HARRISHEALTH SYSTEM

AMBULATORY SURGICAL CENTER (ASC) AT LBJ GOVERNING BODY

Thursday, February 17, 2022
9:00 A.M.

BOARD ROOM
4800 Fournace Place, Bellaire, Texas 77401

The meeting may be viewed online at: **http://harrishealthtx.swagit.com/live**

Mission

Harris Health is a community-focused academic healthcare system dedicated to improving the health of those most in need in Harris County through quality care delivery, coordination of care, and education.

AGENDA

I.	**Call to Order and Record of Attendance**	**Ewan D. Johnson, MD, PhD**	**2 min**
II.	**Approval of the Minutes of Previous Meeting** ASC at LBJ Governing Body Meeting – November 18, 2021	**Ewan D. Johnson, MD, PhD**	**1 min**
III.	**General Action Item(s)**	**Ewan D. Johnson, MD, PhD**	**15 min**
	A. Consideration of Approval of Policies and Procedures for the Ambulatory Surgical Center at LBJ ***– Dr. Scott Perry and Mr. Matthew Reeder*** **(See Attached ASC at LBJ Policy Summary: February 17, 2022)**		*(10 min)*
	B. Consideration of Approval of the Harris Health System Medical Staff Bylaws for the Ambulatory Surgical Center at LBJ ***– Dr. Scott Perry and Mr. Matthew Reeder***		*(5 min)*
IV.	**ASC at LBJ Medical Director and Administrator Reports**	**Ewan D. Johnson, MD, PhD**	**10 min**
	A. Report Regarding Medical Staff Operations, Clinical Operations, Statistical Analysis of Services Performed and Operational Opportunities at the Ambulatory Surgical Center at LBJ, Including Questions and Answers ***– Dr. Scott Perry and Mr. Matthew Reeder***		

V.	**Executive Session**	**Ewan D. Johnson, MD, PhD**	**30 min**
	A. Consideration of Approval of Medical Staff Applicants and Privileges for the ASC at LBJ, Pursuant to Tex. Health & Safety Code Ann. §161.032 and Tex. Occ. Code Ann. §160.007 to Receive Peer Review and/or Medical Committee Report in Connection with the Evaluation of the Quality of Medical and Health Care Services, Including Possible Action Upon Return to Open Session ***– Dr. Scott Perry***		*(10 min)*
	B. Report by the Executive Vice President, Chief Compliance and Risk Officer, Regarding Compliance with Medicare, Medicaid, HIPAA and Other Federal and State Healthcare Program Requirements and a Status of Fraud and Abuse Investigations, Pursuant to Tex. Health & Safety Code Ann. §161.032, Including Possible Action Regarding this Matter Upon Return to Open Session ***– Ms. Carolynn Jones***		*(10 min)*
	C. Report by the Chief Medical Executive Regarding Quality of Medical and Health Care, Pursuant to Tex. Health & Safety Code Ann. §161.032 and Tex. Occ. Code Ann. §160.007 to Receive Peer Review and/or Medical Committee Report in Connection with the Evaluation of the Quality of Medical and Health Care Services including ASC at LBJ Quality Scorecard Report, Quality Review Committee Report and Medical Executive Committee Report, Including Possible Action Upon Return to Open Session ***– Dr. Scott Perry, Dr. Matasha Russell and Mr. Matthew Reeder***		*(10 min)*
VI.	**Reconvene**	**Ewan D. Johnson, MD, PhD**	**1 min**
VII.	**Adjournment**	**Ewan D. Johnson, MD, PhD**	**1 min**

MINUTES OF THE HARRIS HEALTH SYSTEM
AMBULATORY SURGICAL CENTER AT LBJ GOVERNING BODY MEETING
November 18, 2021
9:00 AM

AGENDA ITEM	DISCUSSION	ACTION/RECOMMENDATIONS
I. Call to Order & Record of Attendance	The meeting was called to order at 9:00 a.m. by Ewan Johnson, MD, Chair. It was noted that a quorum present and the attendance was recorded.	**A copy of the attendance is appended to the archived minutes.**
II. Approval Of The Minutes Of The Previous Meeting	Approval of the Minutes of Previous Meetings: • ASC Governing Body Meeting – August 19, 2021	**Motion No. 21.11-13** **Moved by Ms. Linda Morales, seconded by Ms. Alicia Reyes, and unanimously passed that the Governing Body approve the minutes of the previous meeting. Motion carried.**
III. General Action Item(s)	A. Approval of Appointment of Key Positions of the ASC at LBJ. i. Clinical Manager(s) – Rebecca Lee ii. Risk Manager – Scott Stanley Mr. Matthew Reeder, R.N., Administrator, ASC at LBJ, presented the appointment of Key Positions of the ASC at LBJ, stating that this is an American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF) requirement.	**Motion No. 21.11-14** **Moved by Ms. Alicia Reyes, seconded by Ms. Linda Morales, and unanimously passed that the Governing Body approve III.A. Motion carried.**
	B. Approval of Policy ASC-P-4002 Approved Procedures for the ASC at LBJ. Mr. Reeder presented Policy ASC-P-4002 - Approved Procedures for the ASC at LBJ. He stated that the policy was revised to include *Ablation of tumor (larynx/pharynx/oral cavity) and Use of laser* as an approved procedure under the Otolaryngology, attachment A of the policy. A copy of the revised policy is available in the permanent record.	**Motion No. 21.11-15** **Moved by Ms. Alicia Reyes, seconded by Ms. Linda Morales, and unanimously passed that the Governing Body approve III.B. Motion carried.**
	C. Approval of the 2022 ASC at LBJ Governing Body Board Calendar. Mr. Reeder presented the 2022 ASC at LBJ Governing Body Board Calendar for approval. A copy of the calendar is available in the permanent record.	**Motion No. 21.11-16** **Moved by Ms. Linda Morales, seconded by Ms. Alicia Reyes, and unanimously passed that the Governing Body approve III.C. Motion carried.**

IV. ASC at LBJ Medical Director and Administrator Reports	Report Regarding Medical Staff Operations, Clinical Operations, Statistical Analysis of Services Performed and Operational Opportunities at the ASC at LBJ Including Questions and Answers. Dr. Scott Perry, Medical Director, ASC, presented the MEC minutes of the previous meetings. He stated that Ben Taub (BT) Orthopedics has expanded their pool of physicians coming to the ASC and that the providers have been coming on site every other Friday to do cases. This has helped to alleviate some of the volume from the BT emergency center (EC) similarly to what was done to help the LBJ EC. Dr. Perry stated that most of the hand hygiene fallouts have been around the residents and medical students. Consequently, the ASC has made efforts to educate the residents and medical students before they arrive in the ASC. Dr. Perry stated that the ASC received its vitrectomy equipment, in which they can move sicker non-ASC candidates for vitrectomy back to the main operating room (OR) using that second set of equipment. He explained that having the appropriate equipment assists in getting the appropriate patients to the appropriate locations, and establishing a second ophthalmology room to perform cataract surgeries due to the massive backlog that needs to be addressed. Copies of the reports are available in the permanent record.	**As reported.**
V. Executive Session	At 9:15 a.m., Dr. Johnson stated that the Governing Body would enter into Executive Session under Texas Health & Safety Code Ann. §161.032 and Texas Occupations Code Ann. §160.007.	
VI. Reconvene	At 9:29 a.m., Dr. Johnson reconvened the meeting and stated that no action was taken in Executive Session.	
	A. Approval of Medical Staff Applicants and Privileges for the ASC at LBJ, Pursuant to Texas Health & Safety Code Ann. §161.032 and Texas Occupations Code Ann. §160.007 to Receive Peer Review and/or Medical Committee Report in Connection with the Evaluation of the Quality of Medical and Health Care Services, and Possible Action Upon Return to Open Session. Dr. Scott Perry presented the credentialing changes for physicians of the ASC at LBJ medical staff. A copy of the report is available in the permanent record.	**Motion No. 21.11-17** **Moved by Ms. Alicia Reyes, seconded by Ms. Linda Morales, and unanimously passed that the Governing Body approve V.A. Motion carried.**
	B. Report by Executive Vice President, Chief Compliance and Risk Officer, Regarding Compliance with Medicare, Medicaid, HIPAA and Other Federal and State Health Care Program Requirements and a Status of Fraud and Abuse Investigations, Pursuant to Section 161.032 of the Texas Health & Safety Code, and Possible Action Upon Return to Open Session.	**No Action Taken.**
	C. Report by the Chief Medical Executive Regarding Quality of Medical and Health Care, Pursuant to Texas Health & Safety Code Ann. §161.032 and Texas Occupations Code Ann. §160.007 to Receive Peer Review and/or Medical Committee Report in Connection with the Evaluation of the Quality of Medical and Health Care Services including ASC at LBJ Quality Scorecard Report, Quality Review Committee Report and Medical Executive Committee Report, and Possible Action Upon Return to Open Session.	**No Action Taken.**

VII. Adjournment	Moved by Ms. Linda Morales, seconded by Ms. Alicia Reyes, and unanimously approved to adjourn the meeting. There being no further business to come before the Governing Body, the meeting adjourned at 9:30 a.m.	

I certify that the foregoing are the Minutes of the Harris Health System ASC at LBJ Governing Body Meeting held on November 18, 2021.

Respectfully Submitted,

Ewan Johnson, M.D., Chair

Minutes transcribed by Cherry Pierson

Thursday, November 18, 2021

Harris Health System Board of Trustees – ASC at LBJ Governing Body Attendance

Note: For Zoom meeting attendance, if you joined as a group and would like to be counted as present, please submit an email to: BoardofTrustees@harrishealth.org before close of business the day of the meeting.

ASC at LBJ GB BOARD MEMBERS PRESENT	ASC at LBJ GB BOARD MEMBERS ABSENT	OTHER BOARD MEMBERS PRESENT
Dr. Ewan Johnson (Chair)		Professor Marcia Johnson
Ms. Alicia Reyes		
Dr. Arthur Bracey (Ex-Officio)		
Ms. Linda Morales		
Mr. Matthew Reeder, Administrator, ASC		
Dr. Scott Perry, Medical Director, ASC		
Ms. Victoria Nikitin, Senior Vice President, Finance		

EXECUTIVE LEADERSHIP
Ms. Amy Smith, Senior Vice President, Transitions & Post-Acute Care
Ms. Carolynn Jones, Executive Vice President & Chief Compliance and Risk Officer
Dr. Esmaeil Porsa, President & Chief Executive Officer
Dr. Glorimar Medina-Rivera, Executive Vice President, Ben Taub Hospital
Dr. Jackie Brock, Executive Vice President & Chief Nursing Executive
Dr. Jason Chung, Associate Chief Medical Officer & Senior Vice President, Medical Affairs and Utilization
Dr. Jennifer Small, Interim Executive Vice President, Ambulatory Care Services
Dr. Joseph Kunisch, Vice President, Quality Programs
Mr. Louis Smith, Senior Executive Vice President & Chief Operating Officer
Ms. Maria Cowles, Senior Vice President, Chief of Staff
Dr. Matasha Russell, Chief Medical Officer, Ambulatory Care Services
Ms. Olga Rodriguez, Vice President, Community Engagement & Corporate Communications
Ms. Patricia Darnauer, Executive Vice President, Lyndon B. Johnson Hospital
Dr. Sandeep Markan, Chief of Staff, Ben Taub Hospital
Ms. Sara Thomas, Vice President Legal Affairs/Managing Attorney, Harris County Attorney's Office
Dr. Steven Brass, Executive Vice President & Chief Medical Executive
Dr. Tien Ko, Chief of Staff, Lyndon B. Johnson Hospital

OTHERS PRESENT	
Adriana Barron	
Amy Kimes	Nicholas Bell
Cherry Pierson	Paul Lopez
Christie Reno	Randy Manarang
Daniel Smith	Rebecca Lee
Elizabeth Winn	Tai Nguyen
Jennifer Zarate	Xylia Rosenzweig
Jerald Summers	Yasmin Othman
Myles Matherne	

BOARD OF TRUSTEES

HARRISHEALTH SYSTEM

Ambulatory Surgical Center at LBJ Governing Body

Thursday, February 17, 2022

Consideration of Approval of Policies and Procedures for the Ambulatory Surgical Center at LBJ

As part of the regulatory requirements of the Ambulatory Surgical Center (ASC), the Governing Body is to review and approve the ASC's policies annually. Please find a summary of the policies with changes.

- Policy 1000 *Changes in context*
- Policy 1001 *Minor changes in context (Section IV.)*
- Policy 1003 *Minor changes in context (Section III.)*
- Policy 1005 *Minor change in context (Section VII. 2-XIX)*
- Policy 1008 *Changes in context in Section I. H., Section IV and V*
- Policy 2001 *Change in Paragraph 1*
- Policy 2004 – Policy 2005 *Change in Paragraph 1*
- Policy 2010 *Changes in Paragraph 1, Section I and II, Section V, change in references and corporate office address*
- Policy 2018 *Change in Paragraph 1*
- Policy 2020 *Change in Paragraph 1*
- Policy 2023 *Change in Paragraph 1*
- Policy 4000 *Changes in Section II*
- Policy 4012 *Change in reference*
- Policy 5001 – Policy 5003 *Change in reference*
- Policy 5004 *Changes in Page 16-18, Pages 23-24, References, and Attachment A*
- Policy 5008 *Changes in reference*
- Policy 6001 *Changes in the references*
- Policy 6002 *Changes in Section II and I.A*
- Policy 6004 *Changes in reference*
- Policy 6007 *Changes in Section II.*
- Policy 6008 *Changes in Section V.I*
- Policy 6009 *Changes in Section II.A*
- Policy 6010 *Changes in Section III. and IV.*
- Policy 6013 *Changes in reference and numbering format*
- Policy 6014 *Changes in reference removal of Attachment B*
- Policy 6015 *Change in the HVA*
- Policy 6016 *Change in HVA (need to add policy to GB folder)*

Items for the Harris County Hospital District dba Harris Health System - Board of Trustees Report

ASC Policy Summary Matrix: February 17, 2022

Policy Number	Description/Justification	Action, Basis of Recommendation
ASC-P-1000	Acute Pain Management	Changes in context
ASC-P-1001	Blood-Blood Component Administration	Minor changes in context (Section IV.)
ASC-P-1002	Disposal of Outdated Medication	No Changes
ASC-P-1003	Medication Administration	Minor changes in context (Section III.)
ASC-P-1004	Post Surgical Assessments, Anesthesia Recovery Assessment, and Discharge Requirements	No Changes
ASC-P-1005	Pre Surgical Assessments	Minor change in context (Section VII. 2-XIX)
ASC-P-1006	Rapid Response Code Blue Resuscitation	No Changes
ASC-P-1007	Transfer of Patients to Hospital	No Changes
ASC-P-1008	Universal Protocol	Changes in context in Section I. H., Section IV and V
ASC-P-2000	Accounting of Disclosures of Protected Health Information	No Changes
ASC-P-2001	Authorization for Use and Disclosure of Protected Health Information	Change in Paragraph 1
ASC-P-2002	Breach Risk Assessment and Notification Policy	No Changes
ASC-P-2003	Business Associates	No Changes
ASC-P-2004	Complaints Regarding Privacy and Security	Change in Paragraph 1
ASC-P-2005	De-Identification of Protected Health Information	Change in Paragraph 1
ASC-P-2006	Delegation of Authority for Compliance with Privacy and Security Laws	No Changes
ASC-P-2007	Interpretation and Translation Services	No Changes
ASC-P-2008	Making and Disclosing Photographic, Video, Electronic, Digital, or Audio Recordings of Patients	No Changes
ASC-P-2009	Minimum Necessary Standard for Request, Use, or Disclosure of Protected Health Information	No Changes
ASC-P-2010	Patient's Access to Designated Record Set	Changes in Paragraph 1, Section I and II, Section V, change in references and corporate office address
ASC-P-2011	Patient's Request to Amend the Designated Record Set	No Changes
ASC-P-2012	Patient's Request for Confidential Communications	No Changes
ASC-P-2013	Requests for Restricting Use and Disclosure of Protected Health Information	No Changes
ASC-P-2014	Permitted Uses and Disclosures of Protected Health Information Without a Patient's Authorization	No Changes
ASC-P-2015	Privacy & Security Education	No Changes
ASC-P-2016	Privacy Officer Roles and Responsibilities	No Changes
ASC-P-2017	Sanctions for Failure to Comply with Privacy and Information Security Policies	No Changes

Items for the Harris County Hospital District dba Harris Health System - Board of Trustees Report

ASC Policy Summary Matrix: February 17, 2022

Policy Number	Description/Justification	Action, Basis of Recommendation
ASC-P-2018	Use and Disclosure of a Limited Data Set	Change in Paragraph 1
ASC-P-2019	Use and Disclosure of PI for Fundraising	No Changes
ASC-P-2020	Use and Disclosure Protected Health Information for Marketing	Change in Paragraph 1
ASC-P-2021	Use and Disclosure of Protected Health Information for Treatment, Payment, and Health Care Operations	No Changes
ASC-P-2022	Use and Disclosure of Protected Health Information to Persons Involved in Patient's Care and for Disaster Relief Purposes	No Changes
ASC-P-2023	Use and Disclosure of Psychotherapy Notes	Change in Paragraph 1
ASC-P-3000	Information Access Management	No Changes
ASC-P-3001	Information Security Audit	No Changes
ASC-P-3002	Information Security Evaluation	No Changes
ASC-P-3003	Information System User Responsibility	No Changes
ASC-P-3004	Information Systems Password Requirements	No Changes
ASC-P-3005	Information Security Risk Assessment	No Changes
ASC-P-4000	Advanced Cardiac Life Support (ACLS) Required Medications	Changes in Section II
ASC-P-4001	Advanced Directives	No Changes
ASC-P-4002	Approved Procedures	No Changes
ASC-P-4003	Conflict of Interest	No Changes
ASC-P-4004	Human Resources Manual	No Changes
ASC-P-4005	Incapacitated Providers	No Changes
ASC-P-4006	Laboratory Services	No Changes
ASC-P-4007	Management of Patient Belongings and Valuables	No Changes
ASC-P-4008	Medical Records	No Changes
ASC-P-4009	Non-Discrimination in Access to Services, Programs, and Facilities	No Changes
ASC-P-4010	Nurse Chart Audit	No Changes
ASC-P-4011	Smoke-Free/Tobacco-Free Environment	No Changes
ASC-P-4012	Temperature and Humidity Parameters	Change in reference
ASC-P-4013	Management of Disruptive Patients and Visitors Behavior	No Changes
ASC-P-5000	Adverse Drug Event Reporting and Monitoring	No Changes
ASC-P-5001	Disclosure of Adverse Events	Change in reference
ASC-P-5002	Exposure Control Plan	Change in reference
ASC-P-5003	Incident Reporting	Change in reference

Items for the Harris County Hospital District dba Harris Health System - Board of Trustees Report

ASC Policy Summary Matrix: February 17, 2022

Policy Number	Description/Justification	Action, Basis of Recommendation
ASC-P-5004	The Ambulatory Surgical Center (ASC) at LBJ Infection Control Plan	Changes in Page 16-18, Pages 23-24, References, and Attachment A
ASC-P-5005	Informed Consent	No Changes
ASC-P-5006	Patient Complaints and Grievances	No Changes
ASC-P-5007	Protocol for Reporting Infections to Authorities	No Changes
ASC-P-5008	Mandatory Reporting Policy	Changes in reference
ASC-P-6000	Abuse and Neglect	No Changes
ASC-P-6001	Blood Borne Pathogens	Changes in the references
ASC-P-6002	Crash Cart and Emergency Equipment	Changes in Section II and I.A
ASC-P-6003	Fire Drill/Alarm Procedures	No Changes
ASC-P-6004	Hazardous Materials	Changes in reference
ASC-P-6005	Immediate or Timely Return of the Patient to the Operating Room	No Changes
ASC-P-6006	Latex Allergy	No Changes
ASC-P-6007	Malignant Hyperthermia	Changes in Section II.
ASC-P-6008	Management and Accountability of Controlled Substances	Changes in Section V.I
ASC-P-6009	Patient Allergies	Changes in Section II.A
ASC-P-6010	Operating and Safety Procedures for the Medical Use of X-rays at ASC at LBJ	Changes in Section III. and IV.
ASC-P-6011	Radiology Technologist and Therapists Licensure and Certification and Radiology Technologist and Therapist Qualifications	No Changes
ASC-P-6012	Medical Radiography of Pregnant or Potentially Pregnant Patients	No Changes
ASC-P-6013	Fire Watch	Changes in reference and numbering format
ASC-P-6014	Facility Safety Manual of the Ambulatory Surgical Center (ASC) at LBJ	Changes in reference removal of Attachment B
ASC-P-6015	ASC Disaster Preparedness Plan 2022	Change in the HVA
ASC-P-6016	Evacuation Plan and Procedures	Change in HVA (need to add policy to GB folder)
ASC-P-6017	Laser Safety in the ASC at LBJ	No Changes
ASC-P-6018	Lead Apparel Inspection and Inventory	No Changes
	The Ambulatory Surgical Center at LBJ Patient Safety Plan	No Changes

TITLE: ACUTE PAIN MANAGEMENT

PURPOSE: To provide guidance on the assessment and management of acute pain in the perioperative setting.

POLICY STATEMENT:

It is the policy of the Ambulatory Surgical Center (ASC) at Lyndon B. Johnson to assess patients for the level of pain tolerance appropriate to each patient's age, ability, condition, scope of care, treatment, and services received while at the ASC.

POLICY ELABORATIONS:

I. DEFINITIONS:

A. **PAIN ASSESSMENT**: An evaluation that identifies a patient's symptoms, pre-existing conditions, and risk factors to be assessed as it pertains to a patient's level of pain.

B. **QUALIFIED LICENSED PRACTITIONER (QLP**): An individual permitted by law and by Harris Health to provide care and services without relevant direction or supervision within the scope of the individual's license and consistent with individually granted clinical privileges.

II. RESPONSIBILITY:

All QLPs must perform a pain assessment and reassessment and develop an individualized plan of care to meet each patient's personal pain tolerance level.

III. GENERAL PROCEDURE:

A. Upon admission to the ASC, a QLP performs a pain assessment and documents the results of the assessment in each patient's electronic medical record.

B. Patients' pain is assessed for intensity by using a pain scale (see Attachments A-C).

C. Patients' pain is reassessed while receiving care at the ASC. The timing and frequency of a patient's pain reassessment is based on the patient's diagnosis,

desire for care, or in response to any previous care and change in the patient's condition or diagnosis.

D. Patients' shall be informed of his or her right to receive pain management while he or she is a patient of the ASC. The ASC will inform patients that pain management is a priority at the ASC.

REFERENCES/BIBLIOGRAPHY:

Harris Health System Policy and Procedure 412 Pain Assessment and Reassessment

American Association for Accreditation of Ambulatory Surgery Facilities Version 8.0

OFFICE OF PRIMARY RESPONSIBILITY:

The Ambulatory Surgical Center (ASC) at LBJ

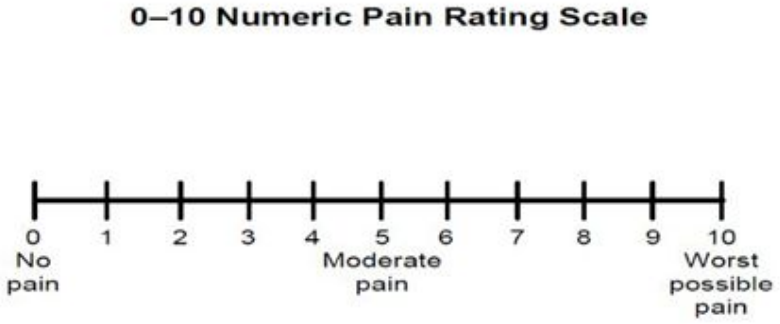
REVIEW/REVISION HISTORY:

Effective Date	Version # (If Applicable)	Review/ Revision Date (Indicate Reviewed or Revised)	Approved by:
9/16/2016	1.0	09/16/2016	The Ambulatory Surgical Center (ASC) Governing Body
		Reviewed / Approved 03/29/2018	The Ambulatory Surgical Center (ASC) Governing Body
		Approved 02/14/2019	The Ambulatory Surgical Center (ASC) Governing Body
		Approved 02/13/2020	The Ambulatory Surgical Center (ASC) Governing Body
		Reviewed / Approved 02/25/2021	The Ambulatory Surgical Center (ASC) Governing Body

APPENDIX "A":
ANALOG PAIN SCALE

Purpose: The Numeric Pain Rating Scale for Pain Assessment (NPRS) is a one-dimensional patient-rated tool based on 11-point numeric scale that is used to measure intensity of pain in adults. It can be used in children over the age of four (4) but it is preferred to be used only for children over the age of twelve (12). Note: Wong-Baker Pain Scale is preferred for ages 3-11.

Procedure: Patients are verbally or graphically (i.e. showing the patient a printed numeric scale) asked to choose the correlating number on the NPRS of 0-10 that most closely represents his or her perception of his or her current level of pain in a response to the following question: "On a scale of 0-10, in which 0 indicates no pain and 10 indicates the most severe pain you can possibly imagine, what number would you give your pain at this moment?"



APPENDIX "B":

WONG-BAKER FACES

Purpose: This scale is a valid and reliable pain scale used to assess acute and chronic pain in patient's ≥ 3 years old.

Procedure: Point to each face using the words to describe the pain intensity. Ask the patient to choose the face that best describes their own pain and document the appropriate number.

APPENDIX "C":
FACES, LEGS, ACTIVITY, CRY AND CONSOLABILITY (FLACC)

Purpose: This interval scale measures pain by quantifying pain behaviors with scores ranging from 0 (no pain behaviors) to 10 (most possible pain behaviors). This scale is appropriate for pre-verbal and non-verbal adult and pediatric patients.

Procedure:

1. Each of the five categories Face (F), Legs (L), Activity (A), Cry (C) and consolability is scored from 0-2, which results in a total score between 0 and 10.

2. Observe the patient for 3-5 minutes during activity/with movement (such as bathing, turning, transferring).

3. For each item included in the FLACC, select the score (0, 1, 2) that reflects the current state of the behavior.

4. Add the score for each item to achieve a total score. Total scores range from 0-10 (based on a scale of 0 to 2 to five items).

5. After each use, compare the total score to the previous score received. An increased suggests an increase in pain, while a lower score suggests pain is decreased.

Scoring			
Categories	0	1	2
Face	No particular expression or smile	Occasional grimace or frown, withdrawn, disinterested	Frequent to constant frown, quivering chin, clenched jaw
Legs	Normal position or relaxed	Uneasy, restless, tense	Kicking or legs drawn up
Activity	Lying quietly, normal position, moves easily	Squirming, shifting back and forth, tense	Arched, rigid or jerking
Cry	No cry (awake or asleep)	Moans or whimpers; occasional complaint	Crying steadily, screams or sobs, frequency complaints.
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to; distractible	Difficult to console or comfort.

-Consider adding "CPOT" scale for PACU pts doi: 10.1097/AJP.0000000000000593

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TITLE: BLOOD/BLOOD COMPONENT ADMINISTRATION

PURPOSE: To provide the guidelines for administering blood and blood products, including the process of identifying those patients who should receive blood or a blood product transfusion.

POLICY STATEMENT:

It is the policy of the Ambulatory Surgical Center (ASC) at LBJ to ensure that blood and blood products are available for administration to patients when necessary and to administer blood and blood products to patients in a safe manner consistent with applicable guidelines.

POLICY ELABORATIONS:

I. DEFINITIONS:

A. **WORKFORCE**: The employees, medical staff, trainees, contractors, volunteers, and vendors.

B. **BLOOD:** Whole blood collected from a single donor and processed either for transfusion or further manufacturing.

C. **BLOOD COMPONENT:** That part of a single-donor's blood separated by physical or mechanical means. This includes:

1. Plasma Products (Fresh Frozen Plasma (FFP); liquid plasma, cryo-poor plasma);
2. Platelets;
3. Red Blood Cells;
4. Cryoprecipitate;
5. Granulocytes; and
6. Pooled product from multiple donors.

D. **BLOOD DERIVATIVES:** Licensed pharmaceutical medications manufactured from in vitro recombinant DNA methods or human plasma donations pooled from large donor populations which have undergone multiple pathogen inactivation steps and fractionation regulated by the FDA to remove impurities,

stabilize product, inactivate and or remove pathogens to ensure sterility. Blood derivatives may be administered following the appropriate order by a physician and distribution of the derivative by the pharmacy department. Blood Derivatives include:

1. Albumin;
2. Immunoglobulins; and
3. Factor concentrates.

II. MEDICAL DISCLOSURE AND REFUSAL TO CONSENT:

A. A physician must disclose to the patient, or the individual authorized to give consent for medical care on behalf of the patient, the risks and hazards involved in the administration or refusal of blood or blood products as defined by the Texas Medical Disclosure Panel.

B. It is the policy of the ASC to not perform surgery on patients who refuse to consent to the administration of blood or blood products for the procedures listed in Appendix A. If a patient refuses to consent to the administration of blood or blood products, the ASC will refer the patient to Lyndon B. Johnson Hospital (LBJ) or Ben Taub Hospital to reschedule his or her surgery.

C. Pursuant to the Letter of Agreement between Harris Health and the ASC, Harris Health will utilize coolers to transport blood products to the ASC from LBJ, when necessary.

