY OF OKLAHOMA HEALTH SCIENCES CENTER OU PHYSICIANS FAMILY MEDICINE CENTER POLICY AND PROCEDURES			
Policy Name:	Crash Carts & Other Emergency Response Equipment		
Subsection:	17 – Medical Equipment & Supplies		
Page:	1 of 2	Source:	OU Physicians Intranet Online Policies CP12
Effective Date:	10-19-2004	Revision Date:	02-15-2016
		Next Review Date:	02-15-2019

STATEMENT OF PURPOSE: The purpose of this policy is to establish guidelines for standardizing and maintaining crash carts and/or stat kits for OU Physicians (OUP) clinics.

STATEMENT OF OBJECTIVE: OUP clinics will have immediate access to emergency equipment as appropriate for their patient population and the clinic services provided.

DEFINITIONS:

Crash Cart – Cart supplied with a wide range of emergency equipment, supplies, and medications

Stat Kit – Compact kit that provides basic life support equipment

Emergency Equipment – Can be either Crash Cart or Stat Kit

OPERATING PROTOCOL FOR ALL EMERGENCY EQUIPMENT:

1. All clinics will have immediate access to emergency equipment. Staff and providers must be familiar with and have access to the designated storage location for emergency equipment.
2. The Clinic Medical Director and Clinic/Nurse Manager are responsible for ensuring that emergency equipment and/or medications, as appropriate for the patient population and procedures/services provided in the clinic, are readily available at all times.
3. The type and size of emergency supplies must be appropriate for all patients served by the clinic. For example, a pediatric clinic stat kit may need to contain each of the following: an infant ambu bag, a pediatric ambu bag, and an adult ambu bag.
4. The Clinic/Nurse Manager is responsible for ensuring emergency equipment and medications are inventoried and not expired per the manufacturer's expiration date, where applicable. The Clinic/Nurse Manager is also responsible for ensuring that emergency equipment is functional.
5. Portable oxygen tanks must be at least half full and secured with a portable oxygen stand, secured to the wall by a chain, or otherwise secured to prevent injury.
6. The crash cart or stat kit must be restocked after each use.
7. If medications are included as a part of the emergency equipment kit then, for security purposes, a temporary lock must be used. When a temporary lock is used, the lock number should be documented as part of the weekly verification process.
 - a. It is the responsibility of the Clinic Medical Director and Clinic/Nurse Manager to ensure that all staff are appropriately trained on the safe and appropriate use of all equipment and medications.
8. Documentation of resuscitation --emergent patient care-- must be completed on the OU Physicians Code Blue Form. This form must be scanned into the patient's chart in EMR. The Code Blue Form is attached to this policy ([attachment A](#)). Report all emergent patient care events to the OUP Patient Safety and Risk Management Department at 405-271-1800.

OPERATING PROTOCOL FOR STAT KIT:

1. The required supplies for a stat kit include the following items:
 - a. Ambu bag(s),
 - b. Airway(s),
 - c. Oxygen tubing and oxygen mask (s)
 - d. Suction catheter(s),
 - e. Portable oxygen tank(s),
 - f. Tubing to connect to suction,
 - g. Portable suction machine or device (unless the clinic has suction available in every exam room),
 - h. Epi-Pen(s) appropriate for population served in clinic. This is not required if no medication is administered in the clinic and there is a written agreement with a nearby clinic to use their Epi-Pen(s) in an emergency and if the Epi-Pen(s) available is appropriate for population served.
2. The Clinic Medical Director and Clinic/Nurse Manager may elect to include additional emergency equipment, supplies, and/or medications in their stat kit.
3. A clinic may choose to share a stat kit with another clinic, in which case the following criteria must be met:
 - a. The clinics must occupy the same floor of the building.
 - b. The clinics must be in close physical proximity.
 - c. The emergency equipment must be easily accessible to each clinic (items should be retrievable within 2-3 minutes).

