Wake Forest Baptist Health	Laboratory Safety Manual	Document Control Number:	
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		Contact:	Laboratory Compliance, Quality & Safety
CLIA Laboratory Director Signature:		Date Approved:	4/11/19

I. General Policy/Procedure Statement:

It is the policy of Wake Forest Baptist Medical Center to ensure that all staff members are aware of all safety guidelines, regulations, standards and laws for the Anatomic and the Clinical Pathology Laboratory department in accordance with the governing bodies that apply. (This is to include, but is not limited to: CLIA, CAP, TJC, OSHA, ANSI, NIOSH, EPA, CDC & the FDA, etc.) It is also the policy of Wake Forest Baptist Medical Center to perform quarterly safety inspections for the Pathology Laboratories in accordance with the EH&S, Security and Risk Management Departments of WFBMC.

1. Scope:

The purpose of the Laboratory Safety Manual is to provide guidelines for all employees of WFBMC laboratories and extensions of these laboratories where laboratory testing is performed. The goal is to ensure that all staff understands the laboratory safety standards, rules and regulations as well as the process for corrective action of deficiencies/discrepancies of laboratory safety inspections.

All WFBMC laboratories and extensions of these laboratories where laboratory testing is performed must adhere to all rules, regulations, procedures and policies set forth by WFBMC. Many of these policies and publications are referenced and are made available in the shared version of this manual.

The Laboratory Safety Governance Committee meets monthly and will discuss relevant safety issues as well as safety inspection findings in conjunction with the regulations of WFBMC.

2. Definitions/Acronyms:

AL, STEL PELS: The information in the Laboratory Safety Manual informs workers of health hazards associated with working in the laboratory to include chemical limits -- action limits (AL), short-term exposure limits (STEL), or permissible-exposure limits (PELS) as established by OSHA.

FDS: Fire, Disaster & Safety Manual

Sentinel Event: an unanticipated death or major permanent loss of function, not related to the natural course of the patient's underlying condition.

3. Responsible Department/Party/Parties:

a. Manual Owner: Laboratory Compliance, Quality & Safety

b. Supervision: The Medical Director and/or Laboratory Director, as indicated shall enforce all regulations outlined in this document.

c. Implementation: Each laboratory director and/or site manager is

responsible for ensuring compliance with processes stated in this document.

II. General Laboratory Safety Guidelines:

- New employees will have safety training during their orientation by the lab manager or designee. Annually, specific required safety training is provided to all hospital employees.
- Do not eat, drink, smoke, apply cosmetics (including lip balm) or handle contacts in the laboratory.
- Wash hands before conducting any of these activities once you have left the laboratory.
- Food and beverages are not to be stored in refrigerators where chemicals, reagents or specimens are stored.
- Do not use mouth suction for pipetting or starting a siphon.
- Confine long hair and loose clothing.
- No sandals, open-toe, open-heel, open-side or open-weave shoes are permitted.
- Never manually manipulate needles or sharps in any way to include recapping, bending or breaking.
- Any patient interaction requires appropriate hand hygiene/cleansing agents.
- It is the responsibility of each employee to take steps in accident prevention.
- Use all instrumentation/equipment minding manufacturer recommendations.
- Work areas should be kept clean and uncluttered and are to be disinfected and/or decontaminated daily.
- Follow hospital policy while transporting specimens, either internally to include via tube system or externally.
- Ergonomics is also a way to personally protect oneself. Consult the hospital ergonomic program and assessment form for guidelines.
- Consult the hospital policy on noise exposure and assessments.
- In the event of a latex allergy, consult the hospital policy.
- During external disasters, remain in your work space and continue tasks. During internal disasters, consult the FDS and area supervisor. All employees should work in accordance with the lab specific Mass Casualty and Bioterrorism policies.
- Evacuate if necessary using the route provided for the appropriate lab section.
- To clean broken glass, the hospital's policy must be followed.
- The hospital has a policy for information on Creutzfeldt-Jakob Disease (CJD) Infection Control Guidelines and a Tuberculosis Plan. If you will potentially be exposed to the disease, you are required to read and abide by the policy.
- All employees are to be offered hepatitis B vaccinations. This is done by Employee Health. They will keep records of vaccination or records signed by employees declining the vaccine.