III. EMERGENCY RELEASE PROCEDURE:

A. When a determination has been made to utilize blood and/or blood products the following procedure must be followed:

1. The individual requesting the blood and/or blood products will call the Nurse Manager (NM) or his or her designee.

2. The NM or his or her designee will call the LBJ Blood Bank to request that the Blood Bank immediately release the blood and/or blood products. The NM or his or her designee will send an available ASC Workforce member

to the Blood Bank with the patient's label to obtain the blood and/or blood products.

3. The Harris Health Blood Bank will supply the ASC Workforce member with a transport cooler and blood and/or blood products.

4. This process will repeat until blood and/or blood products are no longer requested or needed.

B. When blood or blood products are used, a type and screen or type and cross will be conducted by the LBJ Hospital Laboratory.

IV. ADMINISTRATION:

A. Only physicians, dentists, or registered nurses may administer blood or blood products to patients.

~~A.~~ Protocol for blood to be checked and verified should be added, or refer to Harris Health Policy 4170-B through F (Section 6-C-1)

CLIA MEDICAL DIRECTORS			
01/26/2021	**Dr. Scott Perry CLIA Medical Director – ASC at LBJ**	**License #: 45D2111689**	**Signature:**

REFERENCES/BIBLIOGRAPHY:

Harris Health System Blood/Blood Component Administration Policy 4170

42 Code of Federal Regulations (C.F.R.) 416.48(a) (2)

American Association for Accreditation of Ambulatory Surgery Facilities Version 7 §500

OFFICE OF PRIMARY RESPONSIBILITY:

The Ambulatory Surgical Center (ASC) at LBJ

REVIEW/REVISION HISTORY:

Effective Date	Version # (If Applicable)	Review/ Revision Date (Indicate Reviewed or Revised)	Approved by:
8/5/16	1.0	Reviewed / Approved 08/15/2016	The Ambulatory Surgical Center (ASC) at LBJ Governing Body
	1.1	Reviewed / Approved 03/29/2018	The Ambulatory Surgical Center (ASC) at LBJ Governing Body
		Approved 02/14/2019	The Ambulatory Surgical Center (ASC) at LBJ Governing Body
		Reviewed / Approved 02/13/2020	The Ambulatory Surgical Center (ASC) Governing Body
		Revised / Approved 02/25/2021	The Ambulatory Surgical Center (ASC) Governing Body

APPENDIX "A": BLOOD COMPONENT

Purpose: To delineate procedures that require consent for blood administration at the ASC

Procedure:

1. Dilation and Curettage (both non-obstetric and obstetric)
2. Facial Fracture repair and immobilization
3. Mandibular fractures: open reduction, with or without inter-dental wiring
4. All intra-abdominal procedures (open or laparoscopic)
5. All intra pelvic procedures (open and laparoscopic)

APPENDIX B
TRANSFUSION REACTIONS

A. **Transfusion Reaction Procedure:** If signs /symptoms of transfusion reaction are noted at any time during the transfusion, **immediately stop the transfusion** and:

1. Immediately take a full set of vital signs. Repeat the vital signs at a minimum of every 15 minutes, and additionally as needed until reaction is abated.
2. Notify the physician and blood bank.
3. Administer medications/treatments as ordered.
4. Physician to order the Transfusion Reaction Protocol which includes:

    a. Collect one pink top tube of patients' blood and a urine specimen, which is the 1st post transfusion being started. Collect one pink top tube of patients' blood and a urine specimen which is the 1st post transfusion being started.
    b. Sends collected specimens and un-transfused portion of blood component with attached tubing and IV fluid to blood bank.

5. Leave the IV site intact or maintain IV

B. Recognition of an Acute Transfusion Reaction

Common physical signs/symptoms of an acute transfusion reaction may include the signs and symptoms on the following list. However, bear in mind the patient's underlying clinical condition as none of these manifestations are unique to transfusion reactions. **If these signs/symptoms occur for the first time or worsen in severity during or after transfusion, consider transfusion reaction**:

- Chills/Fever
- Vital sign changes/shock
- Flushing
- Chest pain
- Dark/red urine or hemoglobinuria
- Generalized, abdominal, or flank pain
- Pain at infusion site
- Unexplained mucosa hemorrhage

- Dyspnea/Hypoxia
- Fainting or dizziness
- Itching, hives, rash, facial flushing or skin reactions
- New acute complaints of generalized discomfort or "impending sense of doom"

The following vital sign changes (from either pre-transfusion baseline or if representative of a new degree of fluctuation in vital signs) could be indicative of a transfusion reaction, and should be appropriately evaluated by a physician:

1. Fever:

   a. $+1.0^0$ C/$+2^0$ F increase in temperature to above 38^0 C or 100.4^0 F; or
   b. If new chills/rigors are noted without previously stated temperature elevations.

2. Hypoxemia:

   a. 90% or less on pulse-oximetry on room air
   b. PaO2/FiO2 less than or equal to 300 mmHg

3. Blood Pressure:
   a. Greater than or equal to +/-30 mmHg change in systolic blood pressure

4. The absence of these vital sign changes does not necessarily exclude a transfusion reaction.

New or worsening manifestations of these signs/symptoms within 24 hours of starting a transfusion **should be reported to a physician AND the blood bank via phone call for evaluation** of potential transfusion reaction. A "transfusion reaction evaluation" order in EPIC should be submitted to initiate the laboratory workup.

C. Management of a Potential Transfusion Reaction:

If a transfusion reaction is suspected, based on above signs/symptoms, at any time during the transfusion or within 24hrs following a completed transfusion:

1. Immediately stop the transfusion (if reaction occurred during transfusion).
2. Take a full set of vital signs. Repeat the vital signs at a minimum of every 15 minutes, and additionally as needed until reaction is abated.
3. Notify a treating physician, and notify the blood bank (phone call and through "transfusion reaction evaluation" order.
4. Administer medications/treatments as appropriate:

    a. Antihistamines is appropriate for most hives/rash
    b. Antipyretics as appropriate

5. DO NOT restart a transfusion, except in the case of a resolved mild allergic transfusion reaction (ONLY Hives/rash that resolves with or without antihistamines.)

To initiate blood bank investigation of transfusion reaction, perform the following steps:

1. Order "Transfusion Reaction Evaluation" in EPIC (LAB893).
2. Collect one pink top tube of patients' blood and a urine specimen (if available) as part of that order.
3. Send collected specimens and remaining bag/tubing of blood components to the blood bank; include any IV fluids attached to the same circuit as the blood component.
4. Nursing should document first-hand reaction details events via the transfusion flowsheet (aka BPAM, Blood Product Administration Module). Pertinent details of transfusion reaction may also be entered in a separate nursing note if insufficient space to document events in the flowsheet.
5. Leave the IV site intact and/or maintain IV fluids.
4. Expect pathology physicians to contact the bedside nurse and notified provider for an account of the transfusion reaction and response.

TITLE: MEDICATION ADMINISTRATION

PURPOSE: To establish guidelines for the safe and accurate administration of medications to patients at the Ambulatory Surgical Center (ASC) at LBJ.

POLICY STATEMENT:

It is the policy of the Ambulatory Surgical Center (ASC) at LBJ, through the implementation of the measures outlined below, to ensure the accuracy of medication administration and the safety of patients.

POLICY ELABORATIONS:

I. DEFINITIONS:

A. **ADMINISTRATION SYSTEMS**: Commercial products for the preparation of IV products within a single, closed system prior to administration to a patient (i.e., 'Adapt-a-vial' and 'Add-a-vial').

B. **AUTOMATED DISPENSING CABINET (ADC)**: An automated medication supply system (e.g., Pyxis Med Station or Anesthesia Station) used for storage and record keeping of medication.

C. **COMPOUND STERILE PREPARATION (CSP)**: A dose of a medication or nutrient prescribed for a specific patient that must be prepared for administration in a sterile environment. CSP involves specific calculation of doses and multiple transfers of product outside of original containers. "Ready to Use" commercial products, commercial administration systems, and preparation of a single medication for administration via IV push shall not be considered a CSP.

D. **ELECTRONIC MEDICATION ADMINISTRATION RECORD (EMAR)**: A point-of-care process utilizing barcode reading technology to monitor and document beside medication administration.

E. **INTRAVENOUS (IV) PUSH**: The delivery of a small volume of medication directly into the venous circulation via syringe.

F. **MEDICATION ADMINISTRATION RECORD (MAR)**: The printed and/or paper version of the eMAR.

G. **QUALIFIED LICENSED PERSONNEL (QLP)**: Any individual permitted by law and by the ASC to provide care and services, without relevant direction or supervision within the scope of the individual's license and consistent with individually granted clinical privileges.

H. **READY TO USE PREPARATION**: Pre-packaged IV mixtures prepared by a commercial vendor and ready for administration to a patient.

I. **SECURITY OF MEDICATIONS**: For the purposes of this policy, security of the storage area for medications is defined as "under the constant surveillance of authorized users or secured within a locked device, cabinet, or room where only authorized personnel have access."

J. **STANDARD CONCENTRATION**: The accepted "normal" amount of medication to be added to a specific volume of solution.

II. GENERAL PROCEDURES:

A. *Orders for Medication:*

1. All medications and biologics given to patients of the ASC must be approved by a physician with a signed order.
2. Physician orders given verbally for drugs and biologics must be followed by a written order signed by the prescribing physician.

    a) The registered nurse or QLP that receives a verbal order from a physician must repeat the order back to the prescribing physician and the prescribing physician must verify that the order is correct.
    b) When administering a medication pursuant to a verbal order, it must be documented in the patient's medical record that the medication was administered pursuant to a verbal order and must document the name of the prescribing physician.

3. Only a physician, registered nurse, or other QLP may administer the medication to the patient.

B. *Disposal of Medication:*

1. Medications from containers with illegible labels or drugs that have changed color, consistency or are outdated shall be returned to the ASC

Pharmacy for disposal in accordance with the ASC's policy on the *Disposal of Outdated Medication.*

C. *Medications in the ADC:*

1. All medications and biologicals must be current, dated, and refrigerated when necessary. All medication refrigerators will be monitored for proper temperature.
2. The "override" function of the ADC shall be used to access doses when the benefit to the patient receiving the medication is greater than the risk of the pharmacist not reviewing the order prior to administration (i.e., sudden and severe change in the clinical status of the patient).

D. *Medication Administration:*

1. Medications shall be administered utilizing the "eight right" of medication administration.
2. The "eight right" of medication administration includes the following:

    a) Right drug;
    b) Right dose;
    c) Right route;
    d) Right time;
    e) Right patient;
    f) Right reason;
    g) Right documentation; and
    h) Right assessment for administration and response to medication.

3. Medications administrated contrary to any of the first five "rights" shall be documented exactly as administered to the patient and entered into the Harris Health System Electronic Incident Reporting System.
4. Medications not given, refused, or given off schedule shall be documented in the MAR.
5. No medication shall be left at a patient's bedside unless written by a physician.
6. Patients of the ASC are not allowed to self-administer medications.

III. PROCEDURE FOR MEDICATION ADMINISTRATION:

A. Physicians, registered nurses, or other QLPs, shall administer medication according to the following procedure:

1. *Operating Room:*

a) The surgeon prepares a written order prior to surgery of the medications that he or she needs for surgery.

b) A registered nurse obtains the medication from the ADC and/or pharmacy and administers the medication to the patient pursuant to the surgeon's written order.

2. *Pre-Op:*

a) Written Orders: The surgeon or anesthesiologist writes an order prior to admission to the ASC. A registered nurse or QLP obtains the medication from the ADC and administers the medication to the patient.

b) Verbal Orders: The surgeon or anesthesiologist gives a verbal order to a registered nurse or QLP for a medication. The registered nurse or QLP verifies the verbal order by repeating it back and verified to the physician or surgeon. After verification of the verbal order, the registered nurse or QLP obtains the medication from the ADC and administers the medication to the patient. The Registered Nurse or QLP receiving the verbal order documents the order in the patient's medical record.

3. *Post Anesthesia Recovery Unit:*

a) The Anesthesiologist provides written orders for any medications administered in the Post Anesthesia Recovery Unit.

IV. STANDARD ADMINISTRATION TIMES:

A. Medication administration times are followed in accordance with the standards set forth by the Association of Perioperative Registered Nurses (AORN).

B. Standard administration times are followed to provide consistency for medication administration schedules with consideration of pharmacological

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characteristics of certain medications, and patient convenience unless otherwise noted by the physician entering the order in the patient's medical record.

V. MEDICATION STANDARD CONCENTRATIONS:

A. The ASC Pharmacy does not dispense IV CSP medications. .

B. For medication orders with non-standard concentrations, the ASC pharmacy will contact the physician prior to the surgery in order to clarify the order and recommend an appropriate standard concentration.

C. The ASC pharmacy will use ready to use preparations from commercial vendors.

REFERENCES/BIBLIOGRAPHY:

42 Code of Federal Regulations (C.F.R.) §416.48(a).

OFFICE OF PRIMARY RESPONSIBILITY:

The Ambulatory Surgical Center (ASC) at LBJ

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TITLE: PRE-SURGICAL ASSESSMENTS

PURPOSE: To outline the pre-surgical assessments and exams that must be completed prior to a patient's surgery.

POLICY STATEMENT:

It is the policy of the Ambulatory Surgical Center (ASC) at LBJ to assess patients prior to surgery to determine if it is acceptable for the patient to have surgery in the ASC and to ensure positive surgical outcomes.

POLICY ELABORATIONS:

I. DEFINITIONS:

A. **PHYSICIAN**: The following individuals are physicians:

1. Doctor of medicine or osteopathy;
2. Doctor of dental surgery or of dental medicine;
3. Doctor of podiatric medicine; or
4. Doctor of optometry.

B. **QUALIFIED LICENSED PRACTITIONER**: An individual permitted by law and by the ASC to provide care and services without relevant direction or supervision within the scope of the individual's license and consistent with individually granted clinical privileges.

II. COMPREHENSIVE MEDICAL HISTORY AND PHYSICAL:

A. Not more than thirty (30) calendar days before the date of a patient's scheduled surgery, each patient must have a comprehensive medical history and physical assessment completed by a physician or other qualified licensed practitioner.

B. The results of the comprehensive medical history and physical exam must be documented in the patient's medical record. Specifically, the following must be included in the patient's medical record:

1. Physician name;

2. Pertinent past medical history (personal and family);
3. Reason and indications for procedure (chief complaint);
4. Previous significant surgeries, complications, and medical illnesses;
5. Drug and biological sensitivities and allergies;
6. Mental status;
7. Physical examination including a cardio-pulmonary exam and abdominal exam;
8. Pre-procedure diagnosis;
9. Date of visit;
10. Blood pressure;
11. Weight;
12. Current medications; and
13. Current diagnosis.

C. If a patient is scheduled for two surgeries in the ASC within a short period of time, the same comprehensive medical history and physical exam may be used if it is completed within thirty (30) calendar days before each surgery.

D. The comprehensive medical history and physical exam may be performed on the same day as the patient's scheduled procedure in the ASC as long as it is performed by a physician or other qualified licensed practitioner and as long as it is documented in the patient's medical record.

It is not permitted to complete the comprehensive medical history and physical exam after the patient has been prepped and brought into the operating or procedure room.

III. CURRENT HISTORY AND PHYSICAL:

A. Within two weeks prior to surgery, the patient's surgeon, anesthesiologist, or referring physician will assess the patient's history and perform a physical exam.

B. The physical exam and history should cover the organs and systems commensurate with the patient's scheduled surgery.

C. The <u>current</u> history and physical will be documented in the patient's medical record.

IV. PRE-SURGICAL ASSESSMENT:

A. Upon the patient's admission to the ASC for surgery, a physician or other qualified licensed practitioner will examine the patient for any changes in the patient's condition since the completion of the current history and physical.

B. The patient must be assessed for changes in his or her condition that might be significant for the planned surgery. The assessment must identify and document any allergies the patient has to drugs and biologicals.

C. The patient must be assessed for Deep Vein Thromboembolism (DVT) risk as part of their preadmission process.

a. The risk assessment is documented in the patient medical record; and

b. Appropriate intervention(s) will be ordered.

c. A female patient of child-bearing age may be screened with a pregnancy test. A discussion will take place between the physician and/or other qualified licensed practitioner regarding pregnancy testing. The occurrence of the discussion and the outcome must be documented in the patient's record.

D. Assessment(s) must be documented in the patient's medical record.

V. CURRENT MEDICAL HISTORY:

A. On the day of the patient's scheduled surgery and prior to the administration of anesthesia, the patient's surgeon or anesthesiologist will assess the patient's current medical history.

B. The assessment must be documented in the patient's medical record.

VI. ANESTHETIC RISK AND EVALUATION:

A. Immediately prior to surgery, a physician or a Certified Registered Nurse Anesthetist (CRNA) must examine the patient to evaluate the risk of anesthesia and of the procedure to be performed on the patient.

B. The physician must verify that an anesthesia plan of care has been appropriately developed and documented in the patient's medical record.

1. The anesthetic plan of care must be based on:

i. A review of the patient's medical record;
ii. The patient's medical history;
iii. Prior anesthetic experiences;
iv. Drug therapies;
v. Medical examination and assessment of any physical conditions that could affect the decision about the preoperative risk management;
vi. A review of medical tests and consultations that might reflect on the administration of anesthesia;
vii. A determination relative to the appropriate preoperative medications needed for the conduct of anesthesia; and
viii. Providing appropriate preoperative instructions.

C. The exam must be specific to each patient and take into consideration the patient's current condition. Based on the exam and patient parameters set forth below, the physician or CRNA will evaluate the risks associated with the patient's scheduled surgery and with the administration of anesthesia and determine whether it is appropriate to perform the procedure in the ASC.

VII. PATIENT PARAMETERS:

A. Generally, patients who do not fall within the patient parameters set forth below will not be permitted to have surgery in the ASC. However, an exception may be granted by the Medical Director of the ASC and the ASC Administrator for patients who do not fall within the patient parameters.

B. The following patient parameters will be followed when determining if a patient is eligible to have surgery in the ASC:

1. Surgical and elective procedures will only be performed on adult patients and pediatric patients more than ten (10) years of age and that fall within the American Society of Anesthesiologist status classifications: ASA Class I and ASA Class II. Surgical and elective procedures performed on adult

patients and pediatric patients more than ten (10) years of age and who fall within the American Society of Anesthesiologist status classifications ASA III and ASA IV will only be permitted to have surgery at the ASC at the discretion of the Medical Director of the ASC.

2. Patients who have the following medical complications will not be permitted to have surgery or elective procedures performed at the ASC without prior consultation between the surgeon and anesthesiologist:

i. Patients with a known risk of a difficult airway;
ii. Patients with an increased risk of developing malignant hyperthermia;
iii. Patients with predictably difficult IV access and who will likely require central venous access;
iv. Patients with a bleeding or clotting disorder;
v. Patients with moderately severe to severe pulmonary insufficiency (e.g., OSA);
vi. Patients with unstable ischemic heart disease;
vii. Patients with poorly controlled congestive heart failure;
viii. Patients with uncontrolled hypertension and/or diabetes;
ix. Patients who have a significant probability of post-operative voiding problems;
x. Patients with end stage renal disease;
xi. Patients with known infected wounds that will necessitate terminal cleaning of the OR;
xii. Patients with uncontrolled personality disorders;
xiii. Patients with uncontrolled seizure disorders;
xiv. Patients requiring higher levels of nursing care for any medical conditions;
xv. Patients who have had a recent stroke;
xvi. Patients with spinal cord lesions at or above T6;
xvii. Patients who have taken diet medications within two weeks of the scheduled procedure;
xviii. Patients who have a history of arrhythmia not evaluated by a cardiologist; and
xix. Patients with a BMI of greater than 50.

C. If a surgery or elective procedure on a particular patient is expected to exceed the time parameters established by state and federal laws and regulations, that patient is not permitted to have his or her surgery or procedure performed at the ASC.

REFERENCES/BIBLIOGRAPHY:

42 Code of Federal Regulations (C.F.R.) §416.52(a) Admission and pre-surgical assessment

42 Code of Federal Regulations (C.F.R.) §416.42(a) Anesthetic risk and evaluation

American Association for Accreditation of Ambulatory Surgery Facilities 300.005.007

American Association for Accreditation of Ambulatory Surgery Facilities 300.005.010

American Association for Accreditation of Ambulatory Surgery Facilities 300.005.015

American Association for Accreditation of Ambulatory Surgery Facilities 1000.010.010

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06/14/16	1.0	06/14/2016	The Ambulatory Surgical Center (ASC) Governing Body
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		Reviewed / Approved 02/25/2021	The Ambulatory Surgical Center (ASC) Governing Body

Appendix A

1. A DVT risk assessment questionnaire is completed and orders placed by a physician prior to the surgery.

2. Orders are reviewed the day of surgery and implemented.

3. Verification of the patient medical record to ensure indication of a DVT risk assessment and appropriate orders have been performed by a physician will occur.

4. A sample DVT Risk Assessment is included in Appendix A.

HARRISHEALTH
AMBULATORY SURGICAL CENTER AT LBJ

Deep Vein Thrombosis (DVT) Prophylaxis Orders

(For use in ASC Surgery Patients)

Pt Label

Thrombosis Risk Factor Assessment (Choose all that apply)

Each Risk Factor Represents 1 Point

- ☐ Age 41-60 years
- ☐ Swollen legs (current)
- ☐ Varicose veins
- ☐ Obesity (BMI >25)
- ☐ Minor surgery planned
- ☐ Sepsis (<1 month)
- ☐ Acute myocardial infarction
- ☐ Congestive heart failure (<1 month)
- ☐ Medical patient currently at bed rest
- ☐ History of inflammatory bowel disease
- ☐ History of prior major surgery (<1 month)
- ☐ Abnormal pulmonary function (COPD)
- ☐ Serious lung disease including pneumonia (<1 month)
- ☐ Oral contraceptives or hormone replacement therapy
- ☐ Pregnancy or postpartum (<1 month)
- ☐ History of unexplained stillborn infant, recurrent spontaneous abortion (≥ 3), premature birth with toxemia or growth-restricted infant
- ☐ Other risk factors_____

Subtotal:

Each Risk Factor Represents 5 Points

- ☐ Stroke (<1 month)
- ☐ Multiple trauma (<1 month)
- ☐ Elective major lower extremity arthroplasty
- ☐ Hip, pelvis or leg fracture (<1 month)
- ☐ Acute spinal cord injury (paralysis) (<1 month)

Subtotal:

Each Risk Factor Represents 2 Points

- ☐ Age 61-74 years
- ☐ Arthroscopic surgery
- ☐ Malignancy (present or previous)
- ☐ Laparoscopic surgery (>45 minutes)
- ☐ Patient confined to bed (>72 hours)
- ☐ Immobilizing plaster cast (<1 month)
- ☐ Central venous access
- ☐ Major surgery (>45 minutes)

Subtotal:

Each Risk Factor Represents 3 Points

- ☐ Age 75 years or older
- ☐ History of DVT/PE
- ☐ Positive Factor V Leiden
- ☐ Elevated serum homocysteine
- ☐ Heparin-induced thrombocytopenia (HIT)
  (Do not use heparin or any low molecular weight heparin)
- ☐ Elevated anticardiolipin antibodies
- ☐ Other congenital or acquired thrombophilia
  If yes: Type_____
- ☐ **Family History of thrombosis***
- ☐ Positive Prothrombin 20210A
- ☐ Positive Lupus anticoagulant

*** most frequently missed risk factor**

Subtotal:

TOTAL RISK FACTOR SCORE:

FACTORS ASSOCIATED WITH INCREASED BLEEDING

Patient may not be a candidate for anticoagulant therapy and SCDs should be considered.

Active bleed, ingestion of oral anticoagulants, administration of glycoprotein IIb/IIIa inhibitors, history of heparin induced thrombocytopenia

CLINICAL CONSIDERATIONS FOR THE USE OF SEQUENTIAL COMPRESSION DEVICES (SCD)

Patient may not be a candidate for SCDs and alternative prophylactic measures should be considered.

Patients with Severe Peripheral Arterial Disease, CHF, Acute Superficial DVT

Total Risk Factor Score	Risk Level	Prophylaxis Regimen
0	VERY LOW	☐ Early ambulation
1-2	LOW	☐ Sequential Compression Device (SCD)
3-4	MODERATE	Choose **ONE** of the following medications +/- compression devices: ☐ Sequential Compression Device (SCD) - Optional ☐ Heparin 5000 units SQ TID ☐ Enoxaparin/Lovenox: ☐ 40mg SQ daily (WT < 150kg, CrCl > 30mL/min) ☐ 30mg SQ daily (WT < 150kg, CrCl = 10-29mL/min) ☐ 30mg SQ BID (WT > 150kg, CrCl > 30mL/min) (Please refer to Dosing Guidelines on the back of this form)
5 or more	HIGH	Choose **ONE** of the following medications **PLUS** compression devices: ☐ Sequential Compression Device (SCD) ☐ Heparin 5000 units SQ TID **(Preferred with Epidurals)** ☐ Enoxaparin/Lovenox **(Preferred):** ☐ 40mg SQ daily (WT < 150kg, CrCl > 30mL/min) ☐ 30mg SQ daily (WT < 150kg, CrCl = 10-29mL/min) ☐ 30mg SQ BID (WT > 150kg, CrCl > 30mL/min) (Please refer to Dosing Guidelines on the back of this form)

- ☐ Ambulatory Surgery - No orders for venous thromboembolic prophylaxis required
- ☐ VTE Prophylaxis Contraindicated, Reason: _____

Physician Signature	Dr. #	Date	Time
Processed By:		Date/Time:	
			DVT Prophylaxis Regimen

HARRISHEALTH
AMBULATORY SURGICAL CENTER AT LBJ

ENOXAPARIN DOSING GUIDELINES

- MUST wait 24 hours before starting Enoxaparin if patient has epidural catheter
- D/C Enoxaparin 10-12 hours prior to removing epidural catheter
- May restart Enoxaparin 24 hours after epidural catheter has been removed.

NON-PREGNANT PATIENTS

Body weight < 150kg, CrCl > 30mL/min: **Enoxaparin 40mg SQ daily**
Body weight < 150kg, CrCl = 10-29mL/min: **Enoxaparin 30mg SQ daily**
Body weight > 150kg, CrCl > 30mL/min: **Enoxaparin 30mg SQ BID**

PREGNANT PATIENTS

Prevention of DVT:#
Maternal body weight (start of therapy) < 75 kg:
Recommend 30 mg SQ once daily until 20 weeks **Recommend 30 mg SQ BID** after 20 weeks
Maternal body weight (start of therapy) ≥ 75 kg:
Recommend 40 mg SQ once daily until 20 weeks
Recommend 40 mg SQ BID after 20 weeks

#Wait 12 hours before regional anesthesia

MONITORING RECOMMENDATIONS

- Patients who are obese (actual body weight > 150 kg)
- Patients who are pregnant
- Patients with renal insufficiency (creatinine clearance < 30 ml/min)

Indication	Desired Level (Draw 4 hours after the 4th dose)	Recommendations for Dose Alteration		
		Anti-factor Xa Level (units/ml)	Dose Adjustment	Repeat Anti-factor Xa To Be Obtained
Prevention of DVT/PE	0.2 to 0.5 units/ml	< 0.2	Increase by 25 %	4 hours after 4th dose
		0.2 to 0.5	No change	Repeat in 1 week, then monthly thereafter
		0.6 to 1	Decrease by 20 %	4 hours after 4th dose
		> 1	Hold for 3 hours, then decrease next dose by 30%	4 hours after 4th dose

Ideal Body Weight
IBW, men = 50 kg + 2.3 (inches > 5 feet)
IBW, women = 45.5 kg + 2.3 (inches > 5 feet)

TITLE: **UNIVERSAL PROTOCOL (PREVENTING WRONG SITE, WRONG PROCEDURE, OR WRONG PERSON SURGERY)**

PURPOSE: To define the process for the pre-procedure verification of the surgical/procedure site for patients undergoing surgery and/or invasive procedures performed at the Ambulatory Surgical Center (ASC) at LBJ.

POLICY STATEMENT:

The Ambulatory Surgical Center (ASC) at LBJ is committed to improving patient safety by preventing, reducing, and striving to eliminate the occurrence of wrong site/side; wrong procedure; and/or wrong person surgery.

POLICY ELABORATIONS:

This policy addresses the processes to ensure the correct practice is implemented for patient safety.

I. DEFINITIONS:

A. **HEALTHCARE WORKER**: A member of the surgical or procedure team (i.e. surgical technologist, Registered Nurse (RN), Licensed Vocational Nurse (LVN), dental assistant, radiology technician, etc.); other than those individuals identified as a "Qualified Medical Personnel."

B. **LATERALITY**: Indication on the operative side "Left," "Right," or "Bilateral," as applicable.

C. **PRE-PROCEDURE VERIFICATION PROCESS**: An ongoing process on the day of the procedure of information gathering and verification, beginning with the decision to perform a surgery or procedure and continuing through all settings and interventions involved in the pre-procedure preparation of the patient up to and including the Time Out just before the start of the procedure.

D. **PROCEDURE OR SURGICAL SITE**: All procedures performed with any sort of anesthesia, including local or conscious sedation. All procedures that involve percutaneous puncture or incision of the skin, or insertion of an instrument or foreign material into the body, including but not limited to: percutaneous aspirations, biopsies, cardiac and vascular catheterizations, PICC lines, all central

line insertions, chest tube insertion, and endoscopies. Certain routine "minor" procedures are not within the scope of the Universal Protocol.

NOTE: Procedures that may be excluded are: radiation oncology, and performance dialysis (excluding insertion of dialysis catheters), venipuncture, peripheral intravenous (IV) placement, insertion of nasogastric tube, and Foley catheters unless they require anesthesia as described above.