- d. The emergency equipment must be stored in a mutually agreed upon location.
 - e. The clinics must share the responsibility of checking and maintaining the stat kit.
 - f. A written agreement (see [attachment G](#)) must be completed. Signatory approval is required from both Clinic Medical Directors, both Clinic/Nurse Managers, and either the Chief Medical Officer or the Chief Quality Officer.
4. At least weekly, all items in the stat kit must be checked. As part of this weekly assessment, the following steps must be taken:
- a. The portable oxygen tank(s) must be turned on to assess that oxygen flows and the tank(s) remain half full.
 - b. Portable suction must be powered on and confirmed as functional.
 - c. Any other emergency equipment included in the stat kit must also be powered on and confirmed as functional.
 - d. Emergency supplies, and medications where included, must be inventoried to ensure that all necessary items are readily available.
 - e. The expiration dates on emergency supplies, and medications where included, must be monitored. Items that have expired or will expire prior to the next weekly stat kit assessment must be removed from the stat kit and replacements obtained.
 - f. Documentation of this assessment should be recorded on the Weekly Stat Kit Check Form (see template, [attachment C](#)) and maintained within the clinic for a minimum of three years.

OPERATING PROTOCOL FOR CRASH CART:

1. For clinics administering sedation or performing procedures in the clinic that put patients at risk of a significant cardiac or respiratory adverse event, a crash cart must be maintained in the clinic. Examples of procedures that require a crash cart include Exercise Stress Tests, Conscious Sedation, or any other advanced diagnostic test/procedure performed in the clinic.
2. Clinics may not share crash carts.
3. Any clinic that maintains a crash cart must have providers and staff with current ACLS and/or PALS certifications depending on population served. Current ACLS and/or PALS Algorithms appropriate for population served must be kept with the crash cart.
4. A list of required crash cart emergency equipment, supplies, and medications, as recommended by The American Heart Association's Advanced Cardiovascular Life Support (ACLS & PALS) Provider Manual Crash Cart List, is included (see Attachment B).
5. The Clinic Medical Director and Clinic/Nurse Manager may elect to include additional emergency equipment, supplies, and/or medications in their crash cart.
6. Only providers and licensed clinical staff may administer intravenous medications from a crash cart.
7. Certain emergency equipment on the crash cart must be checked weekly. As part of this weekly assessment, the following steps must occur:
 - a. The portable oxygen tank(s) must be turned on to assess that oxygen flows and the tank(s) remain half full.
 - b. Portable suction machine/device must be powered on and confirmed as functional.
 - c. The defibrillator or automatic external defibrillator (AED) must be powered on and confirmed as functional.
 - d. The laryngoscope blade, bulb, and handle must be assembled to confirm that the light works. If the crash cart contains a variety of blade sizes (as appropriate for the patient population served), each blade must be checked.
 - e. Documentation of this assessment should be recorded on the Weekly Crash Cart assessment form ([attachment D](#)) and maintained within the clinic for a period of 3 years.
8. At least monthly, all items included in the crash cart must be checked. As part of this monthly assessment, the following steps must occur:
 - a. Emergency supplies and medications must be inventoried to ensure that all necessary items are readily available.
 - b. The expiration dates on emergency supplies and medications must be monitored. Items that have expired or will expire prior to the next monthly crash cart assessment must be removed from the crash cart and replacements obtained.
 - c. Documentation of this assessment should be recorded on the Crash Cart Equipment Check Form (see [attachment E](#) for adult and [attachment F](#) for pediatrics) and maintained within the clinic for a period of 3 years.

OPERATING PROTOCOL FOR AED:

1. If a clinic elects to maintain an AED, it must be assessed as functional by following the manufacturer's recommendation when the stat/crash cart is checked. Documentation of this assessment must be recorded on either the Crash Cart Equipment Check Form or Stat Kit Weekly Check Form.