III. PPE and other equipment:

Personal protective equipment (PPE) – consists of gloves, aprons, safety glasses, face shields, respirators & other protective equipment. Personal protective equipment is provided for all employees where needed and must be used where required. Personal protective equipment is removed immediately upon leaving the work area. Equipment should be discarded or cleaned and placed in the appropriate location. Some sections of the laboratory require special

respiratory precautions. If a respiratory hazard is determined, or when working with tuberculosis, very strict hospital policies must be followed.

IV. Chemical Use:

Few chemicals are without hazard; therefore, all should be handled with extreme care. Do not smell or taste chemicals. A list of hazardous chemicals and carcinogens is located in each laboratory section. SDS paper copies are available in each area of the laboratory. Annual Chemical Reviews must be done annually using the SDS' to assess Toxicity and Carcinogenicity (see Attachment B). Use chemicals in hoods where required. Use hoods properly with the sash at proper operating height. Report and/or correct any unsafe condition before using any laboratory equipment or chemical. Formaldehyde monitoring will be performed initially on all staff, and randomly annually by EH&S in applicable areas, and upon change of any process dealing with the use of formaldehyde. Xylene monitoring will be performed initially on all staff, and upon change of any process dealing with the use of xylene.

1. Labeling:

All hazardous chemicals received by the laboratory should be properly labeled. Labels must not be removed or defaced unless the bottle is being discarded. Any chemical transferred to a secondary container must be labeled with: chemical name, hazard (if applicable), manufacturer and expiration date. Please consult the Laboratory Reagent Labeling policy for detailed information.

2. Storage:

The hazardous chemical inventory should be kept as small as possible. Storage on bench tops and in hoods should be avoided. Flammable/combustible liquid stored amounts shall not exceed amounts specified by OSHA and NC Fire Code. Chemicals must be stored in appropriate cabinet. One day's working supply may be outside the storage cabinet.
Liquid Nitrogen is in use, follow the hospital, EM or BMT policy depending on where you dispense from. Liquid nitrogen is to be monitored by an O^2 sensor. Look for detailed information near the liquid nitrogen regarding the instructions in the case of an alarm.
Compressed gas cylinders are to be strapped or chained to the wall or bench top and capped when not in use.
The hospitals flammable/combustible liquids guidelines will always be followed when using these substances.

3. Laboratory Chemical Spill Response Procedures:

If the chemical spilled is considered a carcinogen, reproductive toxin or highly toxic chemical, contact (6-9111) and evacuate area immediately, regardless of spill amount. If you are unsure of the type of chemical you are working with, contact (6-9111). For all other spills: Spill less than 300 mL Contact Environmental Health and Safety (6-9375) and clean up spill using spill kit. During quarterly inspections, inspection of the spill kit products will be conducted. To test, shake the SPILL-X shaker(s). As long as the product remains free flowing in its granular form, the product can remain in use. For spills greater than 300 mL- Do not attempt to clean up spill. Immediately report spills to WFBMC Security (6-9111).

V. Waste Disposal to include Chemical and Contaminated Waste:

- Recycle all office paper and PHI in the Info Shred recycle bins.
- Discard cans in can recycling bins.

1. Contaminated/Hazardous waste:

- All hazardous waste will be stored and disposed of in accordance with the WFBMC EH&S FDS manual.
- Biohazard waste containers (Red Bag Trash) should not contain paper, etc. that can be discarded in the regular or shred trash. The weight limit for biohazardous waste is 50 pounds maximum as mandated by NIOSH. When the biohazard box is filled, the bag opening is twisted, taped shut and the box is sealed. Hazardous waste containers should be labeled "Hazardous Waste".
- Waste chemicals can be collected by EH&S for disposal or recycling. Hazardous waste handlers must have annual Hazardous Waste training.

2. Sharps:

Needles should be disposed in the puncture-proof, self-sealing plastic needle box. Once filled ¾ full, or to the mark designated on the sharps container, lock the box.
Full needle boxes and bio-waste is collected by environmental services.

VI. Medical Surveillance and records:

Medical surveillance will be handled according to hospital protocol in cases of: Exposure after spills, leaks, fingersticks etc., When signs or symptoms of over exposure occur, or if monitoring shows exposure (>STEL or >PELS) by EH&S, Employee Health and Risk Management will be notified. All records will be kept as stated by hospital policy.