E. **QUALIFIED MEDICAL PERSONNEL**: Individuals that are determined to be qualified by the Ambulatory Surgical Center (ASC) at LBJ to provide appropriate medical screening and who may be able to provide necessary stabilizing treatment in the event of an emergency. The Qualified Medical Personnel must be credentialed and must perform with the scope of their licensure as designated by the Medical Staff Rules and Regulations.

F. **SITE MARK**: Identification of the intended site of incision/procedure/treatment with the word "yes," using a marker that is sufficiently permanent to remain visible after completion of the skin prep. Other methods such as lines may be used in addition to, but not in place of, the word "yes."

G. **SURGICAL/PROCEDURE TEAM**: The healthcare provider, surgical assistant, anesthesiologist, certified registered nurse anesthetist, scrub nurse/technician, the registered nurse, and any other active participants who will be participating in the surgery or procedure at its inception.

H. **TIME OUT**: Confirmation of the correct patient (using two (2) patient identifiers, procedure, position, side, site, and availability of implants, special equipment, or other special requirements. Confirmation should be done with a completed surgical consent.

I. **VERIFICATION**: Confirmation of the correct patient, procedure, position, side (laterality), site, and availability of implants, special equipment, or special requirements.

II. PRE-PROCEDURE VERIFICATION PROCESS:

A. Verification of the correct patient, correct site, and correct procedure/surgery occurs at the following times:

1. At the time the procedure is scheduled;

2. At the time of pre-admission testing and assessment;
3. At the time of admission or entry into the ASC for a surgery or procedure;
4. Before the patient leaves the pre-procedure area;
5. Anytime the responsibility for the care of the patient is transferred to another member of the Surgical/Procedure Team, including anesthesia providers, at the time of and during the procedure or surgery; or
6. With the patient involved, awake, and aware if possible.

B. Pre-procedure verification occurs before the patient leaves the pre-operative/pre-procedure area. Verify the following with patient participation (if possible):

1. Correct patient identity using two identifiers;
2. Correct procedure;
3. Correct procedure side and site marked by surgeon;
4. Questions regarding the procedure/surgery resolved;
5. Properly completed procedural consent;
6. Anesthesia Consent;
7. VTE Prophylaxis addressed;
8. Equipment/Implant (s) are available;
9. All Surgical/Procedure Team members participated and agree on all elements of the Time Out; and
10. For pre-operative pain block anesthesia, verify with registered nurse
    a. Identity of patient using two (2) identifiers; and
    b. The type of block and laterality (as applicable).

C. When the patient is in the pre-procedural area, immediately prior to moving the patient to the surgical/procedure room, a checklist is used to review and verify that the following items are available and accurately matched to the patient:

1. Relevant documentation (for example, allergies, history and physical, nursing assessment, and pre-anesthesia assessment);
2. Accurately completed and signed procedure consent forms;
3. Correct diagnostic and radiology test results (for example, radiology images and scans, or pathology and biopsy reports) that are properly labeled; and
4. Any required blood products, implants, devices, and/or special equipment for the procedure.

III. MARKING THE PROCEDURE/SURGERY SITE:

A. For all procedures or surgeries involving incision or percutaneous puncture or insertion, the intended site is marked. The marking takes into consideration laterality, the surface (flexor, extensor), the level (spine), or specific digit or lesion to be treated.

NOTE: For procedures that involve laterality of organs but the incision(s) or approaches may be from the mid-line or from a natural orifice, the site is still marked and the laterality noted.

B. The procedure site is initially marked before the patient is moved to the location where the procedure or surgery will be performed and with the patient involved, awake, and aware, if possible.

C. The procedure site is marked by a QMP or other provider who is qualified to perform the intended surgical or non-surgical invasive procedure. This individual will be involved directly in the procedure and will be present, at a minimum, for the key and critical portions of the procedure.

NOTE: Final confirmation and verification of the site mark takes place during the Time-Out.

D. The method of marking the site and the type of mark is unambiguous and is used consistently throughout the ASC.

E. The mark addresses the following:

1. Is made at or near the procedure/surgical site or the incision site. Other non-procedure/surgical site(s) are not marked unless necessary to some other aspect of care;
2. Includes the word "Yes," with or without a line representing the proposed incision;
3. Is made using a marker that is sufficiently permanent to remain visible after completion of the skin prep and sterile draping. Adhesive site markers are not to be used as the sole means of marking the site; and
4. Is positioned to be visible after the patient has had his or her skin prepped, is in his or her final position, and sterile draping is completed.

F. Alternative process for patients who refuse site markings:

1. If an adult patient refuses to have his/her site marked as per policy, the surgeon shall verify the correct patient, procedure, and side/site in comparison to the patient's signed consent form for the procedure, the history and physical, and diagnostic testing results prior to the initiation of the procedure.

2. If a pediatric patient refuses to have his or her site marked as per policy, the site may be marked with the permission of the parent guardian, or legally designated representative, after the patient is sedated or anesthetized. If the parent, guardian, or legally designated representative refuses to have the site marked, the surgeon shall verify the correct patient, procedure, and side/site in comparison to the patient's signed consent form for the procedure, the history and physical, and diagnostic testing results prior to the initiation of the procedure.

G. Alternative processes are outlined below for patients who cannot easily be marked:

1. The ASC will place a temporary unique arm band on the side of the procedure/surgery containing the patient's name and use a second identifier for the intended procedure/surgery and site in the following instances:

   i. For cases that it is technically or anatomically impossible or impractical to mark site (mucosal surfaces, perineum); and

   ii. For interventional procedure cases for which the catheter/instrument site is not predetermined (for example, cardiac catherization, pacemaker insertion).

2. For minimal access procedures that intend to treat a lateralized internal organ, whether percutaneous or through a natural orifice, the intended site is indicated by a mark at or near the insertion site and remains visible after completion of the skin preparation and sterile draping.

3. For teeth, the operative tooth name(s) and number are indicated on documentation or the operative tooth (teeth) is marked on the dental radiographs or dental diagram. The documentation, images, and/or diagrams are available in the procedure room before the start of the procedure.

4. Exemptions from site marking include midline, single organ procedures, as well as endoscopies without intended laterality. Site marking is also not required before procedures in which there is no predetermined site of insertion such as cardiac catherization and other interventional procedures. All other procedures are required to be marked.

IV. TIME-OUT PROCESS:

A. The Time-Out will be conducted prior to starting the procedure/surgery. In addition, a Time-Out will be conducted prior to the introduction of the anesthesia process for regional anesthesia. The Time-Out occurs immediately before starting the procedure/surgery as a final assessment that the correct patient, site, positioning, and procedure are identified, and that, as applicable, all relevant documents, related information, and necessary equipment are available.

B. Immediately prior to the start of the procedure, a Time-Out is initiated by the surgeon/proceduralist of record (Third year resident or higher) and includes interactive verbal communication among all relevant members of the Surgical/Procedure Team. Any team member is able to express concerns about the procedure/surgery verification.

C. During the Time-Out, other activities are suspended, music silenced to the extent possible without compromising patient safety, so that all relevant members of the team are focused on the active confirmation of the correct patient;, procedure;, site/side; , and other critical elements.

D. When more than one procedure/surgery is being performed by separate Surgical/Procedure teams on the same patient, a Time-Out is performed to confirm each subsequent procedure/surgery before it is initiated.

E. The Time-Out addresses but not limited to the following:

1. Relevant documentation is complete, including
   a. Consent(s);
   b. History and Physical; and
   c. Pre-operative notes.
2. Surgeon: Introduction then verbalize

~~1. Correct patient identity using two~~Patient name, DOB, MRN ~~identifiers~~;

~~2. Correct~~ procedure;

- ~~Correct procedure side and site~~and site/side ~~-~~marked by surgeon (CONFIRM WITH CONSENT);
- Relevant images displayed
- Concerns or anticipated critical events
- Duration
- Blood loss

~~3.~~• Fire Risk

~~3.1. Relevant documentation is complete, including~~

~~b.a. Consent(s);~~

~~c.a.~~History and Physical; ~~and~~

~~Pre-operative notes.~~Anesthesia: Introduction then verbalize

- Antibiotic name, dose, route, & time
- Allergies
- Post-op plan
- Concerns or anticipated critical events

4. Scrub Tech: Introduction then verbalize
   - Instrument sterility
   - Medications/solutions on field
5. Circulating RN: Introduction then verbalize
   - Equipment, devices, implants available
   - Blood status
6. Others: Introduction then verbalize

~~d.~~• Reason for being there

7. ~~All Surgical/Procedure Team members in the room participate and agree on all elements of the Time Out.~~Surgeon
   - Solicit questions and make the following statement:

     ~~4.~~ "If anyone has any concerns anytime during this case, I expect you to bring it to my attention immediately."

F. The registered nurse (circulator) or Healthcare Worker will document the required components of the Time Out in the patient's record. Additionally, if a modified Time Out is performed, an EIRS will be initiated.

G. Any discrepancies noted must be resolved before the procedure is initiated.

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H. Anytime the responsibility for care of the patient is transferred to another Attending Physician, a new Time Out must be performed.

I. When other members of the Surgical/Procedural Team change after a Time Out has been completed, hand off should occur in accordance with Harris Health guidelines.

V. POST-PROCEDURE (DEBRIEF) PROCESS:

A. The debriefing is done verbally by the Attending Surgeon or Surgeon of record (if emergent unscheduled surgeries/procedures) initiates ~~Surgical/Procedure Team and includes~~; all members of the team with PAUSE, LISTEN, and Participate.

~~A.~~ Anesthesia, Surgeon of record, Circulating RN, Scrub Tech~~:~~

PROCEDURE CONFIRMATION (Surgical/Procedure Team):

1. Name of procedures;
2. Wound class;
3. Correct instrument, sponge, and needle count;
4. All specimens identified & labeled and sent to appropriate lab (Verification with Attending Surgeon);
~~4.~~5. Verify the correct number of specimens obtained. All specimens identified & labeled and sent to appropriate lab. Verification with Read-back to Attending Surgeon; and
~~5.~~6. Estimated blood loss and transfusions.

DEBRIEF (Surgical/Procedure Team):

1. What went well;
2. What can improve, and how can this improvement happen;
3. Equipment problems;
4. Any events that need reporting;
5. Changes to post-op plan Surgery and Anesthesia; and
6. Armband on patient.

VI. PROCEDURE:

A. At the time the procedure/surgery is scheduled, the scheduler will verify the correct person, correct site, and correct procedure/surgery.

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B. At the time of preadmission testing and assessment, the person(s) performing the testing and/or assessment will verify the correct person, correct site, and correct procedure/surgery.

C. At the time of admission or entry into the ASC for a procedure, the admitting person will verify the correct person, correct site, and correct procedure/surgery.

D. Before leaving the pre-procedure area, the registered nurse or Healthcare Worker will verify the correct patient, correct site, and correct procedure/surgery.

E. The patient will not be moved to the operating room from the pre-operative area until the attending surgeon is present in the ASC facility.

F. The registered nurse or Healthcare Worker assisting the surgeon will perform the following steps to implement the Universal Protocol:

1. On initial patient assessment, verify verbally with the patient, parent, or legally designated representative, the patient's identification, the scheduled procedure/surgery, side, and surgical procedure site.

2. Check the identified surgical/procedure site for site markings as appropriate. If the site has not been marked, contact the surgeon to come and mark the appropriate side/site "yes" with a marker unless contraindicated.

   NOTE: If a bilateral procedure is planned, both sides must be marked "yes." The surgeon will mark the site(s) with the patient's assistance.

3. Repeat the above steps for each separate procedure when multiple procedures are planned.

4. If any discrepancies exist, notify the patient's surgeon for resolution.

5. Document any discrepancy and its resolution

G. Just prior to the introduction of the anesthesia process for regional anesthesia, the anesthesia provider will request a Time-Out verbal confirmation of:

1. The correct patient identity;
2. The correct procedure/surgery side and site;
3. Agreement on the procedure/surgery to be done by all;
4. Questions regarding the procedure/surgery resolved; and
5. All Surgical/Procedure Team members participated.

H. Just prior to the initiation of the surgery, the Surgical/Procedure Team will conduct a Time Out, verbal confirmation of:

1. The correct patient identity;
2. The correct surgery/procedure site;
3. Agreement on surgery/procedure to be done by all;
4. Questions regarding the surgery/procedure resolved; and
5. All Surgical/Procedure Team members participated.

I. The registered nurse or Healthcare Worker assisting the surgeon in the patient care area will clearly document the completed components of the Universal Protocol (pre-procedure Verification, marking of the surgical site, and Time-Out) in the patient's medical record.

J. In the event the Time-Out is not completed in accordance with this policy, the registered nurse or Healthcare Worker assigned to the case will immediately report this to his or her immediate supervisor and document the incident in the electronic incident reporting system (eIRS).

REFERENCES/BIBLIOGRAPHY:

American Association for Accreditation of Ambulatory Surgery Facilities Version 7 § ~~200~~ version 8.0

OFFICE OF PRIMARY RESPONSIBILITY:

The Ambulatory Surgical Center (ASC) at LBJ

Effective Date	Version # (If Applicable)	Review/ Revision Date (Indicate Reviewed or	Approved by:

		Revised)	
6/14/16	1.0	06/14/16	The Ambulatory Surgical Center (ASC) at LBJ Governing Body
		Reviewed / Approved 03/29/18	The Ambulatory Surgical Center (ASC) at LBJ Governing Body
		Approved 02/14/2019	The Ambulatory Surgical Center (ASC) at LBJ Governing Body
		Reviewed / Approved 02/13/2020	The Ambulatory Surgical Center (ASC) at LBJ Governing Body
		Revised / Approved 02/25/2021	The Ambulatory Surgical Center (ASC) at LBJ Governing Body

APPENDIX A
PERIOPERATIVE SURGICAL SAFETY GUIDE

Items in yellow required for emergent surgical procedure or non-surgical invasive procedure

Sign-in (Pre-Op)	Timeout (OR)	Debrief (OR)
Verified in Pre-op Area Before	Prior to any invasive action done on patient by surgical team. All activity stops, music silenced.	Before Surgeon of Record leaves the room
• OR circulator and pre-op RN confirm the following with record and patient.	• Scan patient's arm band upon entering the OR. • Surgeon of record (Third year resident or higher) initiates; all members of the team will **Pause, Listen, and Participate.** • New Surgeon or Procedure – Will require a new timeout • All Services of the case should be present at initial timeout.	• Anesthesia, Surgeon of Record, Circulating RN, Scrub Tech
• Identity – verified with armband using two identifiers • Site/Side – verified and marked with H&P or Pre-op Note • Procedure – verified with H&P and Faculty Note • Consent – verified with H&P and Faculty Note • Allergies – verified with the patient and chart • VTE Prophylaxis addressed (chemical/mechanical) • Anesthesia consent complete **Verify:** • Equipment/implant available • Post-op location/plan • Are blood products available if indicated • For pre-op Block, Anesthesia verifies with pre-op RN 1. Identity of patient (using 2 identifiers) 2. Type of Block and laterality **3. Appropriate NPO status**	**SURGEON: Introduction then Verbalize** • Patient name, MRN, procedure, and site/side (CONFIRM WITH CONSENT FORM) • Relevant images displayed • Concerns or anticipated critical events • Duration • Blood loss • Fire Risk **ANESTHESIA: Introduction then Verbalize** • Antibiotic name, dose, route, & time • Allergies • Post-op plan • Concerns or anticipated critical events **SCRUB TECH: Introduction then Verbalize** • Instrument sterility • Medications/solutions on field **CIRCULATING RN: Introduction then Verbalize** • Equipment, devices, implants available • Blood product status **OTHERS: Introduction then Verbalize** • Reason for being there **SURGEON:** • Solicit questions ***"If anyone has any concerns anytime during this case, I expect you to bring it to my attention immediately."***	**Procedure Confirmation (Surgical/Procedure Team):** Is the patient awake (yes/no)? **If yes, debrief as appropriate** • Name of procedures • Wound class • Correct instrument, sponge, and needle count • All specimens identified & labeled and sent to appropriate lab - (Verification with Attending Surgeon) • Estimated blood loss and transfusions **Debrief (Surgical/Procedure Team)** • What went well • What can improve, and how can this improvement happen • Equipment problems • Any events that need reporting • Changes to post-op plan • Surgery • Anesthesia • Armband on patient

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POLICY AND REGULATIONS MANUAL

TITLE: **AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**

PURPOSE: To specify the requirements for the use and disclosure of Protected Health Information pursuant to the Ambulatory Surgical Center (ASC) at LBJ's authorization.

POLICY STATEMENT:

It is the policy of the Ambulatory Surgical Center (ASC) at LBJ to require individuals requesting protected health information to complete Harris Health's Authorization for Use, Request and Disclosure of Protected Health Information (PHI) form, which meets the requirements of a valid authorization set forth in the Health Insurance Portability and Accountability Act (HIPAA) and in the Texas Health and Safety Code Chapter 181, unless otherwise specified within this policy.

All workforce members are required to report suspected violations of patient-privacy policies to the Office of Corporate Compliance within 24 hours of discovery. Please see ASC-P-2004 Complaints regarding Privacy and Security for reporting options and requirements. Failure to timely report suspected violations of patient-privacy policies could result in disciplinary action under ~~Harris Health System Policy and Procedures 3.11.104~~ASC-P-2017 Sanctions for Failure to Comply with Privacy and Information Security Policies.

POLICY ELABORATIONS:

I. DEFINITIONS:

A. **AUTHORIZATION**: Harris Health Form 280342 Authorization for Use, Request and Disclosure of Protected Health Information. (See Attachment A).

B. **DESIGNATED RECORD SET**: A group of records maintained by or for Harris Health on behalf of the Ambulatory Surgical Center (ASC) at LBJ that is:

1. The medical and billing records about patients;
2. The enrollment, payment, claims adjudication and case or medical management record systems maintained by or for a health plan; or
3. Used, in whole or in part, by or for Harris Health to make decisions about patients.

C. **DISCLOSURE**: The release, transfer, provision of, access to, or divulging in any manner Protected Health Information outside of Harris Health on behalf of the Ambulatory Surgical Center (ASC) at LBJ.

D. **INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI):** Information that is a subset of health information, including demographic information collected from an individual, that:

1. Is created or received by a health care provider, health plan, employer, or health care clearinghouse; and
2. Relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and

    a. Identifies the individual; or
    b. There is a reasonable basis to believe the information can be used to identify the individual.

E. **LEGALLY AUTHORIZED REPRESENTATIVE (LAR)**: An individual with legal standing to represent the interests of another (*e.g.,* parent or spouse) or with the authority to act on behalf of another (as by power of attorney, court order, advance directive, or the executor of a will).

F. **PERSONAL REPRESENTATIVE:** A person with authority under the law to act on behalf of the patient.

For purposes of this policy only, the term Personal Representative also includes a patient's Legally Authorized Representative, defined above.

G. **PRIVACY OFFICER:** An individual designated by Harris Health representing on behalf of the Ambulatory Surgical Center (ASC) at LBJ who is responsible for the development and implementation of the privacy-related functions of Harris Health as further defined in Harris Health Policy and Procedure 3.11.101 Privacy Officer, Roles and Responsibilities.

H. **PROTECTED HEALTH INFORMATION (PHI):** IIHI that is created, received, transmitted or maintained by Harris Health System on behalf of the Ambulatory Surgical Center (ASC) at LBJ in any form or medium that relates to the patient's health care condition, provision of health care, or payment for the provision of health care, as further defined in HIPAA regulations. PHI includes, but is not limited to, the following identifiers:

1. Name;
2. All geographic subdivisions smaller than a state, including street address, city, county, precinct, zip code, and their equivalent geocodes, except for the initial three digits of a zip code if, according to the current publicly available data from the Bureau of the Census:

    a. The geographic unit formed by combining all zip codes with the same three initial digits contains more than twenty thousand (20,000) people; and
    b. The initial three digits of a zip code for all such geographic units containing twenty thousand (20,000) or fewer people is changed to 000.

3. All elements of dates (except year) for dates directly related to an individual, including birth date, admission date, discharge date, date of death; and all ages over eighty-nine (89) and all elements of dates (including year) indicative of such age, except that such ages and elements may be aggregated into a single category of age ninety (90) or older;
4. Telephone numbers;
5. Fax numbers;
6. Electronic mail addresses;
7. Social security numbers;
8. Medical record numbers;
9. Health plan beneficiary numbers;
10. Account numbers;
11. Certificate/license numbers;
12. Vehicle identifiers and serial numbers, including license plate numbers;
13. Device identifiers and serial numbers;
14. Web Universal Resource Locators (URLs);
15. Internet Protocol (IP) address numbers;
16. Biometric identifiers, including finger and voice prints;

17. Full face photographic images and any comparable images; and
18. Any other unique identifying number, characteristic, or code, except as permitted for re-identification purposes.

II. AUTHORIZATION REQUIREMENTS:

A. It is Harris Health's policy that individuals requesting PHI must do so using Harris Health's Form 280342 Authorization for Use, Request, and Disclosure of Protected Health Information.

B. Harris Health only accepts Harris Health's Form 280342 Authorization for Use, Request, and Disclosure of Protected Health Information, unless:

1. Harris Health receives an authorization for the release of PHI pursuant to a Notice of Health Care Claim made under Chapter 74 of the Texas Civil Practice and Remedies Code. If Harris Health receives such a notice and Authorization, Harris Health must immediately forward the notice and Authorization to the County Attorney's Office.
2. Harris Health receives a properly executed Harris Health Form 282758 Authorization for Release of Information – Media, Marketing and Educational Use.
3. The Privacy Officer approves the acceptance of an Authorization different from Harris Health Form 280342 Authorization for Use, Request, and Disclosure of Protected Health Information.

III. DETERMINING VALIDITY AND PROCESSING THE AUTHORIZATION:

A. The valid Authorization (Harris Health Form 280342 Authorization for Use, Request, and Disclosure of Protected Health Information) must be written and delivered to Harris Health.

B. Harris Health, on behalf of the Ambulatory Surgical Center (ASC) at LBJ will review all Authorizations and confirm that the Authorization is complete and the identity of the requestor is valid (See Attachment A for guidance on authorized representatives).

C. Every reasonable attempt must be made to verify the authenticity of the signature on the Authorization. (Verify the authenticity by comparing the signature on the

Authorization form with the signatures within the medical record, the consent for treatment, instruction to the patient, identification (ID) proof, etc.)

D. An Authorization is invalid or defective and will not be acted upon if any of the following are true:

1. The Authorization is not Harris Health Form 280342 Authorization for Use, Request, and Disclosure of Protected Health Information form.
2. The expiration date has passed or the expiration event is known by Harris Health to have occurred;
3. The Authorization has not been filled out completely;
4. Harris Health is unable to verify the signature on the Authorization;
5. The Authorization has been submitted by an individual not legally authorized to request protected health information; ;
6. Harris Health knows the Authorization has been revoked by the patient or the patient's Personal Representative;
7. Harris Health knows material information in the Authorization is false; or
8. The Authorization is not a stand-alone document (i.e., the Authorization is combined with any other document such as a Notice of Privacy Practices or written voluntary consent). See below.

E. If an invalid Authorization is received, the Harris Health will identify why it is invalid and return it to the requestor for completion or correction.

F. If the Authorization is valid and approved, Harris Health will comply with the terms of the Authorization.

IV. WHO MAY REQUEST A DISCLOSURE OF PHI:

A. The patient may request Disclosure of his or her PHI.

B. The patient's Personal Representative, as outlined in Attachment B, may request Disclosure of PHI. Proof of the Personal Representative's right to the PHI must be provided.

V. REVOCATION OF AUTHORIZATIONS:

A. A patient or the patient's Personal Representative may revoke an Authorization.

The revocation must be in writing, submitted to the Privacy Officer or designee, and specify which Authorization, if the patient or patient's Personal Representative has executed more than one Authorization, is being revoked.

B. The Privacy Officer or designee will notify the Health Information Management (HIM) department of the revocation.

C. The HIM department receiving the request to revoke an Authorization must discontinue any further release of the patient's PHI as permitted by the initial Authorization; but the revocation does not apply to actions taken by Harris Health in reliance on the initial Authorization.

D. For insurance purposes, the revocation does not apply if the Authorization was obtained as a condition of obtaining insurance coverage because other law provides the insurer with the right to contest a claim under the policy or the policy itself.

E. As appropriate, the HIM department will notify other areas of Harris Health that may have relied upon the Authorization of the revocation.

VI. TIMEFRAME FOR RESPONDING TO AUTHORIZATIONS REQUESTING DISCLOSURE OF PHI:

A. Each Record Custodian will ensure that requests for Disclosure of PHI are provided pursuant to state and federal law.

B. If Harris Health, on behalf of the Ambulatory Surgical Center (ASC) at LBJ is unable to meet the specified timeframe or locate the record, it will notify the requestor of the delay in writing.

VII. FEES FOR COPIES:

A. Harris Health, on behalf of the Ambulatory Surgical Center (ASC) at LBJ may charge reasonable fees as allowed by state and federal law for copies of protected health information.

B. Harris Health, on behalf of the Ambulatory Surgical Center (ASC) at LBJ may not withhold copies of a patient's PHI requested by the patient or the patient's

personal representative for failure to submit payment for the copies.

VIII. RETENTION OF AUTHORIZATIONS AND REVOCATIONS:

A. Authorizations and revocations of Authorization will be maintained for six (6) years from their last effective date or longer if specified in Harris Health's Policy and Procedure 8.03 Record Retention and Destruction.

B. Authorizations and revocations of Authorization will be maintained in the patient's Designated Record Set.

REFERENCES/BIBLIOGRAPHY:

45 Code of Federal Regulations (C.F.R.) §164.508

TEX. HEALTH & SAFETY CODE ANN. §181.154(b)

TEX. CIV. PRAC. & REM. CODE ANN. §74.051(a)

Harris Health System Policy and Procedure 8.03 Record Retention and Destruction

Harris Health Policy and Procedure 3.11.101 Privacy Officer, Roles and Responsibilities

Harris Health System Form 282758 Authorization for Release of Information – Media, Marketing and Educational Use

Harris Health's Form 280342 Authorization for Use, Request, and Disclosure of Protected Health Information

ATTACHMENTS:

Attachment A - Authorization for Use and Disclosure of Protected Health Information
Attachment B - Guidelines for legally Authorized Representative

OFFICE OF PRIMARY RESPONSIBILITY:

The Ambulatory Surgical Center (ASC) at LBJ

REVIEW/REVISION HISTORY:

Effective Date	Version # (If Applicable)	Review/ Revision Date (Indicate Reviewed or Revised)	Approved by:
06/14/2016	1.0		The Ambulatory Surgical Center (ASC) at LBJ Governing Body
		Reviewed / Approved 02/14/2019	The Ambulatory Surgical Center (ASC) at LBJ Governing Body
		Reviewed / Approved 02/13/2020	The Ambulatory Surgical Center (ASC) at LBJ Governing Body
		Reviewed / Approved 02/25/2021	The Ambulatory Surgical Center (ASC) at LBJ Governing Body

ATTACHMENT A
AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Harris County Hospital District

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT INFORMATION (Please Print)

Hospital Card Number:

Patient Name:	Social Security No.	Date of Birth	Phone No.
Address	City	State	Zip Code

I, _____, authorize Harris County Hospital District to disclose and provide photocopies of the health-care information indicated below from my medical record to the following party:

_____ _____
Name of person(s) or company to receive information Phone Number

_____ _____ _____ _____
Street Address City State Zip Code

Information To Be Released – Covering the Periods of Health Care

From (date)_____ to (date)_____

Please check type of information to be released:

☐ Admission Sheet	☐ History and Physical	☐ Discharge Summary	☐ Clinic Visit
☐ Autopsy	☐ Operative Report	☐ Pathology Report	☐ Other (specify)
☐ Footprints	☐ Laboratory Report	☐ Radiology Report (X-Ray, MRI, Ultrasound, etc)	_____
☐ Entire Record	☐ Entire Record Excluding Nurses Notes	☐ Emergency Room Sheet	_____
☐ Itemized Bill	☐ Lab / Slides	☐ Radiology Film (MRI, chest X-Ray, etc.)	
☐ Complete Billing Record	☐ Block/Specimens	☐ Psychotherapy Notes **(If this box is checked, no other box may be checked)**	

Purpose of Request/Disclosure

☐ Treatment or Consultation ☐ At the request of the Patient ☐ Billing or claims payment ☐ Requested for Government Benefit

☐ Other, (specify)_____

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release

I understand if my information requested above contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, HIV, Aids, Hepatitis B or C testing, and/or other sensitive information, I agree to its release. Check One: ☐Yes ☐ No

Re-Disclosure

I understand the information disclosed by this authorization may be subjected to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act 1996. This facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

This authorization will expire on the following event or date _____or 180 days from the date of signature. I understand that this authorization may be revoked by the person giving the authorization by written and dated notice to Harris County Hospital District, except to the extent that disclosure of information has been made prior to receipt of the revocation by Harris County Hospital District.

Signature of Patient or Personal Representative Who May Request Disclosure

I understand that I do not have to sign this authorization, and my treatment or payment for services will not be denied if I do not sign this form unless specified above under **Purpose of Request**. I can inspect or copy the protected health information to be used or disclosed.