CRASH CART FORMS (MONTHLY CHECKLIST, WEEKLY CHECKLIST, REASON FOR OPENING, CODE BLUE SHEET): see next 7 pages

Crash Cart Contents Check List 2018 – page 1

[illegible][illegible]

Crash Cart Contents Check List 2018 – page 2

[illegible][illegible][illegible]

Crash Cart Contents Check List 2018 – page 3

DRAWER FIVE:	QTY	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC
Armboard: adult & peds	1 ea												
Alcohol wipes	1 box												
IV tubing	2 ea												
Macro drip (60 gtt/ml)	2 ea												
Tape: 1" & 2" paper and silk	1 ea												
Syringes:													
TB	3 ea												
3 cc, 5 cc, 10 cc	3 ea												
20 cc, 60 cc	2 ea												
Needles: 18 g, 20 g, 22 g, 23 g, 25 g	4 ea												
Angiocaths: 18 g, 20 g, 22 g, 24 g	4 ea												
Butterfly infusion sets: assorted sizes	2 ea												
IV start kit	4 ea												
Dextrose 5% 500 ml	2												
NACL 0.9% 250 ml	2												

BOTTOM SHELF:	QTY	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC
Emesis basin	2 ea												
Sheet	2 ea												
Barrier gowns	2 ea												
Ambu bag: adult & peds	1 ea												
Face shield / goggles	2 ea												
Disposable masks	2 ea												
Disposable booties	2 ea												
Biohazard spill kit	1 ea												
Sharps container, small	1 ea												
Biohazard bag	1 ea												

	QTY	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC
Nurse initials for the month	n/a												
Lock number	n/a												

Nurse signature

Crash Cart Weekly Check List 2018 – page 1

January	Defibrillator*	Suction Machine*	Extension Cord*	Oxygen Tank*	Lock #
Week 1					
Week 2					
Week 3					
Week 4 / 5					
February	Defibrillator*	Suction Machine*	Extension Cord*	Oxygen Tank*	Lock #
Week 1					
Week 2					
Week 3					
Week 4 / 5					
March	Defibrillator*	Suction Machine*	Extension Cord*	Oxygen Tank*	Lock #
Week 1					
Week 2					
Week 3					
Week 4 / 5					
April	Defibrillator*	Suction Machine*	Extension Cord*	Oxygen Tank*	Lock #
Week 1					
Week 2					
Week 3					
Week 4 / 5					
May	Defibrillator*	Suction Machine*	Extension Cord*	Oxygen Tank*	Lock #
Week 1					
Week 2					
Week 3					
Week 4 / 5					
June	Defibrillator*	Suction Machine*	Extension Cord*	Oxygen Tank*	Lock #
Week 1					
Week 2					
Week 3					
Week 4 / 5					
*All equipment listed above is checked weekly and is functioning properly					

Crash Cart Weekly Check List 2018 – page 2

July	Defibrillator*	Suction Machine*	Extension Cord*	Oxygen Tank*	Lock #
Week 1					
Week 2					
Week 3					
Week 4 / 5					
August	Defibrillator*	Suction Machine*	Extension Cord*	Oxygen Tank*	Lock #
Week 1					
Week 2					
Week 3					
Week 4 / 5					
September	Defibrillator*	Suction Machine*	Extension Cord*	Oxygen Tank*	Lock #
Week 1					
Week 2					
Week 3					
Week 4 / 5					
October	Defibrillator*	Suction Machine*	Extension Cord*	Oxygen Tank*	Lock #
Week 1					
Week 2					
Week 3					
Week 4 / 5					
November	Defibrillator*	Suction Machine*	Extension Cord*	Oxygen Tank*	Lock #
Week 1					
Week 2					
Week 3					
Week 4 / 5					
December	Defibrillator*	Suction Machine*	Extension Cord*	Oxygen Tank*	Lock #
Week 1					
Week 2					
Week 3					
Week 4 / 5					
*All equipment listed above is checked weekly and is functioning properly					

900 NE 10th Street, Oklahoma City, OK 73104 (405) 271-4311

REASON FOR OPENING CRASH CART LOG

[illegible]



Code Blue Sheet

Patient Label

Time Code Initiated _____ Weight _____

Condition when need for Chest compression/defibrillation was identified? ☐ Pulse (poor perfusion) ☐ Pulse less

Witnessed: ☐ Yes ☐ No Patient Conscious at Onset: ☐ Yes ☐ No

Airway/Ventilation

Type of Ventilation: ☐ Mouth to Mouth ☐ ETT ☐ Other _____

ETT Intubation: Time _____ Size _____ By Whom: _____

Secondary Confirmation: ☐ Auscultation ☐ Other _____

Bolus				Dose / Route				Infusions				Dose / cc				Comments: i.e.: Peripheral Line Placement, Vital Signs, Response to Interventions
Time	Resp. Spontaneous / Assisted	Pulse Spontaneous / Compressions	BP	Rhythm	Defib/Cardio Joules	Amiodarone Dose / IV	Atropine Dose / IV or ET	Epinephrine Dose / IV or ET	Lidocaine Dose / IV or ET	Vasopressin Dose / IV			Dopamine	Dobutamine		