VII. Equipment Inspection and Maintenance:

1. All safety and chemical-hygiene-related equipment must be periodically inspected. Biohazard and fume hoods are inspected and certified annually by a certified vendor, and signage of certification is posted on each hood.
2. Eyewash fountains and safety showers are inspected for proper functioning (flushed) weekly. Records are kept in each lab area (See Attachment C). Weekly checks will ensure:
   - **a.** Controlled, low velocity flow completely rinses area is not injurious to user.
   - **b.** Spray heads are protected from airborne contaminants.
   - **c.** Covers of eyewashes are removed by water flow.
   - **d.** Unit delivers at least 3.0 gallons (11.4 liters) of water per minute for 15 minutes, and water flow pattern is positioned between 33" (83.8 cm) and 53" (134.6 cm) from the floor and at least 6" (15.3 cm) from the wall or nearest obstruction.
   - **e.** Valve/turn on or pull is easy to locate and readily accessible to user.
   - **f.** Eyewash unit washes both eyes simultaneously.
   - **g.** Wash unit within 10 seconds (approximately 55 feet) of any hazard, on the same level as hazard and with unobstructed travel path.
   - **h.** Where strong acids or caustics are being handled, emergency units should be located adjacent to the hazard.
   - **i.** Identify eye/facewash/shower location with highly visible sign in a well-lit area.

j. Water Temperature: Water delivered shall be tepid (60-100°F).
k. Bottled eyewash, inspect weekly for purity and expiration.

3. There is a hospital policy in place to prevent the movement of airborne pathogens or other hazardous materials either to or from the protected spaces through the design, installation, and maintenance of ventilation systems that meet the appropriate airflow patterns for work spaces. Quality and quantity of ventilation are monitored periodically by the engineering department and upon request, by EH&S. There should be no modification of any safety equipment.
4. All safety procedures and policies must be followed to prevent or reduce ultraviolet light exposure from instrument sources. UV light may cause corneal or skin burns from direct or deflected light sources. Wherever UV light sources are used, suitable and adequate personal protective equipment must be used, and appropriate signage must be displayed. If you will be working with any radiologic materials or instruments, the procedures are available. All policies and procedures for radiation safety must be followed at all times. Contact EH&S to monitor for radiation leakage as appropriate after moving or service.
5. Consult the hospital Electrical Safety Guidelines and contact engineering if: the equipment is inoperative, there are frayed or damaged or exposed power cords, wires or leads, there is loose, broken, cracked, damaged switches or plugs, or broken pins on equipment plugs, or damaged wall outlets, receptacles, plates or switches.

VIII. Fire Safety and Prevention:

1. Ensure that fire extinguisher/equipment is appropriate for potential hazards.
2. It is the responsibility of every manager to ensure that all lab personnel know how to execute both the RACE – Rescue – Alarm – Confine (Contain) – Extinguish or Evacuate and PASS – Pull – Aim – Squeeze – Sweep procedures. Each employee will complete annual WFBMC Fire Safety education.
3. In the case of fire: Determine the location of the fire or chemical hazard. Rescue any endangered personnel without endangering yourself. Call 6-9111 or activate an alarm pull station to report a fire. Use available fire equipment or chemical retardant to extinguish the fire or contain the chemical. Close all corridor doors.
4. At least annually the section Lab Safety Officer should walk and evaluate the section evacuation route, and any changes should be given to all section employees (see Attachment D). Evacuation routes should be discussed with ALL staff, and a meeting area outside the hospital and/or area should be determined. Follow the evacuation plan for your area if indicated. Upon reaching your evacuation meeting place, the manager will account for all employees and advise of any missing persons. Wait at your assigned meeting place for further instructions from the person in charge. At the "All Clear", all personnel should return to their normal duties. If any sentinel event takes place, please report.

IX. Safety Inspections Procedure:

1. Safety inspections are conducted quarterly. A member of the Laboratory Compliance, Quality & Safety Department will conduct the inspection. Please see Attachment A.
2. A CAPA (Corrective Action / Preventative Action) form must be filled out if any major deficiency is noted.
3. The CLIA Director will sign off on safety committee minutes and safety inspections. CLIA

Director will also accompany Laboratory compliance on inspection to assess the environment of care and staffing at least annually.