_____ _____
Signature of Patient Date Signed

Authority to Sign if not patient_____

Identity of Requestor Verified via: ☐Photo ID ☐Matching Signature ☐Other, specify_____

Top copy: Facility Bottom copy: Patient Form#_____ Form effective Date:_____

ATTACHMENT B
GUIDELINES FOR LEGALLY AUTHORIZED REPRESENTATIVE

A legally authorized representative is defined as follows:

IF THE INDIVIDUAL IS	AUTHORIZED REPRESENTATIVE
1. Competent Adult Patient	Patient
2. An emancipated minor	Patient
3. An un-emancipated minor (single or unmarried under age 18)	A parent, legal guardian, court-appointed guardian ad litem, or attorney ad litem with legal authority to make health care decisions on behalf of the minor child.
In the case of a minor child whose parents are divorced, the parent having legal custody of the child must sign the Authorization.	
4. Incompetent adult patient	A person with legal authority to make health care decisions on behalf of the individual. Example: Durable power of attorney, court appointed legal guardian, guardian ad litem or attorney ad litem.
5. Deceased	A person with legal authority to act on behalf of the decedent or the estate (not restricted to health care decisions). Examples: Personal Representative (Executor or Administrator), surviving parent, spouse or adult child, or agent authorized by patient's durable power of attorney. Required documentation: Either a letter of testamentary or a letter of administration, durable power of attorney, marriage, death or birth certificate establishing relationship to deceased.

TITLE: COMPLAINTS REGARDING PRIVACY AND SECURITY

PURPOSE: To define a process for submitting and addressing complaints related to federal and state privacy and security laws.

POLICY STATEMENT:

Ambulatory Surgical Center (ASC) at LBJ patients, visitors, and workforce members, may submit alleged violations of federal and/or state privacy and/or security laws, including violations of patient confidentiality, or Harris Health privacy and/or information security policies or procedures, to Harris Health's privacy officer, for investigation.

All workforce members are required to report suspected violations of patient-privacy policies to the Office of Corporate Compliance within 24 hours of discovery. Failure to timely report suspected violations of patient-privacy policies could result in disciplinary action under ASC-P-2017 Sanctions for Failure to Comply with Privacy and Information Security Policies.

POLICY ELABORATIONS:

I. DEFINITIONS:

A. **BUSINESS ASSOCIATE (BA)**: A person or entity that provides certain functions, activities, or services for, to, or on behalf of a covered entity involving the use and/or disclosure of protected health information as further defined in the HIPAA regulations.

B. **CHIEF INFORMATION SECURITY OFFICER (CISO)**: An individual designated by Harris Health System who is responsible for the management and supervision of the use of security measures to protect data and the conduct of workforce members in relation to the protection of data.

C. **COVERED ENTITY**: A health plan, a healthcare clearinghouse, or a health care provider (the Ambulatory Surgical Center (ASC) at LBJ) that electronically transmits health information covered by the HIPAA regulations. The ASC is a Covered Entity.

D. **DISCLOSURE**: The release, transfer, provision of, access to, or divulging in any manner protected health information outside of the ASC.

E. **INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI)**: Information that is a subset of health information, including demographic information collected from an individual, and:

1. Is created or received by a healthcare provider, health plan, or healthcare clearinghouse; and
2. Relates to the past, present, or future physical or mental condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual; and

   i. Identifies the individual; or
   ii. With respect to which there is a reasonable basis to believe the information can be used to identify the individual.

F. **PROTECTED HEALTH INFORMATION (PHI)**: IIHI that is created, received, transmitted, or maintained by the ASC in any form or medium that relates to the patient's healthcare condition, provision of health care, or payment for the provision of health care, as further defined in the HIPAA regulations. PHI includes, but is not limited to, the following identifiers:

1. Name;
2. All geographic subdivisions smaller than a State, including street address, city, county, precinct, zip code, and the equivalent geocodes, except for the initial three digits of a zip code if, according to the current publicly available data from the Bureau of the Census:
   i. The geographic unit formed by combining all zip codes with the same three initial digits contains more than twenty-thousand (20,000) people; and
   ii. The initial three (3) digits of a zip code for all such geographic units containing twenty thousand (20,000) or fewer people is changed to 000.
3. All elements of dates (except year) for dates directly related to an individual, including birth date, admission date, discharge date, date of death; and all ages over eighty-nine (89) and all elements of dates (including year) indicative of such age, except that such ages and elements may be aggregated into a single category of age ninety (90) or older;
4. Telephone numbers;
5. Fax numbers;

6. Electronic mail addresses;
7. Social Security numbers;
8. Medical record numbers;
9. Health plan beneficiary numbers;
10. Account numbers;
11. Certificate/license numbers;
12. Vehicle identifiers and serial numbers, including license plate numbers;
13. Device identifiers and serial numbers;
14. Web Universal Resource Locators (URLs);
15. Internet Protocol (IP) address numbers;
16. Biometric identifiers, including finger and voice prints;
17. Full face photographic image and comparable images; and
18. Any other unique identifying number, characteristic, or code, except as permitted for re-identification purposes.

G. **PRIVACY OFFICER:** An individual designated by Harris Health who is responsible for the development and implementation of the privacy-related functions of the ASC.

H. **USE**: Regarding PHI, the sharing, employment, application, utilization, examination, or analysis of such information within an entity that maintains such information.

I. **WORKFORCE**: The members of the governing body of the Ambulatory Surgical Center (ASC) at LBJ, employees, medical staff, trainees, contractors, volunteers, and vendors. Employees (permanent or temporary) include volunteers, trainee, and other persons whose conduct, in the performance of work for Harris Health, whether or not they are paid by Harris Health.

II. SUBMISSION & INVESTIGATION OF COMPLAINTS:

A. Complaints regarding the Ambulatory Surgical Center (ASC) at LBJ's alleged violations of federal and/or state privacy or security laws and/or Harris Health's privacy and/or security policies and/or procedures are submitted using the following methods: .

1. In writing, such as an email (PatientPrivacy@harrishealth.org or written complaints sent to the Privacy Officer or his or her designee or the CISO or his or her designee;
2. In person in which the Privacy Officer, the CISO, or his or her designee will document the complaint in writing for the individual;
3. By US mail, addressed to:

   Corporate Compliance Officer
   Harris Health System
   Office of Corporate Compliance

   2525 Holly Hall, Suite 171
   Houston, Texas 77054

A. 4. By phone via the Compliance Hotline at 1-800-500-0333 or a direct call to the Privacy Officer or CISO or his or her designee .

B. Complaints may be submitted anonymously using any method above.

C. All complaints will be investigated by the Privacy Officer, the CISO, or their designee depending on the nature of the complaint.

D. All investigations, including the conclusion of the investigation, conducted by the Privacy Officer, the CISO, or their designee will be documented, and the Privacy Officer will retain the documentation of the investigation for six (6) years from the date the documentation was created or received.

III. SUBMISSION OF COMPLAINTS TO THE SECRETARY:

A. To file a privacy or security complaint with the Secretary of the Department of Health and Human Services, a complainant must submit the complaint in writing to the following address:

Officer for Civil Rights
U.S. Department of Health and Human Services
1301 Young Street, Suite 106
Dallas, TX 75202
Customer Response Center: (800) 368-1019
Fax: (202) 619-3818

TDD: (800) 537-7697
Email: ocrmail@hhs.gov

B. The complaint must name the ASC as the subject of the complaint and describe the complaint against the ASC.

C. The complaint must be filed within one hundred eighty (180) days of the time the person knew or should have known that the act or omission complained of occurred, unless the Secretary for good cause waives the time limit.

IV. BUSINESS ASSOCIATES:

V. Harris Health will investigate all complaints that its Business Associates have violated federal or state privacy or security laws or Harris Health's privacy and security policies and procedures, or the terms of the Business Associate Agreement. Harris Health will resolve all such complaints and act on such information, as appropriate.

VI. NON-RETALIATION:

Harris Health will not retaliate against any person who files a complaint regarding violations of federal and/or state privacy and/or security laws to Harris Health and/or to the Secretary of the Department of Health and Human Services.

REFERENCES/BIBLIOGRAPHY:

45 CFR § 164.530(d)(1)

45 C.F.R. § 160.306(b)

https://www.hhs.gov/ocr/about-us/contact-us/index.html

Ambulatory Surgical Center at LBJ Policy 2004 Complaints Regarding Privacy and Security

OFFICE OF PRIMARY RESPONSIBILITY:

The Ambulatory Surgical Center (ASC) at LBJ

REVIEW/REVISION HISTORY:

Effective Date	Version # (If Applicable)	Review/ Revision Date (Indicate Reviewed or Revised)	Approved by:
08/05/2016	1.0	08/05/2016	The Ambulatory Surgical Center (ASC) at LBJ Governing Body
		Reviewed / Approved 03/29/2018	The Ambulatory Surgical Center (ASC) at LBJ Governing Body
		Reviewed / Approved 02/14/2019	The Ambulatory Surgical Center (ASC) at LBJ Governing Body
		Reviewed / Approved 02/13/2020	The Ambulatory Surgical Center (ASC) at LBJ Governing Body
		Revised / Approved 02/25/2021	The Ambulatory Surgical Center (ASC) at LBJ Governing Body

TITLE: DE-IDENTIFICATION OF PROTECTED HEALTH INFORMATION

PURPOSE: To specify the process for (1) de-identifying protected health information and (2) re-identifying de-identified protected health information.

POLICY STATEMENT:

It is the policy of Ambulatory Surgical Center (ASC) at LBJ to use and disclose de-identified protected health information when possible and to de-identify protected health information in accordance with state and federal privacy laws.

All workforce members are required to report suspected violations of patient-privacy policies to the Office of Corporate Compliance within 24 hours of discovery. Please see ASC-P-2004 Complaints regarding Privacy and Security for reporting options and requirements. Failure to timely report suspected violations of patient-privacy policies could result in disciplinary action under ASC-P-2017 Sanctions for Failure to Comply with Privacy and Information Security Policies.

POLICY ELABORATION:

I. DEFINITIONS:

A. **BUSINESS ASSOCIATE**: A person or entity that provides certain functions, activities, or services for, to, or on behalf of a Harris Health involving the use and/or disclosure of protected health information as further defined in the Health Insurance Portability and Accountability Act (HIPAA) regulations.

B. **COVERED ENTITY:** A health plan, a healthcare clearinghouse, or a healthcare provider (the ASC) that electronically transmits health information covered by the HIPAA regulations which include Harris Health.

C. **DE-IDENTIFIED INFORMATION:** Health information that does not identify a patient and for which there is no reasonable basis to believe that the information can be used to identify the patient.

D. **INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI):** Information, including demographic information, that:

1. Is created or received by a health care provider, health plan, employer, or health care clearinghouse; and
2. Relates to the past, present, or future physical or mental condition of an individual, the provision of health care to an individual, or the past, present or future payment for the provision of health care to an individual:

    a. Identifies the individual; or
    b. There is a reasonable basis to believe the information can be used to identify the individual.

E. **PROTECTED HEALTH INFORMATION (PHI)**: Individually Identifiable Health Information that is created, received, transmitted, or maintained by the ASC in any form or medium, that relates to the patient's healthcare condition, provision of healthcare, or payment for the provision of healthcare, as further defined in the HIPAA regulations. PHI includes, but is not limited to, the following identifiers:

1. Name;
2. All geographic subdivisions smaller than a State, including street address, city, county, precinct, zip code, and their equivalent geocodes, except for the initial three digits of a zip code if, according to the current publicly available data from the Bureau of the Census:

    a. The geographic unit formed by combining all zip codes with the same three initial digits contains more than 20,000 people; and
    b. The initial three digits of a zip code for all such geographic units containing 20,000 or fewer people is changed to 000.

3. All elements of dates (except year) for dates directly related to an individual, including birth date, admission date, discharge date, date of death; and all ages over eighty-nine (89) and all elements of dates (including year) indicative of such age, except that such ages and elements may be aggregated into a single category of age ninety (90) or older;
4. Telephone numbers;
5. Fax numbers;
6. Electronic mail addresses;
7. Social Security numbers;
8. Medical record numbers;
9. Health plan beneficiary numbers;
10. Account numbers;

11. Certificate/license numbers;
12. Vehicle identifiers and serial numbers, including license plate numbers;
13. Device identifiers and serial numbers;
14. Web Universal Resource Locators (URLs);
15. Internet Protocol (IP) address numbers;
16. Biometric identifiers, including finger and voice prints;
17. Full face photographic images and any comparable images; and
18. Any other unique identifying number, characteristic, or code, except as permitted for re-identification purposes.

F. **RE-IDENTIFIED INFORMATION:** De-identified information that is subsequently re-identified using a code, key, or other record identifier.

II. CREATING DE-IDENTIFIED INFORMATION:

A. De-Identified information that meets the specifications set forth below is not considered to be Individually Identifiable Health Information, and therefore, is not PHI.

B. Harris Health may use PHI to create De-Identified Information or may disclose PHI to a Business Associate so that the Business Associate may create De-Identified Information on behalf of Harris Health.

C. Creating De-Identified Information:

1. Harris Health may create De-Identified Information by the Safe Harbor method by doing the following:

a. **Statistical Method:**

i. Completely removing all of the following identifiers of the patient or of relatives, employers, or household members of the patient.:

(a) Name;
(b) All geographic subdivisions smaller than a State, including street address, city, county, precinct, zip code,

and the equivalent geocodes, except for the initial three (3) digits of a zip code, if according to the current publicly available data from the Bureau of the Census:

(i) The geographic unit formed by combining all zip codes with the same three (3) initial digits contains more than 20,000 people; and

(ii) The initial three (3) digits of a zip code for all such geographic units containing 20,000 or fewer people are changed to 000.

(c) All elements of dates (except year) for dates directly related to an individual, including birth date, admission date, discharge date, date of death; and all ages over eighty-nine (89) and all elements of dates (including year) indicative of such age, except that such ages and elements may be aggregated into a single category of age ninety (90) or older;

(d) Telephone numbers;

(e) Fax numbers;

(f) Electronic mail addresses;

(g) Social Security numbers;

(h) Medical Record numbers;

(i) Health plan beneficiary numbers;

(j) Account numbers;

(k) Certificate/license numbers;

(l) Vehicle identifiers and serial numbers, including license plate numbers;

(m) Device identifiers and serial numbers;

(n) Web Universal Resource Locators (URLs);

(o) Internet Protocol (IP) addresses;

(p) Biometric identifiers, including finger and voice prints;

(q) Full face photographic images and any comparable images; and

(r) Any other unique identifying number or characteristic or code.

ii. Harris Health and the ASC does not have actual knowledge that the information could be used alone or in combination with the

other information to identify an individual who is the subject of the information.

iii. All identifiers listed above and all parts or derivatives of the identifiers listed above must be completely removed. For example, failure to remove the patient's entire Social Security Number or a patient's initials would not satisfy the Safe Harbor method of de-identification.

iv. Any questions or concerns relating to how to properly de-identify information should be emailed to patientprivacy@harrishealth.org

D. Re-Identified Information:

Harris Health may assign a code or other means of record identification to allow Harris Health to re-identify De-identified Information, provided that:

1. Any code or other means used to re-identify De-Identified Information may not be derived from or related to the patient to whom the information relates or be capable of being translated so that the patient to whom the information relates may be identified; and
2. Workforce members are prohibited from disclosing the code or other means used to re-identify the De-Identified Information.

E. Disclosure of De-Identified Information:

1. Health information that has been properly de-identified is not PHI and therefore may be disclosed, provided that Harris Health does not disclose the code or other means of record identification that enables De-Identified Information to be re-identified; and
2. If the code or means of record identification that enables the De-Identified Information to be re-identified, then that Re-Identified Information is PHI and must be protected in accordance with state and federal privacy rules and regulations.

III. PROCESSING REQUESTS FOR DE-IDENTIFIED INFORMATION:

A. Requests for De-Identified Information must be in writing and be submitted to the Office of Corporate Compliance.

B. Requests for De-Identified Information must include the following information:

1. Requestor's name, address, telephone numbers, title, organization, or department;
2. Date of request;
3. Purpose of the request, which should include the intended uses, expected outcomes, and who will have access to the De-Identified Information;
4. Parameters of the request, including but not limited to, selection criteria, time period, minimum number of records needed, and type of patient records; and
5. Date that the requestor would like the De-Identified Information; and
6. Record parameters or selection criteria, time period included, minimum number of patient records, type of patient records, or other characteristics defined by the responsible department.

C. Harris Health on behalf of the ASC may deny requests for De-Identified Information if:

1. Harris Health cannot de-identify the requested PHI;
2. The requestor refuses to pay Harris Health for the cost of de-identifying the information; or
3. The request for de-identified information is an undue burden on the operations of Harris Health.

D. Approved requests will be routed to the Harris Health department or Business Associate responsible for creating the De-Identified Information. The De-Identified Information must be accompanied by a statement certifying that:

1. The risk is very small that the information could be used, either by itself or in combination with other available information, by the anticipated recipients to identify the patient to whom the information relates;
2. That all identifiers of the patient, relatives, employers, or household members of the patient have been removed; or
3. The ASC and Harris Health does not have actual knowledge that the information could be used alone or in combination with other information to identify the patient to whom the information relates.

IV. FEE SCHEDULE:

Any charge imposed by Harris Health for requests for De-Identified Information will be in accordance with the fee schedule guidance set forth in the Texas Public Information Act.

REFERENCES/BIBLIOGRAPHY:

Department of Health And Human Services 45 Code of Federal Regulations (C.F.R.) §§164.514 164.504, & 160.103.

Harris Health System Policy 3.11.300 Authorization For Use And Disclosure Of Phi For Purposes Other Than Treatment, Payment, And Health Care Operations.

Harris Health System Policy 3.11.308 Use and Disclosure Of Limited Data Sets.

OFFICE OF PRIMARY RESPONSIBILITY:

The Ambulatory Surgical Center (ASC) at LBJ

REVIEW/REVISION HISTORY:

Effective Date	Version # (If Applicable)	Review/ Revision Date (Indicate Reviewed or Revised)	Approved by:
6/14/16	1.0		The Ambulatory Surgical Center (ASC) at Lyndon B Johnson Governing Body
	2.0	Revised / Approved 03/29/2018	The Ambulatory Surgical Center (ASC) at Lyndon B Johnson Governing Body
		Reviewed / Approved 02/14/2019	The Ambulatory Surgical Center (ASC) at Lyndon B Johnson Governing Body
		Reviewed / Approved 02/13/2020	The Ambulatory Surgical Center (ASC) at Lyndon B Johnson Governing Body
		Revised / Approved 01/25/2021	The Ambulatory Surgical Center (ASC) at LBJ Governing Body

TITLE: PATIENT'S ACCESS TO DESIGNATED RECORD SET

PURPOSE: To provide guidelines to assure patient access to his or her designated record set, to describe the procedure for access request submission, processing, and the denial or approval of access requests.

POLICY STATEMENT:

A patient may obtain and review a copy of his or her designated record set containing the patient's protected health information in accordance with applicable federal and state laws. If the patient is denied access, Harris Health System ("Harris Health"), acting on behalf of the ASC, will provide the patient the reason(s) for the denial of access in writing and with instructions on filing an appeal.

All workforce members are required to report suspected violations of patient-privacy policies to the Office of Corporate Compliance within 24 hours of discovery. Please see ASC-P-2004 Complaints regarding Privacy and Security for reporting options and requirements. Failure to timely report suspected violations of patient-privacy policies could result in disciplinary action under ASC-P-2017 Sanctions for Failure to Comply with Privacy and Information Security Policies.

POLICY ELABORATIONS:

I. DEFINITIONS:

A. **AUTHORIZATION**: A signed written document that allows use and disclosure of protected health information for purposes other than treatment, payment, or healthcare operations, or as otherwise required by law.

B. **DESIGNATED RECORD SET (DRS)**: A group of records maintained by or for the ASC that is:

1. The medical and billing records about patients;

2. The enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or

3. Used, in whole or in part, by or for the ASC to make decision about patients.

For purposes of this definition, the term "record" means any item, collection or grouping of information that includes protected health information and is maintained, collected, used, or disseminated by or for the facility. The term "Record" includes (a) patient information originated by another health care provider and used by the facility to make decisions about the patient, and (b) tracings, photographs, videotapes, digital, and other images that may be recorded to document care of the patient.

C. **DISCLOSURE:** The release, transfer, provision of, access to, or divulging in any manner of protected health information (PHI) outside of Harris Health.

D. **INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI)**: Information that is a subset of health information, including demographic information collected from an individual, and:

1. Is created or received by a health care provider, health plan, employer, or health care clearing house;
2. Relates to the past, present, or future physical or mental condition of an individual, or the past, present, or future payment for the provision of health care to an individual; and
3. That identifies the individual; or
4. With respect to which there is a reasonable basis to believe the information can be used to identify the individual.

E. **OPEN RECORDS**: Medical records of patients whose current active medical record is not complete.

F. **PERSONAL REPRESENTATIVE**: A person with authority under the law to act on behalf of the patient.

G. **PRIVACY OFFICER**: An individual designated by Harris Health System who is responsible for the development and implementation of the privacy-related functions of the ASC.

H. **PROTECTED HEALTH INFORMATION (PHI)**: IIHI that is created, received, transmitted, or maintained by the ASC in any form or medium that relates to the patient's health care condition, provision of health care, or payment for the provision of health care, as further defined in the Health Information Portability

and Accountability Act (HIPAA) regulations. PHI includes, but is not limited to, the following identifiers:

1. Name;
2. All geographic subdivisions smaller than a State, including street address, city, county, precinct, zip code, and their equivalent geocodes, except for the initial three digits of a zip code if, according to the currently publicly available data from the Bureau of the Census:
   i. The geographic unit formed by combining all zip codes with the same three initial digits contains more than twenty thousand (20,000) people; and
   ii. The initial three (3) digits of a zip code for all such geographic units containing twenty thousand (20,000) or fewer people are changed to 000.
3. All elements of dates (except year) for dates directly related to an individual, including birth date, admission date, discharge date, date of death; and all ages over eighty-nine (89) and elements of dates (including year) indicative of such age, except that such ages and elements may be aggregated into a single category of age ninety (90) or older;
4. Telephone numbers;
5. Fax numbers;
6. Electronic mail addresses;
7. Social Security numbers;
8. Medical record numbers;
9. Health plan beneficiary numbers;
10. Account numbers;
11. Certificate/license numbers;
12. Vehicle identifiers and serial numbers, including license plate numbers;
13. Device identifiers and serial numbers;
14. Web Universal Resource Locators (URLs);
15. Internet Protocol (IP) address numbers;
16. Biometric identifiers, including finger and voice prints;
17. Full face photographic images and any comparable images; and
18. Any other unique identifying number, characteristic, or code, except as permitted for re-identification purposes.

I. **Records Custodian**: An individual designated by Harris Health System to be responsible for the safekeeping, maintenance, and release of PHI.

II. RESPONSIBILITY OF PROCESSING REQUESTS FOR ACCESS TO A DESIGNATED RECORD SET:

A. Pursuant to the Letter of Agreement between Harris Health System ("Harris Health") and the ASC, Harris Health will process and respond to all requests for access to a patient's DRS on behalf of the ASC.

III. RIGHT OF ACCESS TO PHI:

A. Patient's may inspect and obtain a copy of their PHI maintained in a DRS except:

a. Psychotherapy notes as determined by the treating physician; and
b. Information compiled by the ASC in reasonable anticipation of or for use in a civil, criminal, or administrative action or proceeding.

B. A patient's request for access to his or her DRS may direct Harris Health, acting on behalf of the ASC, to transmit the copy of the specific PHI requested directly to another person designated by the patient. The patient's request must be in writing, signed by the patient, and clearly identify the designated person, and where to send the copy of the DRS. Harris Health must provide the copy to the person designated by the patient on behalf of the ASC.

IV. REQUESTS FOR ACCESS TO DESIGNATED RECORD SET:

A. The ASC has adopted and will use Harris Health's Authorization for Use and Disclosure of Protected Health Information Form. Therefore, all requests to inspect and copy a patient's DRS including Open Records must be submitted in writing by the patient or the patient's Personal Representative to the Record Custodian using the Harris Health's Authorization for Use and Disclosure of Protected Health Information form.

B. The Record Custodian shall review the request and either approve or deny the request no later than fifteen (15) days after the receipt of the request, or if a charge is incurred, fifteen (15) days after the receipt of payment.

V. APPROVAL OF REQUESTS FOR ACCESS TO DESIGNATED RECORD SET:

A. If the Record Custodian approves the request for access to the patient's DRS, the patient or patient's Personal Representative must be informed of the approval. The Record Custodian will provide the access requested, including the opportunity for the patient to inspect and request a copy of the DRS, including the Open Record.

B. Harris Health, acting on behalf of the ASC, must provide access:

1. In the form and format requested, if the DRS is readily producible in such form or format, or if not readily producible in such form or format, in a readable hard copy form or other format and form agreed to by Harris Health and the patient or the patient's Personal Representative.

2. In the electronic form and format requested, if the patient or the patient's Personal Representative requests an electronic copy of such information, or if not readily producible in such form or format, in a readable electronic form and format as agreed to by Harris Health and the patient or the patient's Personal Representative.

C. Harris Health, acting on behalf of the ASC, must arrange for a convenient time and place for the patient or the patient's Personal Representative to inspect or to obtain a copy of the patient's DRS, or mail the copy of the DRS if requested by the patient or the patient's Personal Representative. The patient or the patient's Personal Representative will be required to sign in and will be observed by a Workforce member during an on-site inspection of the DRS, if the patient or the patient's Personal Representative is only inspecting the record.

VI. DENIAL OF REQUESTS FOR ACCESS TO DESIGNATED RECORD SET:

A. Harris Health may deny a patient or the patient's Personal Representative access to the patient's DRS in accordance with a ground for denial set forth in the section on "Unreviewable Grounds for Denial" or in the section on "Reviewable Grounds for Denial" on behalf of the ASC.

B. If Harris Health denies a patient or the patient's Personal Representative access to the patient's DRS on behalf of the ASC, Harris Health shall provide the requestor with a denial document written in plain language containing:

1. The basis for the denial;
2. If applicable, a statement of the patient's rights to review the denial, including a description of how the patient may exercise such rights; and
3. A description of how the patient may file a complaint with the Privacy Officer or with the U.S. Secretary of the Department of Health and Human Services.

C. If Harris Health denies the requested access to any portion of the DRS, Harris Health shall, to the extent possible, provide the patient or the patient's Personal Representative access to any other DRS requested, after excluding the DRS to which Harris Health, has grounds to deny access on behalf of the ASC.

D. If Harris Health does not maintain the DRS requested, but knows where the PHI is maintained, Harris Health must inform the patient where to direct the request in order to access the patient's DRS.

VII. UNREVIEWABLE GROUNDS FOR DENIAL:

A. Harris Health, acting on behalf of the ASC, may deny a patient's or the patient's Personal Representative's request to access the patient's DRS without providing the patient an opportunity to seek review of the denial in the following circumstances:

1. The patient or the patient's Personal Representative requests a DRS to which there is no right of access as described in the section entitled "Right of Access to DRS";

2. The Requested PHI is not maintained by the ASC in a DRS;

3. The ASC acting under the direction of a correctional facility, denies an inmate's request to copy the DRS, if obtaining the PHI would jeopardize the health, safety, security, custody, or rehabilitation of the patient or other inmates, or the safety of any officer, employee, or other person at the correctional facility or person transporting the inmate;

Note: If an inmate requests to inspect the DRS, the request must be granted unless one of the other grounds for denial applies.

4. Harris Health, acting on behalf of the ASC, may temporarily suspend a patient's access to his or her DRS created in the course of research that includes treatment, provided that the patient agreed to the denial of access when consenting to participate in the research, and the ASC has informed the patient that the right of access to the DRS will be reinstated upon completion of the research; or

5. The PHI was obtained from someone other than a health care provider under a promise of confidentiality, and the access requested is reasonably likely to reveal the source of PHI.

VIII. REVIEWABLE GROUNDS FOR DENIAL:

A. The patient or the patient's Personal Representative has the right to have a denial of access reviewed in the following circumstances:

1. A licensed health care professional has determined in the exercise of professional judgment that the access requested is reasonably likely to endanger the life or physical safety of the patient or of another person;

2. The requested PHI refers to another person (other than a health care provider), and a licensed health care professional has determined in the exercise of professional judgment that the access requested is reasonably likely to cause substantial harm to such person; or

3. The request for access to the DRS is made by the patient's Personal Representative and a licensed health care professional has determined in the exercise of professional judgment that the provision of access to the Personal Representative is reasonably likely to cause substantial harm to the patient or to another person.

IX. PROCESS FOR REVIEW OF DENIAL:

A. The patient or the patient's Personal Representative shall submit to the Privacy Officer or his or her designee a written request to review the denial.

B. The Privacy Officer or his or her designee shall promptly refer the request to a licensed health care professional who is designated by the ASC to act as a reviewing official who did not participate in the original decision to deny access to the DRS.

C. The designated reviewing official shall determine, within a reasonable period of time, whether to deny access to the DRS (based on whether a "reviewable ground for denial applies) and notify the Privacy Officer or his or her designee of the decision in writing.

D. The Privacy Officer or his or her designee shall promptly notify the patient or the patient's Personal Representative in writing of the designated reviewing official's determination.

E. If the designated reviewing official overturns the original denial and grants access to the DRS, the patient or the patient's Personal Representative will be provided access to the DRS as described in this policy.

X. COPYING AND FEES:

A. If the patient or the patient's Personal Representative requests a copy of the patient's DRS or agrees to receive the DRS, the Record Custodian, acting on behalf of the ASC, may charge the patient, or such Personal Representative, a reasonable fee which includes only the cost of:

1. Copying, including the cost of supplies for labor of copying; and
2. Postage, if the patient or Personal Representative requested that copies of the DRS be mailed to the patient or the patient's Personal Representative.