Transport

EMSA Notification Time/Person: _____ EMSA Arrival Time: _____

EMSA Departure Time: _____ Resuscitation Event Ended @ _____ Status: ☐ Alive ☐ Dead

Recorder's Signature _____ Physician's Printed Name _____

Nurse's Signature _____ Physician's Signature _____

UNIVERSITY OF OKLAHOMA HEALTH SCIENCES CENTER OU PHYSICIANS FAMILY MEDICINE CENTER POLICY AND PROCEDURES			
Policy Name:	Inventory / Property Control / Moving Services		
Subsection:	17 – Medical Equipment & Supplies		
Page:	1 of 1	Source:	OUHSC Financial Services website
Effective Date:	11-01-1990	Revision Date:	07-09-2018
		Next Review Date:	07-09-2019

STATEMENT OF PURPOSE: The purpose of this policy is to outline and assist in maintaining a permanent and detailed centralized inventory system for recording all moveable tangible capitalized property in the department. For more details visit:

http://www.ouhsc.edu/financialservices/sua/property_inventory.asp

At no time can a University department or office discard a University asset without proper authorization; nor can a University asset be given or donated to any individual, private corporation, or non-profit organization.

Each department chair, director and/or budget unit head is responsible for all property purchased or transferred to his/her area as reflected on the official inventory records of the University.

POLICY & PROCEDURES: The following procedures are for clarification and highlight the overall policy of the University:

1. When the department purchases an item that meets the OU Policy for capitalized asset (lasting more than 1 year and costing \$5000.00 or more), the item will be carried as an asset of the University and posted in the property records.
2. When a capitalized asset is purchased, an inventory number will be assigned by OU Equipment Inventory and tagged by the OU Inventory Clerk. Inventory tags must not be removed from property except by authorized Property Inventory Section personnel.
3. Budgeted items purchased through grants at the request and approval of the principal investigator will be the responsibility of the principal investigator.
4. The department administrator and senior clinics administrator will share the responsibility of inventory control for the department. It should be noted that every effort must be made by division heads, the building manager, the nurse manager, and the senior clinic manager (or other assigned employees) to help assist in the inventory control.
5. Yearly, an inventory check will be performed to compare our property list with the computer generated property list from OU Equipment Inventory. Any differences will be noted and resolved by the department administrator and senior clinics administrator with the help of the reporting area's supervisor.
6. NO inventoried equipment is to be moved from room to room or between locations without written notification to the senior administrative manager. Computer equipment and audio-visual equipment are inventoried, tracked, and reported by IT staff. Clinic equipment and instruments may be moved (as needed) and is the responsibility of the senior clinics administrator.
7. Any inventoried item that needs to be moved is to be coordinated through the senior administrative manager. An electronic OU "Request for Moving Services" form will be submitted by the manager to finance for electronic submission. This documentation will allow the finance division to maintain each item's location on their inventory log.
8. Any inventoried item that is broken and/or not operating should be reported to the senior administrative manager. An electronic OU "Request for Moving Services" form will be submitted by finance so that the item can be moved to Surplus. If the item has an inventory number, the number will be submitted to finance who will then remove the item's inventory number from inventory.
9. Any lost or stolen items are to be reported to the Campus Police and the department administrator or finance director immediately. An Equipment Retirement form will be submitted by finance to Equipment Inventory.
10. Property on loan from the Federal Government must be accounted for and inventoried in the same manner as other University property.

UNIVERSITY OF OKLAHOMA HEALTH SCIENCES CENTER OU PHYSICIANS FAMILY MEDICINE CENTER POLICY AND PROCEDURES			
Policy Name:	Medical Supplies Provided to Patients		
Subsection:	17 – Medical Equipment & Supplies		
Page:	1 of 1	Source:	FMC
Effective Date:	02-27-1998	Revision Date:	07-01-2010
		Next Review Date:	

STATEMENT OF PURPOSE: The purpose of this policy is to establish guidelines for providing patients with medical supplies such as splints, air casts, crutches, glucometer strips, etc. Failure to account for these supplies leads to lost revenues, inaccurate inventory control, and an inaccurate office visit record.