X. Review/Revision/Implementation:

1. Review Cycle: Annually-All new policies/procedures/guidelines and those that have major revisions must be reviewed/signed by the CLIA Laboratory Director.
2. Office of Record: Laboratory Compliance, Quality & Safety

XI. Related Policies:

1. Dept of Pathology: CAPA (Corrective Action/Preventative Action)
2. Dept of Pathology: Reagent Labeling Policy
3. Be aware of all of the following:

WFBMC FDS Manual
WFBMC Accident Prevention Policy
WFBMC Hand Hygiene
WFBMC Cleansing Guide
WFBMC Keeping Employees Safe
WFBMC Transport of Samples
WFBMC Tube System Leak Policy
Managing and Waste Hazards
WFBMC PPE Plan
WFBMC Lab PPE Plan
WFBMC Ergonomics Guide
Hearing/Noise Exposure Guide
WFBMC Latex Allergy Policy
Respiratory Protection Program
WFBMC Tuberculosis Plan
WFBMC Chemical Hygiene Plan
Particularly Hazardous Chemicals
Particularly Hazardous Chemical List
Incompatibilities By Hazard Class
Chemical Incompatibility Table
WFBMC Chemical Inventory
Chemical Exposure Assessment
Compressed Gas Cylinder Safety
WFBMC Disposal of Needles and Sharps Policy
WFBMC Spill Response
WFBMC Body Fluid Spill
WFBMC Electrical Safety
Controlled Air-Pressure Spaces Policy
WFBMC Radiation Protection Policy
WFBMC Radiation Safety Guidelines
IH Monitoring for Formaldehyde
IH Monitoring for Xylene
WFBMC Broken Glass Protocol

Flammable/Combustible Liquids
Fire/Life Safety Plan
WFBMC Reporting Events Policy
WFBMC Sentinel Event Plan
WFBMC Manager's Responsibility Guidelines
WFBMC Risk Assessments
WFBMC Risk Assessment Guidelines
WFBMC Patient Rights and Privacy

12) References:

CAP MANDATE CODE OF FEDERAL REGULATIONS 29 CFR 1910.1450: 29 CFR 1910.1450

13) Attachments:

Attachment A: General Safety Inspection Form
Attachment B: Annual Chemical Review
Attachment C: Eyewash/Shower Flush and Maintenance Record
Attachment D: Fire Evacuation Plan and Power Failure Plan

14) Revision Dates:

Complete re-work, and re-format. 4/19 BAS		

GENERAL LABORATORY SAFETY INSPECTION FORM

SITE:_____DATE:_____

INSPECTOR:_____

Attachment A

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INSPECTION ITEMS/HIGHLIGHTED DISCREPANCIES:	DISCREPANCY #:
Handwashing-handwashing sinks available/labeled specimen sinks labeled, proper handwashing agents available, handwashing after glove removal PPE-gloves-available & used properly, gowns/lab coats-available & used properly, eye protection-available & used properly, mouth/nose protection-available & used properly, respiratory protection-available & used properly, point of use sharps containers, not overfilled Work practice-eating/drinking in work area, specimen refrigerator-labeled, temps recorded, no PPE worn outside designated area, secondary transport, cleaned & used properly, contaminated equipment labeled, broken glass cleanup equipment Waste system-red bags-available & used properly Miscellaneous-exposure protocol known by staff, manager monitoring bloodborne pathogens policy Chemical-proper storage containers, proper storage in cabinets, labeled appropriately, proper protection Electrical-no extension or frayed cords, no space heaters Fire-equipment in place/available, no doors propped open Gases-cylinders strapped in place & only moved with cap on Radiation safety-staff trained & exposure monitored, protection-available & used properly Equipment -shower & eyewash, available & used properly, maintenance done IC/CAP-reagent dates-received, open & expiration boxes on floor, storage too close to ceiling, storage under sinks, no expired reagents in use Waste-labeled "hazardous" & start fill date on container Spill kit shakers- free-flowing, unopened SDS-easily located Other-	

GENERAL LABORATORY SAFETY INSPECTION FORM

Attachment A

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DISCREPANCY# & CORRECTIVE ACTION:		DISCREPANCY & EXPLANTION:

Manager:	Director:
Date:	Date:

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LABORATORY ANNUAL CHEMICAL REVIEW Attachment B

Laboratory Area: Date:

Chemical Name	Common Name	Exposure Limit	*Toxic/ Carcinogenic Y or N

Review Done by:_____ Date:_____

FOR ALL "Y's" IN THIS COLUMN, SEE CORRESPONDING SDS FOR DETAILED INFORMATION ON THE HANDLING, DISPOSAL AND EXPOSURE PROCEDURES OF THE CORRELATING CHEMICAL

Wake Forest Baptist Health

Eyewash/Shower Flush and Maintenance Record

Attachment C

Weekly checks done to ensure- Controlled, sufficient flow. Spray heads are protected. Unit delivers appropriate amount. Water flow pattern is positioned correctly. No obstructions. Valve/pull is easy to locate. Eye unit washes both eyes simultaneously. Located close to hazards, and identified with highly visible sign. Area around wash unit shall be well-lit. Water Temperature: Water delivered by wash unit shall be tepid (60-100°F). Bottled eyewash, inspect weekly for purity and expiration.

Date	Initials	Date	Initials

ECN/LOCATION:

CORRECTIVE ACTION:

Date: Initials:

CORRECTIVE ACTION:

Date: Initials:

CORRECTIVE ACTION:

Date: Initials:

CORRECTIVE ACTION:

Date: Initials:

MANAGER:

DATE:

Wake Forest Baptist Health

Environmental Health and Safety
Phone 336-716-9375 Fax 336-716-8577

Attachment D

BUILDING / AREA EVACUATION PLAN			
EFFECTIVE DATE		**REVISED DATE**	
CAMPUS		**PRIMARY AREA EVACUATION COORDINATOR**	<position>
BUILDING			
LOCATION		**ALTERNATE AREA EVACUATION COORDINATOR**	<position>
DEPARTMENT			

REPORTING AN EMERGENCY
From any telephone, call:

On Campus	**716-9111**
Off Campus	**911**

FIRE (Code Red)

In the event of fire, smoke, or any emergency that requires evacuation from the building, please do the following:

P A S S

PULL • Pull the pin on the extinguisher
AIM • Point the nozzle at the base of the fire
SQUEEZE • Squeeze the lower grip to the handle, discharging the extinguishing agent.
SWEEP • Move the nozzle from side to side in a steady motion until the fire has died down or the extinguisher is empty • If the fire has gone out, back away from the site and exit…shutting the door if possible. • If the fire has died down but flames are still visible, use an additional extinguisher if available. If no additional extinguisher is available, back away and shut the door. Communicate that the fire is still active and evacuate the area immediately.

R A C E

R	**RESCUE** Rescue persons in danger.
A	**ALARM** 1. Pull the fire alarm. Pull stations are located within 10 feet from each exit/entrance. 2. Call the Emergency Number: 6-9111/911. You should remain in communication with the emergency operator providing as much detailed information as possible i.e.: address and location of fire or smoke.
C	**CONTAIN** 1. Contain the fire. 2. Do not break windows. 3. Close but DO NOT lock any doors.
E	**EXTINGUISH/EVACUATE** 1. If smoke or fire is visible, close the door(s) to that area and verbally notify everyone in the immediate area. 2. Notify Emergency Communications. 3. Exit the floor in a quick, orderly fashion via the nearest exit, (*APPENDIX A & B).* 4. Never allow the fire to get between you and the nearest exit. 5. Stay low to the ground to avoid smoke.

	6. Proceed to the assigned emergency assembly point. 7. ***EXTINGUISH*** *For Ambulatory Healthcare Occupancies only*

THE DEPARTMENT'S EMERGENCY ASSEMBLY POINT IS...

_____

(The designated emergency assembly point location for the occupants of the Department/Unit)

Horizontal Evacuation Route	
Primary	
Secondary	

Vertical Evacuation Route	
Primary	
Secondary	

If you have visitors, escort them to the closest unaffected exit and/or instruct them to meet in the designated assembly point. You are responsible for the safety of visitors in your area.

AREA EVACUATION COORDINATOR RESPONSIBILITIES

1. Check all rooms to ensure that all persons are evacuated.
2. Direct persons evacuating to the designated emergency assembly point.
3. Once all personnel are evacuated, move to the assigned assembly point.
4. Be able to provide an accurate head count of all assigned personnel and visitors/patients.