XI. DOCUMENTATION:

A. Harris Health, acting on behalf of the ASC, must document and retain for six (6) years from the date of creation, as applicable, the following:

1. The DRS(s) subject to access by patient or the patient's Personal Representative;
2. The titles of persons or offices responsible for receiving and processing requests to access the DRS;

3. The patient's or the patient's Personal Representative's requests for access and review; and
4. Harris Health's denial and review responses.

REFERENCES/BIBLIOGRAPHY:

Conditions for Coverage 42 Code of Federal Regulations (C.F.R.) §416.50(g).

Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191 (codified at 45 C.F.R. Parts 160 and 164), as amended.

45 Code of Federal Regulations (C.F.R.) §164.524.

OFFICE OF PRIMARY RESPONSIBILITY:

The Ambulatory Surgical Center (ASC) at LBJ

REVIEW/REVISION HISTORY:

Effective Date	Version # (If Applicable)	Review/ Revision Date (Indicate Reviewed or Revised)	Approved by:
06/14/2016	1.0	06/14/2016	The Ambulatory Surgical Center (ASC) at LBJ Governing Body
		Reviewed / Approved 03/29/2018	The Ambulatory Surgical Center (ASC) at LBJ Governing Body
		Reviewed / Approved 02/14/2019	The Ambulatory Surgical Center (ASC) at LBJ Governing Body
		Reviewed / Approved 02/13/2020	The Ambulatory Surgical Center (ASC) at LBJ Governing Body
		Reviewed / Approved 02/25/2021	The Ambulatory Surgical Center (ASC) at LBJ Governing Body

TITLE: USE AND DISCLOSURE OF A LIMITED DATA SET

PURPOSE: To specify how to create a limited data set and to outline the requirements that must be met prior to disclosing a limited data set.

POLICY STATEMENT:

It is the policy of Ambulatory Surgical Center (ASC) at LBJ to protect its patients' privacy by adhering to all applicable state and federal laws and regulations when disclosing limited data sets for purposes of research, public health, or health care operations.

All workforce members are required to report suspected violations of patient-privacy policies to the Office of Corporate Compliance within 24 hours of discovery. Please see ASC-P-2004 Complaints regarding Privacy and Security for reporting options and requirements. Failure to timely report suspected violations of patient-privacy policies could result in disciplinary action under ASC-P-2017 Sanctions for Failure to Comply with Privacy and Information Security Policies.

POLICY ELABORATION:

I. DEFINITIONS:

A. **BUSINESS ASSOCIATE:** A person or entity that provides certain functions, activities, or services for or to a covered entity involving the use and/or disclosure of protected health information.

B. **COVERED ENTITY:** A health plan, a healthcare clearing house, or healthcare provider (the ASC) that transmits health information covered by the Health Insurance Portability and Accountability Act (HIPAA) regulations. The ASC is a Covered Entity.

C. **DATA USE AGREEMENT (DUA):** A written agreement between the Covered Entity and the limited data set recipient that establishes the permitted uses and disclosures of information within the limited data set.

D. **DISCLOSURE**: The release, transfer, provision of, access to, or divulging in any manner of protected health information (PHI) outside of the ASC.

E. **HEALTHCARE OPERATIONS:** Any of the following activities of the Covered Entity to the extent that the activities are related to covered functions:

1. Conducting quality assessment and improvement activities, including outcomes evaluation and development of clinical guidelines, provided that the obtaining of generalizable knowledge is not the primary purpose of any studies resulting from such activities; patient safety activities (as defined in 42 C.F.R. §3.20); population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, contacting of health care providers and patients with information about treatment alternatives; and related functions that do not include treatment;
2. Reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, health plan performance, conducting training programs in which students, trainees, or practitioners in areas of health care learn under supervision to practice or improve their skills as health care providers, training of non-health care professionals, accreditation, certification, licensing, or credentialing activities;
3. Except as prohibited under 45 C.F.R. §164.502(a)(5)(i), underwriting, enrollment, premium rating, and other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance, provided that the requirements of 45 C.F.R. §164.514(g) are met, if applicable;
4. Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs;
5. Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the entity, including formulary development and administration, development or improvement of methods of payment or coverage policies; and
6. Business management and general administrative activities of the entity, including, but not limited to:

    a. Management activities relating to implementation of and compliance with the requirements of the HIPAA Privacy Rule;
    b. Customer service, including the provision of data analyses for policy holders, plan sponsors, or other customers, provided that protected

health information is not Disclosed to such policy holder, plan sponsor, or customer;

c. The sale, transfer, merger, or consolidation of all or part of the Covered Entity with another Covered Entity or an entity that following such activity will become a Covered Entity and due diligence related to such activity; and

d. Consistent with the applicable requirements of 45 C.F.R. §164.514, creating de-identified health information or a limited data set, and fundraising for the benefit of the Covered Entity.

F. **INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI):** Information that is a subset of health information, including demographic information collected from an individual, and:

1. Is created or received by a health care provider, health plan, employer, or health care clearinghouse; and
2. Relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual:

   a. That identifies the individual; or
   b. With respect to which there is a reasonable basis to believe that the information can be used to identify the individual.

G. **LIMITED DATA SET**: Protected health information that excludes the following direct identifiers of the individual or of relatives, employers, or household members of the individual:

1. Names;
2. Postal address information, other than town or city, State, and zip code;
3. Telephone numbers;
4. Fax numbers;
5. Electronic mail addresses;
6. Social Security numbers;
7. Medical record numbers;
8. Health plan beneficiary numbers;
9. Account numbers;
10. Certificate/license numbers;
11. Vehicle identifiers and serial numbers, including license plate numbers;

12. Device identifiers and serial numbers;
13. Web Universal Resource Locators (URLs);
14. Internet Protocol (IP) address numbers;
15. Biometric identifiers, including finger and voice prints; or
16. Full face photographic images and any comparable images.

H. **PROTECTED HEALTH INFORMATION (PHI):** Individually Identifiable Health Information that is created, received, transmitted, or maintained by the ASC in any form or medium, that relates to the patient's healthcare condition, provision of healthcare, or payment for the provision of healthcare, as further defined in the HIPAA regulations. PHI includes, but is not limited to, the following identifiers:

1. Name;
2. All geographic subdivisions smaller than a State, including street address, city, county, precinct, zip code, and their equivalent geocodes, except for the initial three digits of a zip code if, according to the current publicly available data from the Bureau of the Census:

    a. The geographic unit formed by combining all zip codes with the same three initial digits contains more than twenty thousand (20,000) people; and
    b. The initial three digits of a zip code for all such geographic units containing twenty thousand (20,000) or fewer people is changed to 000.

3. All elements of dates (except year) for dates directly related to an individual, including birth date, admission date, discharge date, date of death; and all ages over eighty-nine (89) and all elements of dates (including year) indicative of such age except that such ages and elements may be aggregated into a single category of age ninety (90) or older;
4. Telephone numbers;
5. Fax numbers;
6. Electronic mail addresses;
7. Social Security numbers;
8. Medical record numbers;
9. Health plan beneficiary numbers;
10. Account numbers;
11. Certificate/license numbers;
12. Vehicle identifiers and serial numbers, including license plate numbers;

13. Device identifiers and serial numbers;
14. Web Universal Resource Locators (URLs);
15. Internet Protocol (IP) address numbers;
16. Biometric identifiers, including finger and voice prints;
17. Full face photographic images; and
18. Any other unique identifying number, characteristic, or code, except as permitted for re-identification purposes.

I. **USE:** Regarding PHI, the sharing, employment, application, utilization, examination, or analysis of such information within an entity that maintains such information.

J. **WORKFORCE:** The members of the governing body of the Ambulatory Surgical Center (ASC) at LBJ, employees, medical staff, trainees, contractors, volunteers, and vendors. Employees (permanent or temporary) include volunteers, trained, and other persons whose conduct, in the performance of work for Harris Health, whether or not they are paid by Harris Health.

II. PERMISSIBLE USES AND DISCLOSURES OF A LIMITED DATA SET:

A. Harris Health may create a Limited Data Set to a recipient to be Used or Disclosed by that recipient only for the following purposes:

1. Research purposes;
2. Public health purposes; or
3. Healthcare Operations purposes.

B. A Covered Entity that participates in an Organized Health Care Arrangement may disclose PHI, including a Limited Data Set, about an individual to other participants in the Organized Health Care Arrangement for any health care operations activities of the Organized Health Care Arrangement.

C. Prior to creating a Limited Data Set to be Used or Disclosed by the intended Recipient, Harris Health must enter into a Data Use Agreement with the recipient, specifying that the recipient will only Use or Disclose the protected health information contained in the Limited Data Set for the permissible purposes set forth above.

III. REQUESTS FOR A LIMITED DATA SET:

A. Requests for a Limited Data Set must be in writing and must include the following:

1. The requestors name, address, telephone number(s), title, and organization;
2. Date of the request;
3. Purpose of the request (i.e., research, public health, or Healthcare Operations). Any intended uses, re-disclosures, and who will have access to the Limited Data Set or who will Use the Limited Data Set must be specified;
4. Names of all recipients of the Limited Data Set;
5. Record parameters or selection criteria – time period, minimum number of patient records needed, types of patient records needed (i.e., inpatient, outpatient, diagnosis, procedure, drug use, or other criteria); and
6. Date that the Limited Data Set is needed.

B. When the ASC receives a request for a Limited Data Set, the recipient of the request must:

1. Forward the request to the Office of Corporate Compliance; and the Office of Corporate Compliance will determine whether to approve the request for the Limited Data Set;
2. If approved, the Office of Corporate Compliance will forward the request to the Harris County Attorney's Office to prepare a Data Use Agreement;
3. Once the Data Use Agreement is complete, the recipient of the request will forward the Data Use Agreement to the requestor for signature. Upon receipt of the signed Data Use Agreement, the recipient will send the Data Use Agreement to the Office of Corporate Compliance; and
4. Produce the Limited Data Set to the requestor.

IV. REQUIREMENTS OF THE DATA USE AGREEMENT:

A. The Data Use Agreement between the ASC and the recipient of the Limited Data Set must establish contain or establish the following information:

1. Establish that the recipient will only Use the Limited Data Set for one of the above listed permissible purposes;
2. That the recipient will not Use or further Disclose the Limited Data Set in a manner that would violate the requirements of the HIPAA privacy rule if the same Use or disclosure would violate the HIPAA privacy rule if done by Harris Health;
3. Establish who is permitted to Use or receive the Limited Data Set; and

4. Provide that the recipient of the Limited Data Set will:

   a. Only Use and Disclose the information provided in the Limited Data Set as is permitted under the Data Use Agreement or as required by law;
   b. Use appropriate safeguards to prevent the Use or disclosure of the information in the Limited Data Set other than as provided for in the Data Use Agreement;
   c. Report to the ASC any use or disclosure of information in the Limited Data Set that was not provided for in the Data Use Agreement that it becomes aware of;
   d. Ensure that any agents to whom it provides the Limited Data Set agrees to the same restrictions and conditions that apply to the recipient with respect to the Use and disclosure of the information in the Limited Data Set; and
   e. Not identify the information or contact the patients who are the subject of the information.

V. CREATING A LIMITED DATA SET:

A. The ASC may Use PHI to create a Limited Data Set. Alternatively, the ASC may Disclose PHI to a Business Associate, pursuant to a signed Business Associate Agreement, so that the Business Associate can create a Limited Data Set on behalf of the ASC.

B. The Minimum Necessary standard applies to Limited Data Sets. Specifically, only the PHI determined to be necessary for the purpose of the request should be disclosed to the requestor. (See Harris Health System Policy 3.11.302 for additional guidance regarding the Minimum Necessary standard.)

VI. FEE SCHEDULE:

A. On behalf of the ASC, Harris Health may charge a fee to the requestor of a Limited Data Set for expenditures related to the production of the Limited Data Set. Specifically, the ASC may charge for the use of personnel time, software, hardware and supplies. The fees may be assessed as follows:

   1. Reviewing requests for a Limited Data Set (application fee); and

2. Specified activities related to the production and delivery of the Limited Data set, including personnel time, computer usage, and supplies.

B. When establishing fees for the production of a Limited Data Set, the on behalf of the ASC, Harris Health will give consideration to any existing departmental or Harris Health fees schedules and the fee schedule guidance provided in the Texas Public Information Act, Tex. Gov't Code Ann. §552.01 *et seq.*

C. Prior to the creation of a Limited Data Set, Harris Health must provide an estimate of the cost to produce the Limited Data Set to the requestor.

VII. COMPLIANCE WITH PRIVACY REGULATIONS:

A. If Harris Health becomes aware of a pattern of activity or practice by the recipient of the Limited Data Set that constitutes a material breach or violation of the Data Use Agreement, such breach of violation must be reported to Harris Health's Privacy Officer. Harris Health's Privacy Officer will take steps to cure the breach of end the violation. If such steps are unsuccessful, Harris Health must:

1. Discontinue the disclosure of PHI to the recipient; and
2. Report the violation to the Secretary of the Department of Health and Human Services (DHHS).

B. If Harris Health receives a Limited Data Set and violates the Data Use Agreement, it is not in compliance with HIPAA privacy regulations. Members of the workforce who become aware of such violations must inform Harris Health's Privacy Officer.

REFERENCES/BIBLIOGRAPHY:

Texas Public Information Act, Tex. Gov't Code Ann., Chapter 552 *et seq*.

42 Code of Federal Regulations (C.F.R.) §3.20.

45 Code of Federal Regulations (C.F.R.) §164.514.

Patient Safety and Quality Improvement Act of 2005.

Harris Health System Policy and Procedures 3.11 Delegation of Authority for Compliance with Privacy and Security Laws.

Harris Health System Policy and Procedures 3.11.105 Use and Disclosure of Protected Health Information for Treatment, Payment, and Health Care Operations.

Harris Health System Policy and Procedures 3.11.302 Minimum Necessary Standard for Use or Disclosure of Protected Health Information.

Harris Health System Policy and Procedures 3.11.401 Business Associates.

Harris Health System Policy and Procedures 3.13 Signature Authority on Data Use Agreements.

Harris Health System Policy and Procedures 3.46 Contract Initiation, Review, Approval, and Monitoring.

OFFICE OF PRIMARY RESPONSIBILITY:

The Ambulatory Surgical Center (ASC) at LBJ

REVISION HISTORY:

Effective Date	Version # (If Applicable)	Review/ Revision Date (Indicate Reviewed or Revised)	Approved by:
6/14/16	1.0		The Ambulatory Surgical Center (ASC) at LBJ Governing Body
	2.0	Revised / Approved 03/29/2018	The Ambulatory Surgical Center (ASC) at LBJ Governing Body
		Reviewed / Approved 02/14/2019	The Ambulatory Surgical Center (ASC) at LBJ Governing Body
		Reviewed / Approved 02/13/2020	The Ambulatory Surgical Center (ASC) at LBJ Governing Body
		Revised / Approved 02/25/2021	The Ambulatory Surgical Center (ASC) at LBJ Governing Body

TITLE: **USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR MARKETING**

PURPOSE: To provide guidance on the Ambulatory Surgical Center (ASC) at LBJ Use and Disclosure of Protected Health Information for marketing purposes.

POLICY STATEMENT:

The Ambulatory Surgical Center (ASC) at LBJ will obtain a patient's Authorization for any Use or Disclosure of Protected Health Information (PHI) for marketing purposes in accordance with federal and state privacy laws.

All workforce members are required to report suspected violations of patient-privacy policies to the Office of Corporate Compliance within 24 hours of discovery. Please see ASC-P-2004 Complaints regarding Privacy and Security for reporting options and requirements. Failure to timely report suspected violations of patient-privacy policies could result in disciplinary action under ASC-P-2017 Sanctions for Failure to Comply with Privacy and Information Security Policies.

POLICY ELABORATIONS:

I. DEFINITIONS:

A. **AUTHORIZATION**: For purposes of this policy only, Authorization will mean Permission acquired by execution of Harris Health System's Form No. 282758 Authorization for Release of Information: Media, Marketing, and Educational Use.

B. **BUSINESS ASSOCIATE (BA):** A person or entity that provides certain functions, activities, or services for, to, or on behalf of a covered entity involving the Use and/or Disclosure of PHI as further defined in the Health Information Portability and Accountability Act (HIPAA) regulations.

C. **BUSINESS ASSOCIATE AGREEMENT (BAA):** A written contract between the BA and Harris Health on behalf of the ASC outlining the responsibilities of the BA with respect to the protection of PHI being Used or Disclosed.

D. **COVERED ENTITY:** A health plan, a health care clearinghouse, or a health care provider (the ASC and Harris Health) that electronically transmits health

information covered by the HIPAA regulations. The Ambulatory Surgical Center and Harris Health are Covered Entities.

E. **DEMOGRAPHIC INFORMATION:** Information about a patient that includes the patient's name, address, other contact information (such as telephone number, e-mail address, etc.), age, gender, and insurance status.

F. **DISCLOSURE:** The release, transfer, provision of, access to, or divulging in any manner PHI outside of the ASC.

G. **HEALTH CARE OPERATIONS:** Any of the following activities of the Covered Entity to the extent the activities are related to covered functions:

1. Conducting quality assessment and improvement activities, including outcomes evaluation and development of clinical guidelines, provided that the obtaining of generalizable knowledge is not the primary purpose of any studies resulting from such activities; patient safety activities (as defined in 42 C.F.R. §3.20); population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, contacting of health care providers and patients with information about treatment alternatives; and related functions that do not include treatment;
2. Reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, health plan performance, conducting training programs in which students, trainees, or practitioners in areas of health care learn under supervision to practice or improve their skills as health care providers, training of non-health care professionals, accreditation, certification, licensing, or credentialing activities;
3. Except as prohibited under 45 C.F.R. §164.502(a)(5)(i), underwriting, enrollment, premium rating and other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance) provided that the requirements of 45 C.F.R. §164.514(g) are met, if applicable;
4. Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs;
5. Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the entity,

including formulary development and administration, development or improvement of methods of payment or coverage policies; and

6. Business management and general administrative activities of the entity, including, but not limited to:

    a. Management activities relating to implementation of and compliance with the requirements of this subchapter;
    b. Customer service, including the provision of data analyses for policy holders, plan sponsors, or other customers, provided that PHI is not Disclosed to such policy holder, plan sponsor, or customer.
    c. The sale, transfer, merger, or consolidation of all or part of the Covered Entity with another Covered Entity, or an entity that following such activity will become a Covered Entity and due diligence related to such activity; and
    d. Consistent with the applicable requirements of 45 C.F.R. §164.514, creating de-identified health information or a limited data set, and fundraising for the benefit of the Covered Entity.

H. **INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI):** Information that is a subset of health information, including Demographic Information collected from an individual, and:

1. Is created or received by a health care provider, health plan, employer, or health care clearinghouse; and
2. Relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and

    a. That identifies the individual; or
    b. With respect to which there is a reasonable basis to believe the information can be used to identify the individual.

I. **LEGALLY AUTHORIZED REPRESENTATIVE (LAR)**: An individual with legal standing to represent the interests of another (e.g., parent of a minor patient) or with the authority to act on behalf of another (as by legal power of attorney

when applicable, medical power of attorney when the patient is incapacitated, court order, advance directive, or the executor of a will).[1]

J.

K. **J. MARKETING**: To make a communication about a product or service that encourages recipients of the communication to purchase or use the product or service.

Marketing does NOT include a communication made:

1. To provide refill reminders or otherwise communicate about a drug or biologic that is currently being prescribed for the individual, only if any financial remuneration received by the ASC in exchange for making the communication is reasonably related to the ASC's cost of making the communication.
2. For the following Treatment and Health Care Operations purposes, except where the ASC receives financial remuneration in exchange for making the communication:

    a. For Treatment of an individual by a health care provider, including case management or care coordination for the individual, or to direct or recommend alternative treatments, therapies, health care providers, or settings of care to the individual;
    b. To describe a health-related product or service (or payment for such product or service) that is provided by, or included in a plan of benefits of the ASC including communications about:

        i. The entities participating in a health care provider network or health plan network;
        ii. Replacement of, or enhancements to, a health plan; and
        iii. Health-related products or services available only to a health plan enrollee that add value to, but are not part of, a plan of benefits; or

    c. For case management or care coordination, contacting of individuals with information about treatment alternatives, and related functions to the extent these activities do not fall within the definition of treatment.

[1] Texas Health & Safety Code § 241.151.

3. Financial remuneration means direct or indirect payment from or on behalf of a third party whose product or service is being described. Direct or indirect payment does not include any payment for treatment of an individual.

L. **K. PERSONAL REPRESENTATIVE:** A person with authority under the law to act on behalf of the patient. For purposes of this policy only, the term Personal Representative also includes a patient's Legally Authorized Representative, defined above.

M. **L. PRIVACY OFFICER:** An individual designated by Harris Health to be responsible for the development and implementation of the privacy-related functions of Harris Health as further defined in the Harris Health policy and procedure 3.11.101 Privacy Officer, Roles, and Responsibilities

M. PROTECTED HEALTH INFORMATION (PHI): IIHI that is created, received, transmitted or maintained by the ASC in any form or medium that relates to the patient's health care condition, provision of health care, or payment for the provision of health care, as further defined in the HIPAA regulations. PHI includes, but is not limited to, the following identifiers:

1. Name;
2. All geographic subdivisions smaller than a State, including street address, city, county, precinct, zip code, and their equivalent geocodes, except for the initial three digits of a zip code if, according to the current publicly available data from the Bureau of the Census:

    a. The geographic unit formed by combining all zip codes with the same three (3) initial digits contains more than twenty thousand (20,000) people; and
    b. The initial three digits of a zip code for all such geographic units containing twenty thousand (20,000) or fewer people is changed to 000.

3. All elements of dates (except year) for dates directly related to an individual, including birth date, admission date, discharge date, date of death; and all ages over eighty-nine (89) and all elements of dates (including year) indicative of such age, except that such ages and elements may be aggregated into a single category of age ninety (90) or older;
4. Telephone numbers;

5. Fax numbers;
6. Electronic mail addresses;
7. Social security numbers;
8. Medical record numbers;
9. Health plan beneficiary numbers;
10. Account numbers;
11. Certificate/license numbers;
12. Vehicle identifiers and serial numbers, including license plate numbers;
13. Device identifiers and serial numbers;
14. Web Universal Resource Locators (URLs);
15. Internet Protocol (IP) address numbers;
16. Biometric identifiers, including finger and voice prints;
17. Full face photographic images and any comparable images; and
18. Any other unique identifying number, characteristic, or code, except as permitted for re-identification purposes.

N. N. **SALE OF PHI**: A Disclosure of PHI by Harris Health, where Harris Health directly or indirectly receives remuneration from or on behalf of the recipient of the PHI in exchange for the PHI. Exceptions to the definition "Sale of PHI" can be found at 45 C.F.R. § 164.502(a)(5)(ii)(B)(2).

O. **TREATMENT**: The provision, coordination, or management of health care and related services by one (1) or more health care providers, including the coordination or management of health care by a health care provider with a third (3rd) party; consultation between health care providers relating to a patient; or the referral of a patient from one health care provider to another.

P. **USE**: Regarding PHI, the sharing, employment, application, utilization, examination, or analysis of such information within an entity that maintains such information.

II. AUTHORIZATION REQUIRED FOR USE AND DISCLOSURE OF PHI FOR MARKETING:

A. The ASC or Harris Health acting on behalf of the ASC must obtain a patient's or the patient's Personal Representative's Authorization prior to any Use and Disclosure of PHI for Marketing purposes except as specified in the Section III below. Please see Attachment A for a copy of the Authorization.

B. An Authorization must be specific as to the Use and Disclosure being requested and is not to be written in such a manner that it might be interpreted as a blanket Authorization for the Use and Disclosure of PHI for Marketing. A blanket Marketing Authorization is invalid.

C. To be valid, the Authorization must be completely filled out, signed, and dated by the patient or the patient's Personal Representative.

D. If the Marketing involves financial remuneration (as defined in the definition of Marketing above) to the ASC or Harris Health from another party, the Authorization must explicitly state that such remuneration is involved.

E. For further guidance on Authorizations, see Harris Health System Policy and Procedure 3.11.300 Authorization for Use and Disclosure of Protected Health Information.

III. EXCEPTIONS TO AUTHORIZATION REQUIREMENT FOR USE AND DISCLOSURE OF PHI FOR MARKETING:

The ASC or Harris Health acting on behalf of the ASC, may Use or Disclose PHI for Marketing purposes without an Authorization only if the communication is made in the form of:

A. A face-to-face communication made by the ASC or Harris Health to a patient or the patient's Personal Representative; or
B. A promotional gift of nominal value provided by the ASC or Harris Health and in accordance with Harris Health Policy and Procedure 3.61 Gifts and Harris Health Policy and Procedure 3.42 Conflicts of Interest.

IV. RESPONSIBILITIES OF THE HARRIS HEALTH SYSTEM CORPORATE COMMUNICATIONS DEPARTMENT:

A. The Corporate Communications Department (Corporate Communications) is responsible for evaluating communications made to patients and determining whether the communication constitutes Marketing (or if, on its face, the communication encourages recipients of the communication to purchase or use the product or service, the communication is Marketing).

B. Corporate Communications is responsible for obtaining Authorizations from patients for Use and Disclosure of PHI for Marketing purposes.

C. Corporate Communications is responsible for complying with Harris Health Policy and Procedure 3.61 Gifts and Harris Health Policy and Procedure 3.42 Conflicts of Interest.

D. Corporate Communications will obtain a BAA with any BAs involved in the production, distribution, or processing of Marketing communications.

V. SPECIAL CONSIDERATIONS:

A. The ACS's or Harris Health's Uses:

The ASC, or Harris Health acting on behalf of the ASC, may Use PHI to communicate with patients about Harris Health's or the ASC's own health-related products or services, the patient's Treatment, or case management or care coordination for the patient. The ASC, or Harris Health acting on behalf of the ASC, may make this type of communication itself or use a BA to make the communication.

B. Notice of Privacy Practices:

Harris Health's Notice of Privacy Practices must include a statement that Use and Disclosure of PHI for Marketing purposes requires a patient's or a patient's Personal Representative's written Authorization.

C. Sale of PHI:

Harris Health must obtain an Authorization for any Disclosure of PHI, which results in a Sale of PHI. The Authorization must state that the Disclosure will result in remuneration to the covered entity.[2] The Privacy Officer must approve any Sale of PHI prior to any Sale of PHI.

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[2] 45 CFR §§ 164.502(a)(5)(ii); 164.508(a)(4).

REFERENCES:

45 Code of Federal Regulations (C.F.R.) §164.508(3).

45 Code of Federal Regulations (C.F.R.) §164.501.

45 C.F.R. § 164.502

45 C.F.R. § 164.520

Texas Health & Safety Code § 241.151

Harris Health Policy and Procedure 3.61 Gifts

Harris Health Policy and Procedure 3.42 Conflicts of Interest

Harris Health System Policy and Procedure 3.11.300 Authorization for Use and Disclosure of Protected Health Information

ATTACHMENT(S):

Attachment A: Harris Health System's Form No. 282758 Authorization for Release of Information: Media, Marketing, and Educational Use

OFFICE OF PRIMARY RESPONSIBILITY:

The Ambulatory Surgical Center (ASC) at LBJ

REVIEW/REVISION HISTORY:

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8/5/16	1.0		The Ambulatory Surgical Center (ASC) at LBJ Governing Body
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		02/13/2020	(ASC) at LBJ Governing Body
		Revised / Approved 02/25/2021	The Ambulatory Surgical Center (ASC) at LBJ Governing Body

ATTACHMENT A
HARRIS HEALTH SYSTEM'S FORM 282758
AUTHORIZATION FOR RELEASE OF INFORMATION: MEDIA, MARKETING, AND EDUCATIONAL USE

English - http://hhintranet01/forms/patient-consent-form-english.pdf

Spanish - http://hhintranet01/forms/patient-consent-form-spanish.pdf

TITLE: USE AND DISCLOSURE OF PSYCHOTHERAPY NOTES

PURPOSE: To provide guidance on the use and disclosure of psychotherapy notes.

POLICY STATEMENT:

The Ambulatory Surgical Center (ASC) at LBJ may only use and disclose psychotherapy notes in accordance with all applicable state and federal privacy rules and regulations.

All workforce members are required to report suspected violations of patient-privacy policies to the Office of Corporate Compliance within 24 hours of discovery. Please see ASC-P-2004 Complaints regarding Privacy and Security for reporting options and requirements. Failure to timely report suspected violations of patient-privacy policies could result in disciplinary action under ASC-P-2017 Sanctions for Failure to Comply with Privacy and Information Security Policies.

POLICY ELABORATIONS:

I. DEFINITIONS:

A. **AUTHORIZATION:** A signed written document that allows use and disclosure of protected health information (PHI) for purposes other than treatment, payment, or healthcare operations, or as otherwise required by law.

B. **DESIGNATED RECORD SET:** A group of records maintained by or for the ASC include:

1. The medical and billing records about patients;
2. The enrollment, payment, claims adjudication and case or medical management record systems maintained by or for a health plan; or
3. Used, in whole or part, by or for the ASC to make decisions about patients.