POLICY & PROCEDURES: Clinic supplies are to be entered on the Encounter Form BEFORE being provided to the patient.

- An ABN should be filled out with prices, patient information, and the name of the supply needed.
- The ABN should be signed and dated.
- A copy of the ABN should be attached to the encounter form.
- The original ABN should be scanned into the patient's electronic medical record (EMR) chart.

The distribution of supplies to patients shall be viewed as an order by the nursing staff, which requires written documentation on the Encounter Form.

UNIVERSITY OF OKLAHOMA HEALTH SCIENCES CENTER OU PHYSICIANS FAMILY MEDICINE CENTER POLICY AND PROCEDURES			
Policy Name:	Expired Clinical Supplies		
Subsection:	17 – Medical Equipment & Supplies		
Page:	1 of 1	Source:	OU Physicians Intranet Online Policies CP24
Effective Date:	04-08-2008	Revision Date:	04-21-2017
		Next Review Date:	04-21-2020

STATEMENT OF PURPOSE: The purpose of the policy is to provide guidelines for the safe handling and disposal of expired drugs and clinical supplies.

STATEMENT OF OBJECTIVE: It is the policy of OU Physicians to assure the safety of patients and employees. Clinics must make every effort to promptly and appropriately dispose of expired drugs and clinical supplies.

DEFINITIONS:

Clinic – any clinical location under the direction of OU Physicians, OU Children’s Physicians or University of Oklahoma College of Medicine

DEA – Drug Enforcement Administration

EHSO – Environmental Health and Safety Office of the University of Oklahoma

OBND – Oklahoma Bureau of Narcotics and Dangerous Drugs

OPERATING PROTOCOL:

1. This policy will follow all applicable university policies.
2. Clinics are encouraged to develop appropriate purchasing and storage procedures to avoid excessive and unnecessary waste of drugs and clinical supplies.
3. Clinic managers are responsible for ensuring that all drugs and clinical supplies are used, or disposed of, on or prior to the expiration date.
4. Each clinic will follow a process for assessing and the disposal of expired drugs according to CP29 Safe Medication Administration in the Clinic Areas. The process will be documented in a log at a minimum monthly.
5. Clinics will appropriately dispose of expired drugs and clinical supplies according to the Environmental Health and Safety Office (EHSO) policy:
 - a. Pharmaceuticals - drugs that are not a controlled substance or hazardous waste may be sent back to the supplier/vendor or may be disposed of through a biomedical waste disposal vendor
 - b. Controlled drugs - all controlled drugs will be disposed of according to DEA and OBND requirements.
 - c. Hazardous drugs (cytotoxic/antineoplastic agents) - disposal of all hazardous drugs will be arranged through an outside biomedical waste disposal vendor.
 - d. Expired non-hazardous clinical supplies such as gowns, gloves, casting materials etc., may be discarded in an appropriate waste receptacle.
 - e. Expired hazardous clinical supplies including supplies that contain sharps including needles, syringes and breakable items may be placed in a biohazard receptacle or disposed of through an outside biomedical waste disposal vendor.
6. University policy prohibits the selling or donating of university property except through established procedures of the University. Donations of unused and expired supplies may be sent to the Clinical Skills Education and Testing Center (CSETC). The OU Surplus Property Policy should be followed in all instances. Clinics may not donate or sell surplus, unwanted, or expired drugs or clinical supplies to any other organization, entity or individual. Clinics should not accept the donation of expired drugs or clinical supplies. Employees may not expropriate university property including drugs or clinical supplies for personal, non-clinical or non-university use.
7. Questions concerning the safe disposal of expired drugs or clinical supplies may be directed to the OUHSC Environmental Health and Safety Office at 271-3000 or consult the EHSO web site at [www. http://w3.ouhsc.edu/ehso/](http://w3.ouhsc.edu/ehso/)