SPECIAL NOTES

1. Procedures for moving or evacuating disabled employees and or non-ambulatory patients should be determined prior to any emergency.
2. The building will not be reoccupied until the Authority Having Jurisdiction (AHJ) provides information that the building is in a safe condition for re-entry.
3. For unit specific evacuation plan, please contact the supervisor.

DEPARTMENT/ UNIT SPECIFIC EVACUATION PLAN

Building Location:		**Department/ Unit:**		**Floor:**		**Manager:**	
Contact Number:		**Effective Date:**		**Last Reviewed:**			

The manager or designee is responsible for the execution of the evacuation plan.

This plan is to be used in conjunction with the attached checklist.

I. Establish Evacuation Route:

A. Determine Destination or Assembly Area

1. Emergency Assembly Point Location:
2. Area of Refuge:
3. Alternate Assembly Points:

B. Horizontal Evacuation Route

1. Primary Route:
2. Secondary Route:

C. Vertical Evacuation Route

1. Primary Route
2. Secondary Route

II. Establish Priorities:

A. Logistical Needs (Portable O_2, Wheel Chairs, Blankets, Office Supplies, Communication Devices, etc.) After evacuation

B. Notification of evacuation to: Other:

III. Determine Additional Staffing Needs:

A. During Evacuation:

B. At the Assembly Point:

IV. A. Specific Information:

DEPARTMENT/ UNIT SPECIFIC POWER FAILURE PLAN

Unit: | **Building:** | **Floor:** | **Unit Mgr.**

Asst. Unit Mgr. | **Effective Date:** | **Last Reviewed:**

THIS SECTION TO BE COMPLETED AT THE TIME OF THE POWER FAILURE:

1. Are the **RED OUTLETS** functioning:

   If **YES**, refer to **Section A** of the Emergency Power/Power Failure Utility Matrix to determine availability of utilities.

   If **NO**, refer to **Section B** of the Emergency Power/Power Failure Utility Matrix to determine availability of utilities.

2. What is the current total unit bed census?

3. What is the current bed census of patients on critical life support?

4. Based on the answers to questions 1, 2, and 3, is there sufficient power available to sustain critical life support?

   If **YES**, defend in place

   If **NO**, begin unit specific evacuation procedures (Refer to Unit Specific Evacuation Template)

THIS SECTION TO BE COMPLETED PRIOR TO THE POWER FAILURE

1. Who (what position) will be assigned to survey adjoining units to determine the extent of the power failure?

2. Who (what position) is authorized to order a unit evacuation?

3. Where is the closest unit, not on the same generator, that this unit can evacuate to? (See Engineering Policy WFBMC-ENG. PROTOCOL-58: Emergency Power Summary)

4. Where is the next closest unit, not on the same generator, that this unit can evacuate to?

5. Where will this plan be located for quick reference?

6. Who (what position) will be responsible for making notifications?

7.

Who must be notified?	Number

8. What additional personnel (by position) will be needed and how many?

Personnel	How Many?

9. Who is responsible for maintaining power failure related equipment? (IE: ensuring rechargeable battery operated devices such as portable suctions, transport vents, portable monitor/defibrillators, are plugged into red outlets and are always operable)

10. What power failure equipment is available, and where is it stored? (IE: Ambu bags, flashlights and batteries, paper charts, manual sphygmomanometers, portable suctions, transport vents, portable monitor/defibrillators etc.)

Equipment	Location

11. Who is responsible for maintaining the Unit's Business Continuity Recovery Box. (See unit specific INTERNAL DISASTER RESPONSE AND RECOVERY PLAN)

12. Where is the Unit's Business Continuity Recovery Box located?

13. In the event of a total power failure that includes total HVAC failure, what additional precautions should be taken for immuno-compromised patients?

14. Who will be responsible for manually unlocking automated drug supply cabinets?

15. What critical refrigeration is located on the unit, and where, i.e. lab specimens, research experiments, etc?

Refrigerator Contents	Location

16. Are those refrigerators marked or identified for responding personnel? ☐

17. What power failure telephones are available on the unit (extension) and where are they located?

Extension	Location
777-	
777-	
777-	

Comprehensive List of Power Failure Emergency Phones
http://intranet.wakehealth.edu/Departments/Help-Desk/Software-and-Services/Power-Failure-Phone-List-Distribution.htm

(Link also found on the Intranet: Click on Help Desk, then scroll to bottom of page and find "Power Failure Phones