*Note: For purposes of this definition, the term "record" means any item, collection, or grouping of information that includes protected health information and is maintained, collected, used, or disseminated by or for the facility; the term "record" includes:

1. Patient information originated by another healthcare provider and used by the ASC to make decisions about the patient; and

2. Tracings, photographs, videotapes, digital and other images that may be recorded to document care of the patient.

C. **DISCLOSURE:** The release, transfer, provision of, access to, or divulging in any manner protected health information outside of the ASC.

D. **HEALTHCARE OPERATIONS:** Any of the following activities of the covered entity to the extent that the activities are related to covered functions:

1. Conducting quality assessment and improvement activities, including outcomes evaluation and development of clinical guidelines, provided that the obtaining of generalizable knowledge is not the primary purpose of any studies resulting from such activities; patient safety activities (as defined in 42 C.F.R. §3.20); population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, contacting of health care providers and patients with information about treatment alternatives; and related functions that do not include treatment;
2. Reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, health plan performance, conducting training programs in which students, trainees, or practitioners in areas of health care learn under supervision to practice or improve their skills as health care providers, training of non-health care professionals, accreditation, certification, licensing, or credentialing activities;
3. Except as prohibited in under 45 C.F.R. §164.502(a)(5)(i), underwriting, enrollment, premium rating, and other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance), provided that the requirements of 45 C.F.R. §164.514(g) are met, if applicable;
4. Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs;
5. Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the entity; or
6. Business management and general administrative activities of the entity, including but not limited to:

a. Management activities relating to implementation of and compliance with the requirements of this subchapter;
b. Customer service, including the provision of data analyses for policy holders, plan sponsors, or other customers, provided that the protected health information is not disclosed to such policy holder, plan sponsor, or customer;
c. The sale, transfer, merger, or consolidation of all or part of the covered entity with another covered entity, or an entity that following such activity will become a covered entity and due diligence related to such activity; and
d. Consistent with the applicable requirements of 45 C.F.R. §164.514, creating de-identified health information or a limited data set, and fundraising for the benefit of the covered entity.

E. **INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI):** Information that is a subset of health information, including demographic information collected from an individual:

1. Is created or received by a health care provider, health plan, employer, or health care clearinghouse; and
2. Relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual:

   a. That identifies the individual; or
   b. With respect to which there is a reasonable basis to believe that the information can be used to identify the individual.

F. **PAYMENT**:

1. The activities undertaken by:

   a. Except as prohibited under §164.502(a)(5)(i), a health plan to obtain premiums or to determine or fulfill its responsibility for coverage and the provision of benefits under the health plan; or
   b. A health care provider or health plan to obtain or provide reimbursement for the provision of health care.

2. The activities in paragraph one (1) of this definition relate to the individual to whom health care is provided and include, but are not limited to:

a. Determinations of eligibility or coverage (including coordination of benefits or the determination of cost sharing amounts), and adjudication or subrogation of health benefit claims;
b. Risk adjusting amounts due based on enrollee health status and demographic characteristics;
c. Billing, claims management, collection activities, obtaining payment under a contract for reinsurance (including stop-loss insurance and excess of loss insurance), and related health care data processing;
d. Review of health care services with respect to medical necessity, coverage under a health plan, appropriateness of care, or justification of charges;
e. Utilization review activities, including precertification and preauthorization of services, concurrent and retrospective review of services; and
f. Disclosure to consumer reporting agencies of any of the following protected health information relating to collection of premiums or reimbursement:

i. Name and address;
ii. Date of birth;
iii. Social Security number;
iv. Payment history;
v. Account number; and
vi. Name and address of the health care provider and/or health plan.

G. **PROTECTED HEALTH INFORMATION (PHI):** IIHI that is created, received, transmitted, or maintained by Harris Health on behalf of the ASC in any form or medium, that relates to the patient's healthcare condition, provision of healthcare, or payment for the provision of healthcare, as further defined in the Healthcare Insurance Portability and Accountability Act (HIPAA) regulations. PHI includes, but is not limited to, the following identifiers:

1. Name;
2. All geographic subdivisions smaller than a state, including street address, city, county, precinct, zip code, and their equivalent geocodes, except for the initial three digits of a zip code if, according to the current publicly available data from the Bureau of the Census:

a. The geographic unit formed by combining all zip codes with the same three initial digits contains more than twenty thousand (20,000) people; and
b. The initial three digits of a zip code for all such geographic units containing twenty thousand (20,000) or fewer people is changed to 000.

3. All elements of dates (except year) for dates directly related to an individual, including birth date, admission date, discharge date, date of death; and all ages over eighty-nine (89) and all elements of dates (including year) indicative of such age, except that such ages and elements may be aggregated into a single category of age ninety (90) or older;
4. Telephone numbers;
5. Fax numbers;
6. Electronic mail addresses;
7. Social Security numbers;
8. Medical record numbers;
9. Health plan beneficiary numbers;
10. Account numbers;
11. Certificate/license numbers;
12. Vehicle identifiers and serial numbers, including license plate numbers;
13. Device identifiers and serial numbers;
14. Web Universal Resource Locators (URLs);
15. Internet Protocol (IP) address numbers;
16. Biometric identifiers, including finger and voice prints;
17. Full face photographic images and any comparable images; and
18. Any other unique identifying number, characteristic, or code, except as permitted for re-identification purposes.

H. **PSYCHOTHERAPY NOTES:** Notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of a conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. Psychotherapy notes *excludes* medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items:

1. Diagnosis;

2. Functional status;
3. Treatment plan;
4. Symptoms;
5. Prognosis; and
6. Progress to date.

I. **TREATMENT:** The provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; or the referral of a patient for health care from one health care provider to another.

J. **USE:** Regarding PHI, the sharing, employment, application, utilization, examination, or analysis of such information within an entity that maintains such information.

II. PATIENT'S RIGHT OF ACCESS TO PSYCHOTHERAPY NOTES:

A. The ASC is not required to Disclose Psychotherapy Notes to the patient who is the subject of the Psychotherapy Notes.

B. The ASC will use its discretion regarding whether to Disclose Psychotherapy Notes to the patient who is the subject of the Psychotherapy Notes on a case-by-case basis.

III. USES AND DISCLOSURES OF PSYCHOTHERAPY NOTES:

A. The ASC may Use and/or Disclose a patient's Psychotherapy Notes without obtaining the patient's Authorization only in the following circumstances:

1. When the Use is by the originator of the Psychotherapy Notes for Treatment;
2. When the Use or Disclosure is by the ASC for its own internal training programs in which students, trainees, or practitioners in mental health learn under supervision to practice or improve their skills in group, joint, family, or individual counseling;
3. When the Use or Disclosure is by the ASC to defend itself in a legal action or other proceeding brought by the individual who is the subject of the Psychotherapy Notes;

4. When the Use or Disclosure is required by the Secretary of the Department of Health and Human Services (DHHS) to investigate or determine the ASC's compliance with federal and state laws;
5. When the Use or Disclosure is required by law and is limited to the relevant requirements of such law;
6. When the Disclosure is to a health oversight agency for activities with respect to the oversight of the originator of the Psychotherapy Notes;
7. When the Disclosure is to coroners and medical examiners for the purpose of identifying a deceased individual, determining a cause of death, or other duties as authorized by law; or
8. When the ASC has a good faith belief that the Use or Disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and is made to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

B. For any other Use or Disclosure of Psychotherapy Notes, the ASC must obtain a valid Authorization, However, the ASC is not required to Disclose Psychotherapy Notes pursuant to a valid Authorization, and the ASC will use its discretion regarding whether to Disclose Psychotherapy Notes on a case-by-case basis..

IV. AUTHORIZATIONS:

A. The ASC must obtain a patient's Authorization prior to the Use or Disclosure of the patient's Psychotherapy Notes for purposes not listed above in Section III. A. Harris Health's Form entitled *"Authorization for Use, Request, and Disclosure of Protected Health Information,"* must be used to obtain a patient's Authorization.

B. The ASC may not condition Treatment or Payment on whether the patient executes an Authorization for the Use or Disclosure of Psychotherapy Notes.

C. A copy of the signed Authorization must be given to the patient.

D. Compound Authorizations:

an Authorization for the Use or Disclosure of Psychotherapy Notes may not be combined with an Authorization for the Use or Disclosure of any other PHI. Therefore, if the selection entitled "Psychotherapy Notes" is checked on the Authorization, all other requests for medical records must be requested with a separate Authorization.

REFERENCES/BIBLIOGRAPHY:

45 Code of Federal Regulations (C.F.R.) §164.501

45 Code of Federal Regulations (C.F.R.) §164.508

45 Code of Federal Regulations (C.F.R.)§164.524(a)(1)(i)

Does a parent have a right to receive a copy of psychotherapy notes about a child's mental health treatment?, https://www.hhs.gov/hipaa/for-professionals/faq/2094/does-parent-have-right-receive-copy-psychotherapy-notes-about-childs-mental-health-treatment.html#:~:text=Psychotherapy%20notes%20are%20primarily%20for,of%20access%20for%20psychotherapy%20notes (last visited on June 4, 2020) (noting that "Psychotherapy notes are primarily for personal use by the treating professional and generally are not disclosed for other purposes," and that Covered Entities have discretion regarding whether to Disclose Psychotherapy Notes to the patient or patient's personal representative).

OFFICE OF PRIMARY RESPONSIBILITY:

The Ambulatory Surgical Center (ASC) at LBJ

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		Revised / Approved 02/25/2021	The Ambulatory Surgical Center (ASC) at LBJ Governing Body

TITLE: ACLS REQUIRED MEDICATIONS

PURPOSE: To list the medications required to be immediately available in the Ambulatory Surgical Center (ASC) at LBJ at all times as set forth in the Advanced Cardiac Life Support (ACLS) Algorithms.

POLICY STATEMENT:

It is the policy of the Ambulatory Surgical Center (ASC) at LBJ to promote patient safety by ensuring that the ACLS-recommended medications are readily available at all times in the ASC.

I. DEFINITIONS:

A. **Emergency Cart**: A term used to identify either a Crash Cart or a Malignant Hyperthermia cart.

II. ACLS MEDICATIONS REQUIRED IN ASC:

Pursuant to the current ACLS Algorithms, the following medications must be immediately available in the ASC at all times:

1. Epinephrine;
2. Lidocaine;
3. Narcotic antagonist;
4. 1000cc (IV bag or similar container) of preservative-free H_2O diluent for Dantrolene;
5. Four (4) 50cc ampules of $NaHCO_3$;
6. Thirty-six (36) vials of Dantrolene;
7. Seizure arresting medication;
8. Bronchospasm arresting medication;
9. Vasopressors (other than Epinephrine);
10. IV Antihistamines;
11. Anti-Hypertensives;
12. Atropine;
13. Neuromuscular blocking agents, including non-depolarizing agents such as rocuronium or depolarizing agents such as succinylcholine;
14. Intravenous corticosteroids;
15. Benzodiazepine reversing agent;
16. Oral nitroglycerine sublingual or spray;

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17. Seizure arresting medication; and
18. Short acting beta-blocker.
~~18.~~19. Adenosine

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III. ACLS MEDICATIONS REQUIRED ON CRASH CART:

A. All of the above listed medications are available on an Emergency Cart; and
B. Copies of the complete and current ACLS Algorithms and MHAUS Algorithms must also be available on each Emergency Cart.

REFERENCES/BIBLIOGRAPHY:

American Association for Accreditation of Ambulatory Surgery Facilities Version 7 §500

http://acls-algorithms.com/acls-drug

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TITLE: TEMPERATURE AND HUMIDITY PARAMETERS

PURPOSE: To establish the current temperature and humidity parameters for the perioperative area at the Ambulatory Surgical Center (ASC) at LBJ.

POLICY STATEMENT:

It is the policy of the Ambulatory Surgical Center (ASC) at LBJ to follow the guidelines and recommendations of the Association of Perioperative Registered Nurses (AORN) regarding the temperature and humidity parameters for the perioperative area of the ASC. Additionally, the ASC will follow all manufacturer recommendations regarding the maintenance of temperature of ASC supplies, e.g., linens.

POLICY ELABORATIONS

I. GENERAL PROVISIONS:

A. The environmental humidity and temperature of the perioperative area of the ASC will be maintained in accordance with the parameters established by AORN.

II. HUMIDITY:

A. Semi-Restricted Areas:

1. The relative humidity level in a restricted area of the ASC should be maintained within a range between twenty percent (20%) to sixty percent

(60%). The relative humidity level in a semi-restricted area is determined by the function performed in that area:

a) Clean/sterile storage – maximum humidity should be no greater than sixty percent (60%);
b) Sterile processing clean workroom - should be no greater than sixty percent (60%);
c) Soiled workroom/decontamination room – AORN offers no relative humidity recommendations;
d) Endoscope Cleaning room/ Equipment sterilization workroom – AORN offers no relative humidity recommendations; and
e) Semi-restricted corridor – AORN offers no relative humidity recommendations.

B. Unrestricted Area:

1. The relative humidity level in an unrestricted area is determined by the function performed in that area:
   a) PACU/ Procedure room – the humidity should be between twenty percent (20%) to sixty percent (60%);

III. TEMPERATURE:

A. Restricted Area:
1. The temperature range in a restricted area should be between 68°F to 75° F (20° C to 24° C). However, this range may be intentionally modified for a limited period of time based on the individual needs of each patient.
2. Patient's undergoing procedures that require intentional hypothermia may require that the room temperature be adjusted outside of the recommended range.

B. Semi-Restricted Area:

1. The temperature in a semi-restricted area is dependent on the use of that specific area of the ASC:
   a) Clean/sterile storage – the temperature should be no greater than 75° F (24° C);
   b) Sterile processing clean workroom- the temperature should be between 68° F to 73° F (20° C to 23° C);

c) Decontamination room – the temperature should be between 60º F to 73º F (16º C to 23º C);
d) Soiled workroom- AORN offers no temperature recommendations;
e) Endoscope Cleaning room/ Equipment sterilization workroom – AORN offers no temperature recommendations; and
f) Semi-restricted corridor – AORN offers no temperature recommendations.

C. Unrestricted Area:

1. The temperature in an unrestricted area is determined by the function performed in that area:

a) PACU/ Procedure room- the temperature should be between 70º F and 75º F (21º C and 24 º C).

REFERENCES/BIBLIOGRAPHY:

American Association for Accreditation of Ambulatory Surgery Facilities- version ~~7 §200~~ 8.0

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TITLE: ADVERSE DRUG EVENT REPORTING AND MONITORING

PURPOSE: To identify procedures and outline the process for reporting adverse drug events.

POLICY STATEMENT:

The Ambulatory Surgical Center (ASC) at Lyndon B. Johnson (LBJ) Hospital Pharmacy Department is assigned to monitor all known medication-related adverse events that occur at the ASC as identified by voluntary reporting, medical record reviews, and analysis of medication related symptoms.

POLICY ELABORATIONS:

I. DEFINITIONS:

A. **ADVERSE DRUG EVENT (ADE):** An actual or near miss occurrence or suspected reaction involving the use of a drug, including failure to administer or late administration of a drug. This term is inclusive of medication errors, potential medication errors, and adverse drug reactions.

B. **ADVERSE DRUG REACTION (ADR):** Any response to a drug that is harmful or unintended and that occurs at doses used in humans for prophylaxis, diagnosis, or therapy, excluding failure to accomplish the intended purpose. This does not include side effects, (expected, well-known reactions resulting in little or no change in patient management) or any drug effects which may occur when the drug is given inappropriately. Allergic and idiosyncratic reactions are also considered ADRs.

C. **MEDICATION ERROR (ME):** Any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the healthcare professional or patient. This may include prescribing errors, dispensing errors, medication administration errors, and patient compliance errors.

D. **MEDICATION USE PROCESS:** The cycle of medication management that includes ordering, dispensing, administering, and monitoring. The cycle also includes all systems supporting these processes.

E. **POTENTIAL MEDICATION ERROR (PME):** A mistake in prescribing, dispensing, or planned medication administration that is detected and corrected through intervention prior to patient exposure to harm.

F. **SERIOUS REPORTABLE EVENT (SRE):** An event that can result in death, loss of a body part, serious harm/injury/disability, loss of bodily function, or require major intervention for correction. It is also considered to be an event that is unambiguous, largely preventable, and serious, as well as adverse, indicative of a problem in a healthcare setting's safety systems.

II. GENERAL PROCEDURES:

A. All actual and potential ADE occurrences shall be reported by the individual who makes, discovers, or witnesses the event.

B. All actual and potential ADE occurrences shall be submitted using the electronic incident reporting system located on Harris Health's secure intranet site.

C. Actual or suspected ADRs must also be documented in a progress notes section of the patient's chart.

D. Information submitted via the electronic incident reporting system is privileged and confidential.

E. The appropriate provider must be notified, as soon as reasonably possible of medication errors when:

1. The error is deemed to be clinically significant; and
2. The error involves medications that are not administered as ordered (examples: wrong dose, wrong route, omitted dose, etc.).

F. The appropriate provider must be notified as soon as reasonably possible of all ADRs.

III. RESPONSIBILITY:

A. The ASC Pharmacy will:

1. Review and investigate all reported adverse drug events;
2. Flag the medical record of the patient of all confirmed or suspected adverse drug reactions; and
3. If patient care is affected, notify the appropriate provider.

B. Pursuant to the Letter of Agreement between the Harris Health System and the ASC, the Harris Health Risk Management department will review ADEs in

accordance with the ASC Patient Safety Plan, with an emphasis on events that have caused a serious reportable event (SRE).

C. Upon discovery of an ADE, the provider will ensure:

1. Proper assessment of the patient relative to the type of error and medication given; and
2. Notification of any other appropriate providers as required in Section II E.

D. The provider will assess the patient for the degree of potential harm and prescribe and/or order measures appropriate to resolve the ADE. Such measures may include, but are not limited to:

1. Diagnostic testing;
2. Monitoring of vital signs; and
3. Administration of medications, antidotes, intravenous fluids, and all other supportive measures.

IV. ADE INVESTIGATION AND ANALYSIS:

A. All reported ADEs shall be:

1. Verified for completeness and accuracy by the pharmacist-in-charge or designee;
2. Routed to related health care professionals and administrators as per the online incident reporting system;
3. Investigated by the department involved; and
4. Routed to Harris Health's Risk Management department for additional investigation as outlined in Section III B.

B. Reports of trended information shall be provided to the ASC Quality Review Council (QRC). In addition, pursuant to the Letter of Agreement between Harris Health and the ASC, reports of trended information shall also be provided to

Harris Health System's Medication Use and Safety Committee (MUSC) and Pharmacy and Therapeutics Committee (P&T) on a quarterly basis.

C. An evaluation of the medication use process will be performed based on the outcomes identified and will occur no less than annually.

REFERENCES/BIBLIOGRAPHY:

42 Code of Federal Regulations (C.F.R.) §416.50(a).

Ambulatory Surgical Center (ASC) at LBJ Incident Reporting Policy

Ambulatory Surgical Center (ASC) at LBJ Patient Safety Plan

American Association for Accreditation of Ambulatory Surgery Facilities- version ~~7 §500.~~8.0

25 Texas Administrative Code (TAC) § 135.27

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The Ambulatory Surgical Center (ASC) at LBJ

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TITLE: EXPOSURE CONTROL PLAN

PURPOSE: To outline those policies and procedures that must be followed in the event of an exposure to a hazardous material or substance in the Ambulatory Surgical Center (ASC) at LBJ.

POLICY STATEMENT:

It is the policy of the Ambulatory Surgical Center (ASC) at LBJ to protect its patients and workforce members by properly responding to and controlling any exposure or potential exposure to a hazardous material or substance in the ASC.

POLICY ELABORATIONS:

I. GENERALLY:

A. Depending on the nature of the hazardous substance, the following ASC policies are to be followed in the event there is an exposure or there is the potential for an exposure to a hazardous material or substance:

1. Blood-Borne Pathogen:
    a) *Bloodborne Pathogens (refer to ASC-P-6001)*
    b) *Safe Handling of Needles and Sharps (refer to Harris Health System Policy #1.30)*
    c) *Personal Protective Equipment (refer to Harris Health Policy #3003)*
2. Communicable Diseases:
    a) *Standard and Transmission Based Precautions (refer to Harris Health System Policy #3000)*
    b) *Detection and Management of Outbreaks*
    c) *Communicable Disease Work Restrictions for Workforce Members (refer to Harris Health System Policy #3.55.04)*
    d) *Communicable Disease Exposure Evaluation Policy (refer to Harris Health System Policy #3.55.03)*
3. Hazardous Materials:

a) *Personal Protective Equipment (refer to Harris Health Policy #3003)*

b) *Hazardous Materials (refer to Harris Health Policy #7201)*

REFERENCES/BIBLIOGRAPHY:

American Association for Accreditation of Ambulatory Surgery Facilities Version 8

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		Revised 12/7/2021	

TITLE: INCIDENT REPORTING

PURPOSE: To provide guidance regarding the reporting of Incidents involving patients, visitors, or Workforce members, which are inconsistent with the standard of care, and/or the routine operations of the Ambulatory Surgical Center (ASC) at LBJ.

POLICY STATEMENT:

All injuries and hazards involving patients, visitors, and Workforce members shall be reported using the Harris Health System (Harris Health) electronic incident reporting system (eIRS) pursuant to the Letter of Agreement between Harris Health System and the Ambulatory Surgical Center (ASC) at LBJ. The ASC does not tolerate retaliation against Workforce members who report Incidents.

POLICY ELABORATIONS:

I. DEFINITIONS:

A. **ADVERSE EVENT:** A patient care event that is unfavorable, undesirable, and usually unanticipated that causes death or serious injury, or the risk thereof. Adverse events may result from unintentional acts or omissions. Adverse Events may include, but are not limited to:

1. Patient falls;
2. Medication errors;
3. Procedural errors/complications;
4. Completed or attempted suicides;
5. Iatrogenic injuries, i.e., injuries due to medical treatment or procedure;
6. Failure to make a timely diagnosis;
7. Untimely implementation of appropriate therapeutic intervention; and
8. Missing patient events.

B. **ADVANCED PRACTICE PROFESSIONAL (APP):** An individual who holds a state license in their profession as well as other education credentials attesting to training and qualifications to provide services in one or more of the following categories: Physician Assistant (PA), Certified Registered Nurse Anesthetist (CRNA), Nurse Practitioner (NP) or Clinical Nurse Specialist (CNS),

Optometrist (OD), Certified Nurse Midwife (CNM), Clinical Psychologist, Registered Dietician, and Clinical Pharmacist.

C. **INCIDENT:** An accident or injury that occurs within Harris Health staffed locations that is inconsistent with the standard of care of a patient or routine operations of Harris Health which may result in an unanticipated harm or injury to patients, visitors, affiliates, employees, and others. "Incident" shall include, but is not limited to events that are:

1. Adverse Events;
2. Inconsistent with any Harris Health policy or procedures; or
3. Non-anticipated and non-routine patient, employee, affiliate, contractor, visitor, volunteer or other injuries resulting from accidents or errors.

D. **MEDICAL ERROR:** The failure of a planned action to be completed as intended, the use of a wrong plan to achieve an aim, or the failure of an unplanned action that should have been completed that results in an adverse event.

E. **MEDICAL STAFF:** All physicians, dentists, podiatrists and oral-maxillofacial surgeons who are appointed to the Medical Staff and who either (i) hold a faculty appointment at Baylor College of Medicine and/or The University of Texas Health Science Center at Houston or (ii) are employed by ASC to provide healthcare services at designated ASC Facilities.

F. **NEAR MISS:** An event or situation that could have resulted in an accident, injury, or illness, but did not, either by chance or through timely intervention. An example of a Near Miss would be a surgical or other procedure almost performed on the wrong patient due to lapses in verification of patient identification but caught at the last minute by chance. Near Misses are opportunities for learning and afford the chance to develop preventive strategies and actions. Near Misses will receive the same level of scrutiny as Incidents that result in actual injury.

G. **SERIOUS REPORTABLE EVENT (SRE):** An event that can result in death, loss of a body part, serious harm/injury/disability, loss of bodily function, or require major intervention for correction. It is also considered to be an event that is unambiguous, largely preventable, and serious, as well as adverse, indicative of a problem in a healthcare setting's safety systems.

Events qualifying as serious reportable events include, but are not limited to, the following categories:

1. Surgical or invasive procedure events;
2. Product or device events;
3. Patient protection events;
4. Care management events;
5. Environmental events;
6. Radiologic events; and
7. Potential criminal events.

See the Appendix A and the ASC Patient Safety Plan for further description of the events included in these categories.

H. **WORKFORCE:** The, employees, medical staff, trainees, contractors, volunteers and vendors.

II. GENERAL PROVISIONS:

A. All Medical Errors, Adverse Events, and Serious Reportable Events involving patients, visitors, Medical Staff, Advanced Practice Professionals, and Workforce members shall be reported within 24 hours of becoming aware of the event using the Harris Health Electronic Incident Reporting System ("eIRS"). The eIRS report should be made by the person who is involved in, observes, or discovers the event.

B. The Workforce member, member of the Medical Staff, or Advance Practice Professional who discovers an Incident involving a patient shall immediately stabilize the patient and notify the patient's care team of the Incident.

C. An objective description of the Incident should be written in the medical record by both the medical and nursing staff along with any observations, diagnostic studies and results, and/or related treatment; however, Workforce members and Medical Staff shall **not** make reference to the eIRS system, an incident report, or communication with Risk Management in a patient's medical record.

D. Workforce members are accountable for ensuring all Incidents are documented in the eIRS. If a Workforce member does not timely report an event into the eIRS system, the Workforce member's supervisor will be notified and the employee will be counseled.

E. Workforce members, Medical Staff, and APPs must not print, copy, or electronically copy and paste any eIRS report into a document or email.

All Incidents, Serious Reportable Events, Adverse Events, and Near Misses will be evaluated and handled in accordance with the ASC Patient Safety Plan.

III. INCIDENTS THAT MUST BE REPORTED:

A. All Incidents, Serious Reportable Events, Adverse Events, and Near Misses must be reported, including, but not limited to:

1. A medication error resulting in a patient's unanticipated death or major permanent loss of bodily function in circumstances unrelated to the natural course of the illness or underlying condition of the patient;
2. The suicide of a patient in a setting in which the patient received care 24 hours a day;
3. The sexual assault of a patient during treatment or while the patient was on the premises of the ASC;
4. A hemolytic transfusion reaction in a patient resulting from the administration of blood or products with major blood group incompatibilities;
5. A surgical procedure on the wrong patient or on the wrong body part of a patient;
6. A foreign object accidently left in a patient during a procedure; and
7. A patient death or serious disability associated with the use or function of a device designed for patient care that is used or functions other than as intended.

B. Patient identification issues (incorrect medical record number, mislabeled or wrong lab/diagnostic results reported, etc.);

C. Blood product administration errors;

D. Procedural errors;

E. Falls for any reason, with or without injuries;

F. Workforce, Medical Staff, or APP injuries that occur at the ASC;

G. Any faulty/defective equipment;

H. The existence of hazardous conditions within Harris Health staffed locations;

I. Vocal or written expressions of dissatisfaction from a patient or a patient's family concerning professional and non-professional services and/or treatment received within a Harris Health staffed location. Please see the ASC's Grievance policy for further guidance. Patients exhibiting threatening or aggressive behavior that requires assistance by Security or law enforcement; or

J. Patient or visitor's lost, stolen, or damaged property, claimed or actual.

IV. PRIVILEGE AND CONFIDENTIALITY OF INCIDENT REPORTS

A. Actions taken and documents developed during the patient safety process, which includes the reporting and investigation of Incidents, Serious Reportable Events, Adverse Events, and Near Misses, are privileged, confidential, and not subject to disclosure. Actions and documents include, but are not limited to, reports, investigations, analysis, data aggregation, summaries, and documentation of patient safety events. Actions are taken and documents are developed at the direction of the ASC Quality Review Council, which is both a medical peer review committee and medical committee as those terms are defined in Chapter 161 of the Texas Health & Safety Code and Chapter 151 of the Texas Occupations Code. Confidential information maintained by the Risk Management department includes, but is not limited to, committee minutes, organizational risk management and/or patient safety reports, electronic data gathering and reporting, and incident reports. The ASC Quality Improvement Program contains further description of the privilege and confidentiality of patient safety activities.

B. In order to safeguard protected health information and to maintain the privileged nature of this data, the following must be observed:

1. Electronic Incident Reporting System ("eIRS") reports must not be printed, copied, or electronically copied and pasted into a document or email;

2. No reference to the eIRS system, an incident report, or communication with Risk Management should be made in a patient's medical record; and

3. Information contained in eIRS should be extracted and shared with other departments only as needed.

C. Failure to follow these procedures may result in disciplinary action, up to and including termination.

REFERENCES/BIBLIOGRAPHY:

The Ambulatory Surgical Center at LBJ Quality Improvement Program

The Harris Health System Patient Safety Plan

National Quality Forum,
http://www.qualityforum.org/topics/sres/serious_reportable_events.aspx

25 Texas Administrative Code (TAC) § 135.26~~7~~

42 Code of Federal Regulations (C.F.R.) §416.50(a).

OFFICE OF PRIMARY RESPONSIBILITY:

The Ambulatory Surgical Center (ASC) at LBJ

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		Reviewed / Approved 03/29/2018	The Ambulatory Surgical Center (ASC) at LBJ Governing Body
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		Reviewed / Approved 02/13/2020	The Ambulatory Surgical Center (ASC) at LBJ Governing Body
		Reviewed / Approved 02/25/2021	The Ambulatory Surgical Center (ASC) at LBJ Governing Body

Appendix A

National Quality Forum
Serious Reportable Events

1. Surgical or Invasive Procedure Events
   a. Surgery or other invasive procedure performed on the wrong site
   b. Surgery or other invasive procedure performed on the wrong patient
   c. Wrong surgical or other invasive procedure performed on a patient
   d. Unintended retention of a foreign object in a patient after surgery or other invasive procedure
   e. Intraoperative or immediately postoperative/post procedure death in an ASA Class 1 patient
2. Product or Device Events
   a. Patient death or serious injury associated with the use of contaminated drugs, devices, or biologics provided by the healthcare setting
   b. Patient death or serious injury associated with the use or function of a device in patient care, in which the device is used or functions other than as intended
   c. Patient death or serious injury associated with intravascular air embolism that occurs while being cared for in a healthcare setting
3. Patient Protection Events
   a. Discharge or release of a patient/resident of any age, who is unable to make decisions, to other than an authorized person
   b. Patient death or serious injury associated with patient elopement (disappearance)
   c. Patient suicide, attempted suicide, or self-harm that results in serious injury, while being cared for in a healthcare setting
4. Care Management Events
   a. Patient death or serious injury associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration)
   b. Patient death or serious injury associated with unsafe administration of blood products
   c. Maternal death or serious injury associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare setting
   d. Death or serious injury of a neonate associated with labor or delivery in a low- risk pregnancy

e. Patient death or serious injury associated with a fall while being cared for in a healthcare setting
f. Any Stage 3, Stage 4, and unstageable pressure ulcers acquired after admission/presentation to a healthcare setting
g. Artificial insemination with the wrong donor sperm or wrong egg
h. Patient death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen
i. Patient death or serious injury resulting from failure to follow up or communicate laboratory, pathology, or radiology test results

5. Environmental Events
   a. Patient or staff death or serious injury associated with an electric shock in the course of a patient care process in a healthcare setting
   b. Any incident in which systems designated for oxygen or other gas to be delivered to a patient contains no gas, the wrong gas, or are contaminated by toxic substances
   c. Patient or staff death or serious injury associated with a burn incurred from any source in the course of a patient care process in a healthcare setting
   d. Patient death or serious injury associated with the use of physical restraints or bedrails while being cared for in a healthcare setting
6. Radiologic Events
   a. Death or serious injury of a patient or staff associated with the introduction of a metallic object into the MRI area
7. Potential Criminal Events
   a. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider
   b. Abduction of a patient/resident of any age
   c. Sexual abuse/assault on a patient or staff member within or on the grounds of a healthcare setting
   d. Death or serious injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a healthcare setting

The Ambulatory Surgical Center (ASC) at LBJ Infection Control Plan

Table of Contents

Statement of Adherence:

The Ambulatory Surgical Center (ASC) at LBJ's Infection Control Plan follows the standards set forth and prescribed by the following entities as applicable:

1. Centers for Disease Control (CDC)
2. Association of PeriOperative Registered Nurses (AORN)
3. Association for Professionals in Infection Control (APIC)

Please see the references in each specific section of the Infection Control Plan to determine which entity's standards the Ambulatory Surgical Center (ASC) at LBJ is adopting and following.

TITLE: SANITARY ENVIRONMENT PROTOCOL

PURPOSE: To establish the procedures and processes the Ambulatory Surgical Center (ASC) at LBJ will follow to maintain a sanitary environment for its patients and personnel to prevent the spread of infections and communicable diseases.

POLICY STATEMENT:

The Ambulatory Surgical Center (ASC) at LBJ is committed to creating and maintaining a sanitary environment to prevent the spread of infections and communicable diseases to its patients and Workforce members.

POLICY ELABORATIONS:

I. VENTILATION & WATER SYSTEMS

A. Ventilation Systems:

1. It is the policy of the ASC that all ventilation system(s) be evaluated on a routine basis to prevent the deployment of reservoirs of infection.

2. The following must be verified and documented in the evaluation of the ASC ventilation system(s):

   i. Negative pressure for isolation rooms with appropriate Air Changes per Hour ("ACH");
   ii. Positive pressure for operating rooms with appropriate ACH;
   iii. Use of biocide and routine cleaning of cooling towers; and
   iv. Appropriate filter efficiency.

3. In the event of an interruption or disruption of the ASC's ventilation systems, the following steps must be taken:

   i. Evaluate air handling systems for particle counts and bio aerosol
   ii. Assess ventilation system filters, ACH and pressure differentials;
   iii. Assess dust and debris and institute appropriate measures, including but not limited to the following:

      1. Wet mop or clean areas regularly with disinfectant to control dust;

2. Provide negative air pressure and/or partitions around the area of disruption to prevent dust movement to adjacent areas, if needed, or isolate HVAC system where the construction/work is being done;
3. Use walk off mats to prevent dust from spreading to adjacent areas;
4. Seal windows and/or air intakes;
5. Sanitize air handling duct, if necessary depending on the magnitude of the disruption;
6. Clean or sanitize cooling towers, if needed;
7. Cover debris for removal and transport debris during periods of low activity, if applicable.

iv. If the interruption or disruption of the ASC ventilation system involves biohazardous material, Workforce members must use personal protective equipment.

B. Water Systems:

1. It is the policy of the ASC that all components of the ASC's water supply system be evaluated on a routine basis to prevent the development of reservoirs of infection.

2. The routine evaluation of the ASC's water supply system includes at a minimum:

i. Verification of the appropriate hot water temperatures; and
ii. Periodic flushing of water system(s) and holding tank maintenance.

3. In the event of an interruption of water services, the following steps must be taken:

i. Identify and make provisions for waterless hand washing products;
ii. Identify and make provisions for products for patient use;
iii. Determine if toilets can be flushed;
iv. Identify sources of water for flushing if the water is off, but flushing can be done;
v. Provide alternate toilet sites, if indicated;

vi. Make provisions for environmental and/or equipment cleaning and sanitation;
vii. Evaluate the need for cleaning and chlorinating water system(s) and/or the need for culturing to assure acceptable water quality;
viii. Determine the communication process to be used for the restriction of water use and when water use can resume; and
ix. Test water for coliforms prior to clearing ASC water for use.

C. Prevention, Management, and Treatment of Legionella:

1. The following protocol must be followed to prevent the transmission of Legionella:

i. Maintain hot water in the ASC water system(s) at 140 degrees Fahrenheit with a minimum return of 120 degrees Fahrenheit.
ii. Maintain a continuous flow-adjusted injection of chlorine into the water system;
iii. Periodically flush all hot water tanks;
iv. Minimize the formation of biofilms and growth of organisms by appropriate ongoing maintenance and the continuous use of oxidizing biocide and an intermittent use of a non-oxidizing biocide;
v. Install drift eliminators on cooling towers and evaporative coolers; and
vi. Keep adequate maintenance records.

2. If a possible outbreak of Legionella is suspected, the following steps must be taken:

i. Review medical and microbiological records to verify diagnosis;
ii. Initiate active surveillance to identify other possible cases;
iii. Develop a line listing by person, place, and time;
iv. Form a multidisciplinary team, if indicated to guide remediation efforts;
v. Examine possible sources and collect water samples;
vi. Initiate water treatment;
vii. Consider restrictions from showering for high-risk patients if water is proven to contain legionella; and
viii. After water has been treated, continue surveillance to monitor the effectiveness of the treatment.

3. If Legionella is identified in the water system of the ASC, the following remediation measures may be taken:

   i. Superheat and flush system with water temperature at 160-170 degrees Fahrenheit to disinfect system; and/or
   ii. Hyper chlorinate water system with >10mg/L of chlorine and flush all outlets.

D. Treatment, Prevention and Management of Aspergillosis:

1. The following protocol should be followed to prevent the transmission of Aspergillosis:

   i. Minimize dust generation in the ASC;
   ii. Limit excess moisture and humidity in the ASC;
   iii. Construction areas should have barriers to eliminate the dispersion of dust to the ASC. If barriers are not practical or not adequate, patient relocation may be necessary;
   iv. Minimize traffic through the ASC;
   v. Thoroughly clean newly occupied areas; and
   vi. Check particle counts (>0.5 microns diameter) and/or bio aerosols.

   HEPA filtered areas can be expected to have particle counts <1000 cubic foot of air and non HEPA areas with 30/90 progressive filtration can be expected to have <5000/cubic foot of air. These numbers are based on the assumption that the ASC's HVAC system has been running for at least 24 hours.

2. If a suspected outbreak of Aspergillosis is suspected, the following steps should be taken:

   i. Review medical and microbiological records to verify diagnosis;
   ii. Initiate active, prospective surveillance to identify other possible cases;
   iii. If there is no evidence of a continuing transmission, continue routine maintenance procedures;
   iv. If evidence of continuing infection is present, conduct environmental investigations to find the source;

v. Develop a line listing by person, place, and time;
vi. Form a multidisciplinary team, if indicated, to guide remediation efforts; and
vii. During and after remediation, continue surveillance to monitor effectiveness.

II. CLEANING AND DISINFECTING THE ASC:

A. It is the policy of the ASC to adequately disinfect and clean the ASC to prevent the risk of infection to patients, visitors, and employees of the ASC.

B. **General Disinfection:** The ASC will follow the general disinfection methods listed in Attachment A.

C. **General Cleaning of Perioperative and Postoperative Care Areas:** The ASC will adopt and follow the Association of Perioperative Registered Nurses (AORN) Guidelines for Environmental Cleaning when cleaning ASC operating rooms and perioperative and postoperative care areas.

D. **Surgical Instruments Sterilization:** The ASC will adopt and follow the Association of Perioperative Nurses (AORN) Guidelines for Cleaning and Care of Surgical Instruments and Guideline for Sterilization when sterilizing surgical instruments.

III. DISPOSAL OF WASTE:

A. Generally:

1. Per the Letter of Agreement between Harris Health and the ASC, Harris Health will manage the ASC's disposal of waste.

2. All waste at the ASC will be disposed of in accordance with the Waste Disposal Chart listed in Attachment B.

3. All medical and infectious/biohazardous waste will be segregated from ordinary trash and/or rubbish at the point of generation. Disposal containers will be lined with approved bags and liners and must be tied up prior to removing and transporting.

4. All Workforce members must follow universal precautions and wear personal protective equipment when disposing of medical waste, sharps, broken glass, debris, or trash.

B. Safe Handling and Disposal of Needles and Sharps:

1. Needles and other disposable sharps are discarded in puncture resistant containers.

2. Sharps containers should be placed where they are easily accessible in operating rooms.

3. Syringes should not be disconnected from needles to discard unless it is required for processing specimens.

4. Large bore reusable needles should be placed in a designated area for transport.

5. Needles and sharps may not be placed in wastebaskets.

6. A contaminated collection container may not be reused. When containers are three-fourths (3/4ths) full, the top must be secured and the container must be taken to an area designated in the ASC..

7. All contaminated broken glass and needles should be picked up with forceps, brush and dust pan, or another tool to avoid contact with hands.

8. When disposing of the sharp, it is important to keep hands behind the sharp tip.

9. Workforce members must maintain control of the tubing and the needle when disposing a sharp with the attached tubing, (e.g., winged steel needle) because the tubing can recoil and lead to injury.

IV. PEST CONTROL:

A. Pests will be controlled or eliminated from the ASC to provide a safe environment for patients, visitors, and staff.

B. Preventative Measures: The following preventative measures will be taken by the ASC to prevent and control pests:

1. Food:

   i. All food brought into the ASC must be kept in airtight containers; and
   ii. Food spillage should be promptly cleaned.

2. Waste:

   i. Waste should be stored in a manner that prevents access by pests and vermin; and
   ii. Waste containers should be regularly cleaned to prevent buildup of material that may attract flies or gnats.

3. Water:

   i. Drains should be covered
   ii. when possible with screens; and
   iii. Leaking pipes should be immediately repaired.

4. Building:

   i. Cracks in plaster or woodwork should be immediately repaired; and
   ii. Wall and firewall penetrations should be sealed.

C. Procedure to follow to control or eliminate pests from the ASC:

1. Insects: If insects are identified in the ASC, the ASC must remediate the source for their presence, e.g., closing propped exterior door, eliminating food or water that is drawing the insects into the ASC.

2. Vermin: If vermin are identified in the ASC, a pest control specialist must be contacted to control and eliminate the vermin.

3. Lice: If lice are identified on a patient in the ASC, all of the patient's linen must be laundered.

4. Bed Bugs: If bed bugs are identified in the ASC, a pest control specialist must be contacted to remediate the ASC. Please see Attachment C.

REFERENCES/BIBLIOGRAPHY:

42 Code of Federal Regulations (C.F.R.)§416.51(a).

Guideline for Disinfection and Sterilization in Healthcare Facilities, 2008 http://www.cdc.gov/hicpac/pdf/guidelines/Disinfection_Nov_2008.pdf

Guideline for Environmental **Cleaning** *DOI: 10.6015/psrp.15.01.009*

Guideline for **Cleaning** and Care of Surgical Instruments *DOI: 10.6015/psrp.15.01.615*

Guideline for Sterilization: *DOI: 10.6015/psrp.15.01.665*

42 Code of Federal Regulations (C.F.R.) §416.41(a)

42 Code of Federal Regulations (C.F.R.) §416.42

42 Code of Federal Regulations (C.F.R.) §416.51(a) and (b)

American Association for Accreditation of Ambulatory Surgery Facilities ~~§200.040.040~~v8.0

Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings 2007. http://www.cdc.gov/hicpac/pdf/isolation/Isolation2007.pdf

OFFICE OF PRIMARY RESPONSIBILITY:

The Ambulatory Surgical Center (ASC) at LBJ

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ATTACHMENT "A"

Table 1. Methods of sterilization and disinfection

	Sterilization			Disinfection	
	Critical items (will enter tissue or vascular system or blood will flow through them)		**High-level (semicritical items; [except dental] will come in contact with mucous membrane or nonintact skin)**	**Intermediate-level (some semicritical items[1] and noncritical items)**	**Low-level (noncritical items; will come in contact with intact skin)**
Object	**Procedure**	**Exposure time**	**Procedure (exposure time 12-30 min at ≥20°C)[2,3]**	**Procedure (exposure time ≥ 1 m) [9]**	**Procedure (exposure time ≥ 1 m) [9]**
Smooth, hard Surface[1,4]	A B C D F G H	MR MR MR 10 h at 20-25°C 6 h 12 m at 50-56°C 3-8 h	D E F H I[6] J	K L[5] M N	K L M N O
Rubber tubing and catheters[3,4]	A B C D F G H	MR MR MR 10 h at 20-25°C 6 h 12 m at 50-56°C 3-8 h	D E F H I[6] J		
Polyethylene tubing and catheters[3,4,7]	A B C D F G H	MR MR MR 10 h at 20-25°C 6 h 12 m at 50-56°C 3-8 h	D E F H I[6] J		
Lensed instruments[4]	A B C D F G H	MR MR MR 10 h at 20-25°C 6 h 12 m at 50-56°C 3-8 h	D E F H J		
Thermometers (oral and rectal)[8]					K[8]
Hinged instruments[4]	A B C D F G H	MR MR MR 10 h at 20-25°C 6 h 12 m at 50-56°C 3-8 h	D E F H I[6] J		

Modified from Rutala and Simmons. 15, 17, 18, 421 The selection and use of disinfectants in the healthcare field is dynamic, and products may become available that are not in existence when this guideline was written. As newer disinfectants become available, persons or committees responsible for selecting disinfectants and sterilization processes should be guided by products cleared by the FDA and the EPA as well as information in the scientific literature.

A, Heat sterilization, including steam or hot air (see manufacturer's recommendations, steam sterilization processing time from 3-30 minutes)
B, Ethylene oxide gas (see manufacturer's recommendations, generally 1-6 hours processing time plus aeration time of 8-12 hours at 50-60°C)
C, Hydrogen peroxide gas plasma (see manufacturer's recommendations for internal diameter and length restrictions, processing time between 45-72 minutes).
D, Glutaraldehyde-based formulations (≥2% glutaraldehyde, caution should be exercised with all glutaraldehyde formulations when further in-use dilution is anticipated); glutaraldehyde (1.12%) and 1.93% phenol/phenate. One glutaraldehyde-based product has a high-level disinfection claim of 5 minutes at 35°C.
E, Ortho-phthalaldehyde (OPA) 0.55%
F, Hydrogen peroxide 7.5% (will corrode copper, zinc, and brass)
G, Peracetic acid, concentration variable but 0.2% or greater is sporicidal. Peracetic acid immersion system operates at 50-56°C.
H, Hydrogen peroxide (7.35%) and 0.23% peracetic acid; hydrogen peroxide 1% and peracetic acid 0.08% (will corrode metal instruments)
I, Wet pasteurization at 70°C for 30 minutes with detergent cleaning
J, Hypochlorite, single use chlorine generated on-site by electrolyzing saline containing >650-675 active free chlorine; (will corrode metal instruments)
K, Ethyl or isopropyl alcohol (70-90%)
L, Sodium hypochlorite (5.25-6.15% household bleach diluted 1:500 provides >100 ppm available chlorine)
M, Phenolic germicidal detergent solution (follow product label for use-dilution)
N, Iodophor germicidal detergent solution (follow product label for use-dilution)
O, Quaternary ammonium germicidal detergent solution (follow product label for use-dilution)
MR, Manufacturer's recommendations
NA, Not applicable

1 See text for discussion of hydrotherapy.
2 The longer the exposure to a disinfectant, the more likely it is that all microorganisms will be eliminated. Follow the FDA-cleared high-level disinfection claim. Ten-minute exposure is not adequate to disinfect many objects, especially those that are difficult to clean because they have narrow channels or other areas that can harbor organic material and bacteria. Twenty-minute exposure at 20°C is the minimum time needed to reliably kill *M. tuberculosis* and nontuberculous mycobacteria with a 2% glutaraldehyde. Some high-level disinfectants have a reduced exposure time (e.g., ortho-phthalaldehyde at 12 minutes at 20°C) because of their rapid activity against mycobacteria or reduced exposure time due to increased mycobactericidal activity at elevated temperature (e.g., 2.5% glutaraldehyde at 5 minutes at 35°C, 0.55% OPA at 5 min at 25°C in automated endoscope reprocessor).
3 Tubing must be completely filled for high-level disinfection and liquid chemical sterilization; care must be taken to avoid entrapment of air bubbles during immersion.
4 Material compatibility should be investigated when appropriate.
5 A concentration of 1000 ppm available chlorine should be considered where cultures or concentrated preparations of microorganisms have spilled (5.25% to 6.15% household bleach diluted 1:50 provides > 1000 ppm available chlorine). This solution may corrode some surfaces.
6 Pasteurization (washer-disinfector) of respiratory therapy or anesthesia equipment is a recognized alternative to high-level disinfection. Some data challenge the efficacy of some pasteurization units.
7 Thermostability should be investigated when appropriate.
8 Do not mix rectal and oral thermometers at any stage of handling or processing.
9 By law, all applicable label instructions on EPA-registered products must be followed. If the user selects exposure conditions that differ from those on the EPA-registered products label, the user assumes liability from any injuries resulting from off-label use and is potentially subject to enforcement action under FIFRA.

ATTACHMENT "B"

HARRISHEALTH SYSTEM

WASTE DISPOSAL CHART

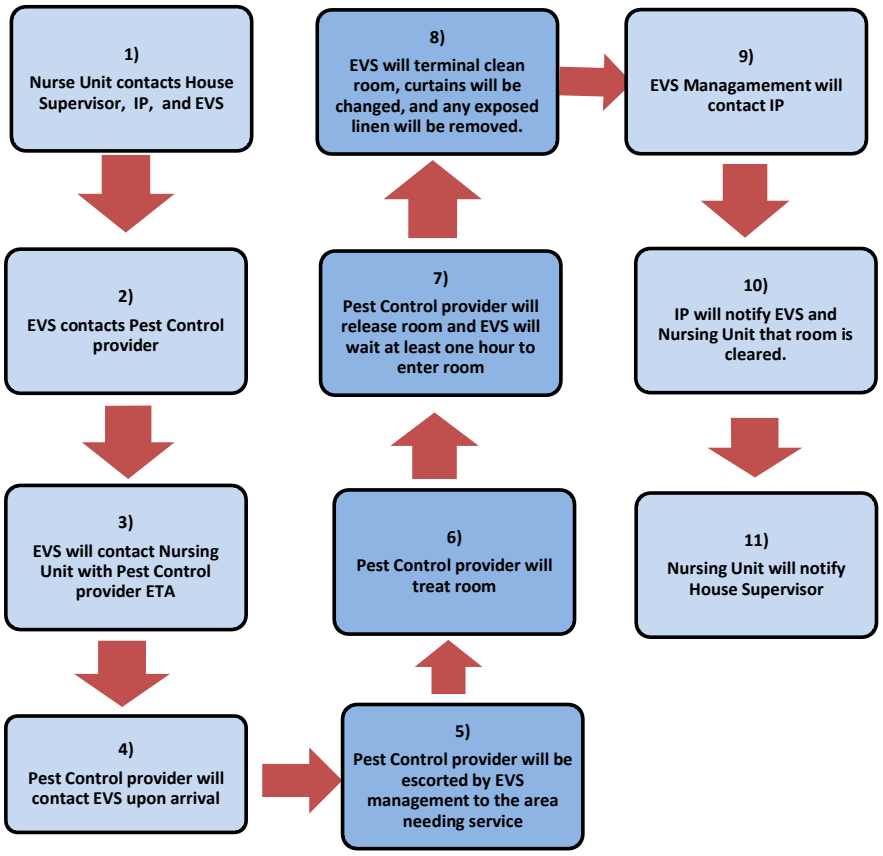
Regulatory Compliance

Regulated Medical Waste Disposal 30 TAC §326 No Pharmaceuticals	Sharps Disposal and Re-useable Sharps Container Program	Pharmaceutical Waste: 40 CFR §260 All Waste Medications	DEA Controlled Substances and Narcotics	Low Level Radioactive Waste 25 TAC §289	Solid Waste: Clear; Black; White bags
BIOHAZARD BAGS All items saturated with blood or body fluids or Other Potentially Infectious Materials (OPIM) should be discarded as infectious waste. Examples: • Blood tubing/bags soaked/dripping bloody dressings • Glass or plastic items/bottles with blood • Suction liners/canisters or body fluid/liquid Thoracentesis • Pacemakers Never put biohazard bags in regular trash All liquid infectious waste must be solidified prior to disposal. pathology • Human or animal body parts and tissues • Organs • Large tissue specimens • Fetuses • Orthopedic & OB Instruments • External Fixators • Non-reusable medical instruments/implants • Pathological waste	SHARPS CONTAINER Sharps program in place for BT, LBJ, GM, Outpatient Center, and South Clinic Examples: • Needles • Needles with syringes • Broken glass • Broken ampoules • Blades, Scalpels • Pasteur pipettes • Microscope slides • Any item capable of puncturing the skin Hazardous Materials Non-inclusive Hazardous Waste Examples: • Waste Gram • Xylene • Formaldehyde Autoclave & all necessary containing equipment Contact the Hazardous Materials office for proper disposal guidelines. Never pour chemicals down the drain or sewer	NO SHARPS OR DEA CONTROLLED SUBSTANCES Pharmaceutical (Rx) waste includes: all non DEA regulated pharmaceuticals: • Pills & Tablets • Medicinal Liquids • Antiseptics • Allergenic • Transdermal Patches • Gums & Lozenges • Lotions & Creams • Ointments & Pastes Also include: containers which have held hazardous Rx waste. For example: • Bottles, Vials, IV Bags, Gels & Creams, Ampules RX waste must be disposed of in black hazardous waste container. All Bulk and Trace Chemo Creditable pharmaceuticals should be returned via the Reverse Distributor	CONTROLLED SUBSTANCES Any DEA scheduled items that requires a witness to waste Narcotics and Controlled Substances should be witness Wasted per Harris Health Policy 010 and 082 RETURNING AND WASTING MEDICATION: • Nursing shall waste medication items if the medication package is not intact per standard operating procedures. Regarding controlled substances, note that: • The wasting of controlled medications shall be witnessed by two (2) licensed professionals (Registered Nurse, Licensed Vocational Nurse, Pharmacist, or Physician). • When at all possible, the documentation of the wastage shall be completed at the time the controlled substance is actually wasted.	NUCLEAR MEDICINE Step 1: Radioactive waste generated during patient treatment shall be disposed of in designated BLUE BAGS LINERS Step 2: Only the facility Radiation Safety Officer (RSO) can authorize removal of radioactive waste, after authorization is granted the material is placed in RED BIO BAG LINERS for disposal Nuclear Medicine patient rooms should never be entered while isotope is present on patient room floors. All waste linens should remain in isotope room until cleared for removal by the RSO or Designee. All BT & LBJ soiled linen and waste - must pass through the Radioactive Waste Portal Monitors to exit facility.	NON-CONTAMINATED ITEMS No Biohazard bags: • IV bags & tubing • Non contaminated glass items; glass/non-glass or containers • Trash/wrappers • Dressings • Drapes & Clean • Gloves • Empty Foley bags • Empty drainage bags • Disposable patient items NOTE: If not saturated with blood, body fluid or OPIM, dispose of as regular solid waste LINEN 29CFR 910.1030 Caution, may contain sharps Contaminated laundry shall be handled as little as possible with minimum agitation. Contaminated laundry shall be placed and transported in a labeled designated bag. At no time should soiled linen be sorted or placed in red bags, or solid waste.

Revised 10/08/2015 20140 - 0117

LBJ Nursing, EVS, and Pest Control Provider

Bed Bug Protocol Process



1. Nurse Unit contacts EVS via email and via Phone at 713-566-~~6960~~ 9660 or 713-566-~~6961~~9661.

Unit is required to leave all linen in the room contained in a plastic bag for extermination process. Bed linen should be contained in one linen bag, while the curtains in a second linen bag. Nursing staff of the department should attempt to capture the bed bug if able to do so via a container or tape to ensure proper extinction procedure and close the room until further notice. Point of contact for Infection Prevention is the Ambulatory Care Services (ACS) Infection Prevention Department which can be reached at 346-426-0144.

2. EVS contacts ~~ECOLAB at 800-325-1671~~contracted Pest Control provider requesting service and ensuring to document

who they spoke to, the time, the date, and the name of the service technician who will contact EVS for an estimated time of arrival (ETA). All documentation will be scanned and filed in the appropriate data storage location. Technicians will then be sent an email from management to inform them of the request. ~~at the following emails stated below:~~

- ~~Brent.Armbruster@ecolab.com~~
- ~~Robert.Day@ecolab.com~~
- ~~Alexcander.Esquivel@ecolab.com~~

3. A follow-up assessment must be performed by EVS Management by inspecting the location of the request and speaking to the requestor so that they are aware that ~~ECOLAB~~ Pest Control has been contacted and provide an ETA.

4. ~~ECOLAB~~ The Pest Control provider will contact EVS upon arrival to begin their ~~4.~~5. service.

6. ~~ECOLAB~~ The Pest Control provider will then be escorted to the requested service area ~~5.~~7. then proceed to inspect the room under EVS supervision.

~~6.~~8. ~~ECOLAB~~ The Pest Control provider will begin treatment based on their findings and guidelines.

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~~7.~~9. ~~ECOLAB~~ The Pest Control provider will release room after treatment ends and instruct EVS to wait at least an hour before entering the room.

~~8.~~10. EVS will begin their procedures which will include a terminal clean, removal of any exposed linen, and the change of curtains to complete their protocol.

~~9.~~11. EVS Management will contact the ACS Infection Prevention (IP) Department at 346-426-0144 to inform the department of the completion of the terminal clean. Upon speaking to the ACS IP Department the EVS Management will send an email to the ACS IP Department to maintain documentation of the process.

~~10.~~12. The ACS Infection Prevention Department will assess the area and inform EVS and the Nursing Unit when the room is cleared for further use.

TITLE: HAND HYGIENE GUIDELINES

PURPOSE: To prevent the transmission of infection to patients and healthcare workers.

POLICY STATEMENT:

The Ambulatory Surgical Center (ASC) at LBJ implements hand hygiene guidelines to reduce the transmission of infectious agents to patients and Workforce members.

POLICY ELABORATIONS:

I. DEFINITIONS:

A. **HAND HYGIENE**: A general term that applies to hand washing, antiseptic hand wash, antiseptic hand rub, or surgical hand antisepsis.

B. **DECONTAMINATE HANDS**: Means to reduce bacterial counts on hands by performing antiseptic hand rub or antiseptic hand wash.

C. **OTHER POTENTIALLY INFECTIOUS MATERIALS (OPIM)**: Refers to:

a. The following human body fluids: semen, vaginal secretions, cerebrospinal fluid, synovial fluid, pleural fluid, pericardial fluid, peritoneal fluid, amniotic fluid, saliva in dental procedures, any body fluid that is visibly contaminated with blood, and all body fluids in situations where it is difficult or impossible to differentiate between body fluids;
b. Any unfixed tissue or organ (other than intact skin) from a human (living or dead); and
c. Human Immunodeficiency Virus (HIV) containing cell or tissue cultures, organ cultures, and HIV or Hepatitis B Virus (HBV) containing culture medium or other solutions; and blood, organs, or other tissues infected with HIV or HBV.

D. **WORKFORCE:** The members of the governing body of the Ambulatory Surgical Center (ASC) at LBJ, employees, medical staff, trainees, contractors, volunteers, and vendors.

II. GENERAL PROVISIONS:

A. Hand washing stations shall be maintained with appropriate supplies and conveniently located throughout the ASC in accordance with state and federal requirements.

B. Hands must be cared for by washing with soap and water as follows:

1. When hands are visibly dirty or contaminated or are visibly soiled with blood or other bodily fluids;
2. If exposure to potential spore-forming organisms is strongly suspected or proven;
3. After using the restroom;
4. Before eating; and
5. Prior to starting work.

C. In all other clinical situations, it is preferred that Workforce members must Decontaminate their hands by using an alcohol-based hand rub, unless washing hands with soap and water is indicated. Specifically, hands must be Decontaminated with an alcohol-based hand rub in the following situations:

1. Decontaminate hands before and after having direct contact with patients.
2. Decontaminate hands before inserting indwelling catheters or other invasive devices that do not require a surgical procedure.
3. Decontaminate hands after contact with a patient's intact skin (e.g., taking a pulse or blood pressure, or lifting a patient).
4. Decontaminate hands after contact with bodily fluids or excretions, mucous membranes, non-intact skin, and wound dressings.
5. Decontaminate hands if moving from a contaminated-body site to a clean-body site during patient care.
6. Decontaminate hands after contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient.
7. Decontaminate hands after removing gloves.

D. Areas that do not have immediate access to hand washing stations will have readily available an alcohol-based waterless antiseptic agent.

E. In the event of interruption of the ASC's water supply, alternative agents, such as detergent containing towelettes and alcohol-based hand rubs will be available.

F. Use of communal bar soap is prohibited in the ASC.

G. The ASC will follow and adopt all additional guidelines and recommendations of the Association of Perioperative Registered Nurses (AORN) regarding hand hygiene, available at: *DOI: 10.6015/psrp.15.01.097*.

III. OTHER ASPECTS OF HAND CARE AND PROTECTION:

A. Gloves should be used for hand-contaminating activities, but are not a substitute for hand washing.

B. When it can be reasonably anticipated that contact with blood or other potentially infectious materials, mucous membranes, and non-intact skin will occur, wear gloves.

1. Hands should be decontaminated before donning sterile gloves.
2. Gloves should be removed and hands washed when procedure task is completed.
3. Change gloves during patient care if moving from a contaminated body site to a clean body site.

IV. PROCEDURE:

The procedures that shall be used in the implementation of this policy may be found in Appendix "A" attached.

REFERENCES/BIBLIOGRAPHY:

42 Code of Federal Regulations (C.F.R.) §416.50(b).

American Association for Accreditation of Ambulatory Surgery Facilities §200.055.050

American Association for Accreditation of Ambulatory Surgery Facilities §200.055.060.

Guideline for Hand Hygiene in Health-Care Settings, Recommendations of the Healthcare Infection Control Practices Advisory Committee and the HICPAC/SHEA/APIC/IDSA Hand Hygiene Task Force. CDC Morbidity and Mortality Weekly Report, Vol. 51. October 25, 2002.

OFFICE OF PRIMARY RESPONSIBILITY:

The Ambulatory Surgical Center (ASC) at LBJ

REVIEW/REVISION HISTORY:

Effective Date	Version # (If Applicable)	Review/ Revision Date (Indicate Reviewed or Revised)	Approved by:
06/14/2016	1.0	06/14/2016	The Ambulatory Surgical Center (ASC) at LBJ Governing Body
		Review / Approved 03/29/2018	The Ambulatory Surgical Center (ASC) at LBJ Governing Body
		Revised / Approved 02/14/2019	The Ambulatory Surgical Center (ASC) at LBJ Governing Body
		Reviewed / Approved 02/13/2020	The Ambulatory Surgical Center (ASC) at LBJ Governing Body

ATTACHMENT A

A. ***Hand Hygiene Techniques: Soap and Water:***

1. *Turn on Water:* Keep water running continuously throughout hand washing procedure. Adjust water temperature comfortable to hands. Extremely hot or cold water tends to dry skin.
2. *Wet Hands and Wrists with Water:* If long sleeves are worn, raise sleeves before washing hands. Hold hands down toward sink. Water should drain from wrists to finger tips to carry away bacteria.
3. Apply sufficient amount of liquid soap or antiseptic agent sufficient to form a good lather and thoroughly distribute over hands.
4. Wash palms, wrists, and the back of each hand. Interlace hands, rub and massage in a rotary (circular) motion. Vigorously rub hands together for ~~fifteen~~ twenty (20~~15~~) seconds covering all surfaces of the hands and fingers.
5. Hold hands slanted downward and rinse well under running water. Running water should flow from wrists down to fingers, thus carrying suds and germs down the drain.
6. Dry wrists then hands with paper towel, and turn off faucets with paper towel, and discard towels in wastebasket. Use of paper towels prevents contamination of clean hands by touching of faucet. All faucets must be considered contaminated.
7. Paper towels should be within easy reach of sink, but beyond splash contamination.
8. Lever-operated towel dispensers should be activated before beginning hand washing.

B. ***Hand Hygiene Techniques: Waterless Product:***

1. Apply product to palm of one hand; and
2. Interlace hands and rub hands together covering all surfaces of hands and fingers until hands are dry.

C. ***Hand Hygiene Technique: Surgical Hand Scrub:***

The ASC will follow the procedure and guidelines set forth by the Association of Perioperative Nurses (AORN) for surgical hand scrub for ORs and special procedure areas within the ASC performing diagnostic/invasive/ procedures, available at:

~~http://www.aornstandards.org/content/1/SEC6.body?sid=5a03ed28-2095-479a-b026-a70067de9358~~AORN eGuidelines +

Field Code Changed

ATTACHMENT B

A. *Hand Hygiene Observations at the ASC*

1. The ASC at LBJ will maintain ~~3 S~~ecret ~~s~~Shoppers (SS) and Just –in-Time-coaches (JITC) ~~(SS) with one rotating out every three months.~~
2. ~~Once SS is selected, their initial obligation is for six months. Once their first six month tour is complete, they will need to speak with Quality Manager or their NCM if they no longer wish to continue as an SS.~~
3. ~~2.~~ The expectation of each SS is to document ~~at least thirty~~ observations; totaling a combined number of 40 per month for the ASC. Half of these must be completed by the fifteenth of the month before close of business and the rest before the twenty fifth of the month before close of business.
4. ~~3.~~ There will also be ~~four~~ Just-in-Time coaches who will be responsible for documenting ~~ten~~ 15 observations per month before the last day of the month. These coaches will give feedback to staff and providers noted to be in violation of our hand hygiene policy.


Your 5 moments for
HAND HYGIENE
1 BEFORE PATIENT CONTACT
2 BEFORE ASEPTIC TASK
3 AFTER BODY FLUID EXPOSURE RISK
4 AFTER PATIENT CONTACT
5 AFTER CONTACT WITH PATIENT SURROUNDINGS


5 Moments for Hand Hygiene
1
Before Patient Contact
WHEN? Clean your hands before touching a patient.
EXAMPLES: Pre-Surgical Assessment, helping patients to transfer, bagging personnel items, and assisting patients in getting undressed.
2
Before an Aseptic Task
WHEN? Clean hands before and after an aseptic task.
EXAMPLES: Starting of an IV, taking a tissue sample, drawing blood, catheter placement, medication administration, helping with a procedure and skin preparation.
3
After Body Fluid Exposure Risk
WHEN? Clean your hands immediately after an exposure to a bodily fluid and after removing gloves.
EXAMPLES: After contact with any bodily fluids to include urine, saliva, sputum, feces, blood, etc.
4
After Patient Contact
WHEN? Clean your hands after any patient contact.
EXAMPLES: Patient transfers, post operative vital signs, assisting patients with urinals/bedpans, and checking post operative wounds.
5
After Contact with Patient Surroundings
WHEN? Clean your hands after you have had contact with a surface that a patient may have touched.
EXAMPLES: After cleaning up a recovery bed, picking up cups or food trays, handling of catheter or IV lines, and getting the patient dressed.

TITLE: PERSONAL PROTECTIVE EQUIPMENT

PURPOSE: To establish guidelines to follow to protect the workforce members of the Ambulatory Surgical Center (ASC) from exposure to or contact with infectious organisms or agents.

POLICY STATEMENT:

It is the policy of the Ambulatory Surgical Center (ASC) at LBJ to assume that every person is potentially infected or colonized with an organism that could be transmitted and that all members of the ASC's workforce wear personal protective equipment to lower the risk of exposure or contact with those infectious organisms or agents.

POLICY ELABORATIONS:

I. DEFINITIONS:

A. PERSONAL PROTECTIVE EQUIPMENT (PPE): A variety of barriers used alone or in combination to protect mucous membranes, skin, and clothing from contact with infectious agents or organisms. PPE includes gloves, masks, respirators, goggles, face shields, and gowns.

B. STANDARD PRECAUTIONS: A group of Infection Prevention Practices that apply to all patients, regardless of suspected or confirmed diagnosis or presumed infection status. Standard Precautions is based on the principle that all blood, body fluids, secretions, excretions except sweat, non-intact skin, and mucous membranes may contain transmissible infectious agents. Standard Precautions includes, but is not limited to, the use of gloves, gown, mask, eye protection, or face shield.

C. TRANSMISSION-BASED PRECAUTIONS:

a. Transmission-Based Precautions are used when the routes of transmission are not completely interrupted using Standard Precautions alone. There are three categories of Transmission-Based Precautions:
   i. Contact Precautions;
   ii. Droplet Precautions; and
   iii. Airborne Precautions.

b. They may be combined together for diseases that have multiple routes of transmission. When used either singularly or in combination, they are to be used in addition to Standard Precautions.

D. **WORKFORCE**: The employees, medical staff, trainees, contractors, volunteers, and vendors.

II. GENERAL PROVISIONS:

A. Standard Precautions: This presumes that all body substances may carry infectious agents. PPE appropriate to the potential exposure should be worn. PPE may not be worn in hallways or at nursing stations.

B. Contact Transmission Precautions: Contact Transmission Precautions are based on direct contact with an infected patient or contact with a contaminated environment. Gowns and gloves should be work to protect Workforce members against contact with bodily fluids or contaminated surfaces.

C. Droplet: Droplet Transmission Precautions are based on an infectious agent being transmitted from droplets that can reach respiratory tracts of a susceptible host. The following Droplet Transmission Precautions must be taken:

1. A surgical face mask must be work within 3-6 feet of an individual with a respiratory infection; and
2. A gown and gloves should be worn if the Workforce member is touching surfaces where droplets may have landed.

D. Airborne: Airborne Transmission occurs by the dissemination of small particles that can remain suspended in the air for considerable amounts of time. Therefore, N95 Respirators are required to be worn by ASC Workforce members if necessary to protect against Airborne Transmission.

E. Any visibly or knowingly contaminated protective equipment will be cleaned or discarded, if disposable, immediately after use.

III. PROCEDURES:

Please see Appendix "C" for procedures to follow regarding Personal Protective Equipment.

REFERENCES/BIBLIOGRAPHY:

American Association for Accreditation of Ambulatory Surgery Facilities §800.060.030
42 Code of Federal Regulations (C.F.R.) §416.51.

OFFICE OF PRIMARY RESPONSIBILITY:

The Ambulatory Surgical Center (ASC) at LBJ

REVIEW/REVISION HISTORY:

Effective Date	Version # (If Applicable)	Review/ Revision Date (Indicate Reviewed or Revised)	Approved by:
6/14/16	1.0		The Ambulatory Surgical Center (ASC) at LBJ Governing Body
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		Revised / Approved 02/14/2019	The Ambulatory Surgical Center (ASC) at LBJ Governing Body
		Reviewed / Approved 02/13/2020	The Ambulatory Surgical Center (ASC) at LBJ Governing Body
		Revised / Approved 02/25/2021	The Ambulatory Surgical Center (ASC) at LBJ Governing Body

ATTACHMENT "C"

1. ***Gloves:***

a. Disposable latex, nitrile, or vinyl gloves are available for use in the ASC. The gloves are not puncture-resistant; nor are the gloves one-hundred percent protective against infectious agents or organisms.
b. Gloves must be replaced as soon as practical when contaminated (at a minimum, after each patient). Torn or punctured gloves must be replaced as soon as feasible. Gloves must be removed prior to leaving the treatment area.
c. Gloves may not be washed for reuse.
d. Grossly contaminated gloves will be discarded appropriately.
e. Gloves must be used in the following circumstances:
   i. During all surgical procedures;
   ii. If a Workforce member's skin is cut, abraded or chapped;
   iii. During an exam of a patient's mouth, oropharynx, gastrointestinal tract, or genitourinary tract;
   iv. While examining abraded or non-intact skin or patients with active bleeding;
   v. During invasive procedures;
   vi. When performing phlebotomy, processing and/or testing blood, preparing pathology specimens, or other potentially infectious specimens; and
   vii. During housekeeping and decontaminating procedures.

2. ***Eyewear:***

a. Protective eyewear includes goggles, face shields, or glasses with solid side shields.
b. Protective eyewear must be worn when a procedure or surgery presents a danger of splashing or if a manufacturer recommends that protective eyewear be worn when using their product.
c. Protective eyewear must be removed prior to exiting the treatment area. Goggles and face shields will be cleaned and decontaminated after each use or disposed of properly, if disposable.

3. ***Masks:***

a. Masks should be used when indicated and disposed of properly after use.

b. Contaminated masks will be replaced immediately or as soon as feasible. Contaminated masks must be disposed of properly.

4. ***Gowns, Aprons, Lab Coats:***

a. Gowns are worn to protect clothing and the arm and neck areas of Workforce members from contamination.
b. Gowns may be worn until soiled, damaged, or made wet, at which time they must be immediately removed and replaced.
c. Protective laboratory coats, gowns, and aprons must be removed and replaced when they become visibly damaged or contaminated.

5. ***Donning and Removing Personal Protective Equipment:***

a. ***Donning:*** The following order will be followed when donning PPE:
   i. Gown;
   ii. Mask;
   iii. Goggles/face shield;
   iv. Gloves

b. ***Removing:*** The following order will be followed when removing PPE:
   i. Gloves;
   ii. Goggles/face shield;
   iii. Gown;
   iv. Mask.

TITLE: STANDARD AND TRANSMISSION BASED PRECAUTIONS

PURPOSE: To prevent the transmission of healthcare associated or community acquired organisms and/or infections to patients, visitors, and members of the Ambulatory Surgical Center at LBJ's workforce.

POLICY STATEMENT:

It is the policy of the Ambulatory Surgical Center (ASC) at LBJ ("ASC") that every person is potentially infected or colonized with an organism that could be transmitted in the healthcare setting.

POLICY ELABORATIONS:

I. DEFINITIONS:

A. **AIRBORNE INFECTION ISOLATION ROOM (AIIR):** Formerly, negative pressure isolation room, an AIIR is a single-occupancy patient-care room used to isolate persons with a suspected or confirmed airborne infectious disease. AIIRs should provide negative pressure in the room so that air flows under the door gap into the room; and an air flow rate of 6-12 ACH and direct exhaust of the air from the room to the outside of the building or recirculation of air through a HEPA (high-efficiency particulate air) filter before returning to circulation.

B. **COHORTING**: Applies to the practice of grouping patients infected or colonized with the same infectious agent together to confine their care to one area and prevent contact with susceptible patients. Cohorting patients during outbreaks, Workforce members may be assigned to a cohort of patients to further limit opportunities for transmission to Cohorting staff.

C. **MULTI-DRUG RESISTANT ORGANISM (MDRO)**: In general, bacteria, excluding M. Tuberculosis, that are resistant to one or more classes of antimicrobial agents and usually are resistant to all but one or two commercially available antimicrobial agents e.g, MRSA, VRE, Extended Spectrum Beta-Lactamse (ESBL) producing or intrinsically resistant gram negative bacilli, or Carbapenem Resistant Enterobacteriacae (CRE). In addition, organisms of clinical significance or that have special virulent properties such as *Clostridium difficile* will be considered in the same fashion.

D. **OTHER POTENTIAL INFECTIOUS ORGANISMS**: Human body fluids shall be treated as if they are known to be infectious for blood borne pathogens. These fluids include, but are not limited to:

a. Amniotic Fluid;
b. Pleural Fluid;
c. Blood;
d. Saliva (in dental procedures);
e. Cerebrospinal Fluid;
f. Semen;
g. Pericardial Fluid;
h. Synovial Fluid;
i. Peritoneal Fluid; and
j. Vaginal Secretions.

E. **PERSONAL PROTECTIVE EQUIPMENT (PPE)**: A variety of barriers used alone or in combination to protect mucous membranes, skin, and clothing from contact with infectious agents. PPE includes gloves, masks, respirators, goggles, face shields, and gowns.

F. **QUALIFIED LICENSE PRACTITIONER (QLP)**: Any individual permitted by law and by the ASC to provide care and services, without relevant direction or supervision within the scope of the individual's license and consistent with individually granted clinical privileges.

G. **REGULATED MEDICAL WASTE**:

a. A liquid or semi-liquid blood or Other Potentially Infectious Material (OPIM); contaminated items that would release blood in a liquid or semi-liquid state if compressed;
b. Items that are caked with dried blood or OPIM and are capable of releasing these materials during handling; contaminated sharps; and pathological and microbial wastes containing blood or other potentially infectious materials.

H. **RESPIRATORY HYGIENE/COUGH ETIQUETTE**: A combination of measures designed to minimize the transmission of respiratory pathogens via droplet or airborne routes in healthcare settings.

I. **STANDARD PRECAUTIONS**: A group of infection prevention practices that apply to all patients, regardless of suspected or confirmed diagnosis or presumed infection status. Standard Precautions are based on the principle that all blood, body fluids, secretions, excretions except sweat, non-intact skin, and mucous membranes may contain transmissible infectious agents. Standard Precautions includes hand hygiene, and depending on anticipated exposure, the use of gloves, gowns, masks, eye protection, or face shields.

J. **TRANSMISSION-BASED PRECAUTIONS**:

a. Transmission-Based Precautions are used when the routes of transmission are not completely interrupted using Standard Precautions alone. There are three categories of Transmission-Based Precautions:
   i. Contact Precautions;
   ii. Droplet Precautions; and
   iii. Airborne Precautions.

b. They may be combined together for diseases that have multiple routes of transmission. When used either singularly or in combination, they are to be used in addition to Standard Precautions.

K. **WORKFORCE:** Employees, Medical Staff, trainees, contractors, volunteers, and vendors.

II. GENERAL PROVISIONS:

A. It is safer to "Over-Isolate" than to "Under-Isolate." If there is a question regarding isolation, then the more stringent Isolation Precaution should be used in until a definitive diagnosis is confirmed.

B. All QLPs, nurses, students, etc., are responsible for complying with Isolation Precautions.

C. Education and training on preventing transmission of infectious agents associated with healthcare will be provided during orientation to the ASC and thereafter, annually.

D. Identification of MDROs:

1. The ASC's pre-procedure screening clinic will aid in the coordination of patient care by identifying patients with MDROs so that those patients receive the appropriate level of care, i.e. care at either Lyndon B. Johnson Hospital or Ben Taub General Hospital.

2. Harris Health System's Laboratory will alert infection prevention and the nursing of a MDRO laboratory result pursuant to the Letter of Agreement between Harris Health System and the ASC.

3. Nursing will initiate the appropriate isolation immediately.

4. The patient will be placed in the isolation room. The appropriate signage must be placed on the isolation room door and the isolation type should be entered into the patient's medical record.

E. Categories of Standard and Transmission-Based Precautions:

1. Standard Precautions: This presumes that all body substances may carry infectious agents. PPE appropriate to the potential exposure should be worn. PPE may not be worn in hallways, nursing stations, other areas outside of the ASC, or in isolation rooms, when applicable.

2. Contact Transmission Precautions: These precautions are based on direct contact with an infected patient or contact with a contaminated environment. Gowns and gloves should be worn by ASC QLP or other personnel to protect against contact with body fluids or contaminated surfaces.

3. Droplet: Droplet Transmission Precautions are based on an infectious agent being transmitted from droplets that can reach the respiratory tract of a susceptible host; and

   i. Surgical face masks must be worn within 3-6 feet of an individual with a respiratory infection;
   ii. Gowns and gloves should be worn if Workforce members or QLPs are touching surfaces where droplets may have landed.

4. Airborne Precautions: Airborne transmission occurs by the dissemination of small particles that can remain suspended in the air for considerable time. N95 Respirators are required to be worn by Workforce members and QLPs as an Airborne Precaution.

F. Workforce members will instruct visitors about precautions to be taken while visiting patients in the isolation room. PPE must be worn by all visitors in the isolation room.

Patients having the same pathogen may be cohorted in the absence of private rooms.

III. GUIDELINES FOR ISOLATION OF PATIENTS WITH MULTI-DRUG RESISTANT ORGANISMS:

A. Patients colonized or infected with any identified MDRO must be initially placed in the ASC isolation room. Appropriate signage must be placed on the door of the isolation room to alert Workforce members.

B. After the MDRO has been identified, the following steps will be followed:

1. TB Infection:
   i. If a patient has TB, that patient will remain in the ASC isolation room. The patient's surgery/procedure at the ASC will be cancelled.
2. Other MDROs:
   i. If a patient has another MDRO (e.g., MRSA, VRE, VIRE), the ASC Medical Director and Administrator and Infection Prevention Manager in consultation with the surgeon will make a determination as to whether that patient's scheduled surgery/procedure may continue as scheduled and what precautions, if any, need to be taken.

IV. MANAGEMENT OF THE ENVIRONMENT:

A. Environmental Services: All trash, linen, and cleaning of rooms in the ASC are the same for all patients regardless of whether that patient has been in the isolation room. Privacy curtains must be changed at the patient's discharge.

B. Patient Care Equipment: When possible, equipment should be dedicated. If common equipment is unavoidable, then that equipment must be cleaned and disinfected after each use with an ASC approved product.

C. Patient Supplies: Supplies that are kept in the isolation room should be kept to a minimum and any leftover supplies from the isolation room should be discarded when the patient is discharged.

V. SPECIAL CONSIDERATIONS:

A. Surgery and Procedure Rooms: In the event that patients with a communicable disease are scheduled for surgery at the ASC and who are placed in the ASC isolation room, those patient's surgeries and/or procedures should be done as the last case of the day with a terminal clean being completed after the procedure concludes. If it is not possible to perform this surgery as the last case of the day, then a terminal clean must be performed on the operating room before the next surgery is performed.

B. Guest Transportation: Patients transported outside of the ASC must be transported with appropriate barriers in place, such as surgical masks on patients with a respiratory illness. Workforce members must wear appropriate PPE during the transport.

REFERENCES/BIBLIOGRAPHY:

APIC Text On-Line, Chapter 29 Isolation Precautions-Recommendations.

Siegel JD, Rhinehart E, Jackson M, Chiarello L, and the Healthcare Infection Control Practices Advisory Committee, 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings.

42 Code of Federal Regulations (C.F.R.)§ 416.51.

OFFICE OF PRIMARY RESPONSIBILITY:

The Ambulatory Surgical Center (ASC) at LBJ

REVIEW/REVISION HISTORY:

Effective Date	Version # (If Applicable)	Review/ Revision Date (Indicate Reviewed or Revised)	Approved by:
6/14/16	1.0		The Ambulatory Surgical Center (ASC) at LBJ Governing Body
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		Revised / Approved 02/25/2021	The Ambulatory Surgical Center (ASC) at LBJ Governing Body

TITLE: VACCINE PREVENTABLE DISEASE POLICY

PURPOSE: To reduce the transmission of infectious and communicable diseases.

POLICY STATEMENT:

The Ambulatory Surgical Center (ASC) at LBJ strives to protect the health and safety of its workforce, visitors, patients, patient and employee family members, and the community as a whole against the transmission of infectious and communicable diseases.

All individuals providing patient care and/or services or having direct patient contact in the ASC must utilize all appropriate measures to prevent the spread of infectious and communicable diseases through vaccination; by utilizing personal protective equipment, if applicable; or by utilizing a combination of these controls, where appropriate.

POLICY ELABORATIONS:

This policy is intended to protect patients, employees, visitors, and others affiliated with the ASC from the spread of vaccine preventable diseases. The goal is to maximize vaccination rates against vaccine preventable diseases among Workforce members.

I. DEFINITIONS:

A. **PATIENT**: Any individual undergoing medical assessment or active treatment at the ASC.

B. **PATIENT CARE OR CLINICAL CARE AREA**: Includes the physical or recognized borders of the ASC where patients may be seen, evaluated, treated, or waited to be seen.

C. **PUBLIC HEALTH DISASTER**: A declaration by the governor of a state of disaster and a determination by the commissioner that there exists an immediate threat from a communicable disease that: (i) poses a high risk of death or serious long-term disability to a large number of people and (ii) creates a substantial risk of public exposure because of the diseases high level of contagion or the method by which the disease is transmitted.

D. **QUALIFIED EXEMPTION**: Immunity from the imposed immunization requirements based on medical or religious reasons that have been approved by Harris Health System's Human Resources department for members of the ASC

workforce who are not part of the medical staff and by Medical Staff Services for members of the ASC Medical Staff.

E. **VACCINE PREVENTABLE DISEASES**: The diseases included in the most current recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

F. **WORKFORCE:** The members of the governing body of the Ambulatory Surgical Center (ASC) at LBJ, employees, medical staff, trainees, contractors, volunteers, and vendors.

II. GENERAL PROVISIONS:

A. As a condition of employment, appointment to the medical staff, or access to provide patient care and/or services covered by this policy, as appropriate to each covered person's circumstances and in accordance with patient safety standards, all Workforce members are required to have vaccinations for the following Vaccine Preventable Diseases, have proof of immunity, or obtain a Qualified Exemption for the Vaccine Preventable Disease(s):

1. Hepatitis B;
2. Influenza (received annually);
3. Measles;
4. Mumps;
5. Rubella;
6. Pertussis;
7. Varicella; and
8. Neisseria Meningitdis (Meningococcal).

B. Persons born prior to 1957 are considered immune for Measles, Mumps, and Rubella and are not required to have these immunizations.

III. PROCEDURES:

A. Harris Health System (Harris Health) Employee Health Services (EHS) may offer immunizations, and when appropriate, provide antibody or serologic testing to Workforce members at no cost, per the Letter of Agreement between Harris Health System and the ASC. EHS shall inform Workforce members about the following:

1. Requirements for vaccinations;
2. Procedures for receiving vaccination, including completion of the appropriate vaccine consent form;
3. Procedures for submitting written proof of vaccination(s) obtained outside of the EHS;
4. Procedures for declining vaccination(s) due to a Qualified Exemption; and
5. Effects of declining vaccination(s).

B. All Workforce members must:

1. Receive appropriate vaccination(s), when applicable;
2. Provide EHS with written proof of vaccination or immunity from vaccination for each of the Vaccine Preventable Diseases listed above if obtained from the Workforce member's physician, another health care facility, or other vaccination services available in the community. Acceptable proof of vaccination includes a physician note or immunization record, which includes date of vaccination and lot number, if available. Proof of vaccination must include the date of the vaccination; or
3. Obtain a Qualified Exemption.
4. Note: Workforce members are required to be immunized against influenza each year unless a specific exemption is requested and approved by the ASC. Proof of immunization of influenza obtained outside of Harris Health's EHS must be provided to the Harris Health's EHS on an annual basis.

IV. QUALIFIED EXEMPTIONS:

A. Medical Exemptions: Medical exemptions for required immunizations may be provided for certain conditions identified as medical contraindications or precautions by the most current recommendations of the Centers for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practices (AICP).

1. Workforce members requesting a medical exemption because of medical contraindications must complete and submit to Harris Health's EHS within thirty (30) days of being notified of the required vaccination, the appropriate Request for Medical Exemption form.

2. The Request for Medical Exemption form must include an original signature, the date signed, and be completed by the Workforce member's private physician attesting to the medical contraindications.
3. If a medical exemption is provided for a temporary condition, the Workforce member must complete and submit the appropriate Request for Medical Exemption form annually.
4. If a medical exemption is provided for a permanent condition, a subsequent Request for Medical Exemption form need only be completed and submitted if vaccine technology changes eliminating the contraindication on which the medical exemption is based.
5. If a medical exemption request is denied for incompleteness, the Workforce member will be notified of the denial, including the basis for the denial, and will be required to be immunized pursuant to this policy unless the Workforce member resubmits a fully completed Request for Medical Exemption form.

B. Religious Exemptions:

1. If a Workforce member declines a vaccination because it conflicts with the Workforce member's religious beliefs, the Workforce member must complete and submit a Request for Religious Exemption form to Harris Health's Human Resources Department within thirty (30) days of being notified of the required vaccination.
2. The Request for Religious Exemption form must include an original signature, the date signed, and be completed by the Workforce member's clergy.
3. A request for religious exemption will be evaluated on a case-by-case basis by Harris Health's Human Resources Department, per the Letter of Agreement between Harris Health and the ASC, within twenty (20) business days of receipt of the request.
4. The Workforce member requesting the religious exemption will be notified in writing as to whether his or her request for a religious exemption has been granted. If a religious exemption request is denied, the Workforce member will be notified of the denial, including a basis for the denial, and will be required to be immunized pursuant to this policy.

C. The ASC shall not discriminate or retaliate against a Workforce member who is medically exempt from the required immunizations for Vaccine Preventable Diseases.

V. INFECTION CONTROL PROCEDURES:

A. All Workforce members are responsible for monitoring their health status and reporting to work only when they are not in a status that would put others at risk of contracting an infection, whether viral or bacterial.

B. All Workforce members are responsible for performing appropriate infection control standards to prevent risk to others and themselves. This includes, but is not limited to, frequent hand washing, masking, covering coughs, and sneezing, disinfecting equipment and work stations, and not reporting to work when ill.

VI. NON-VACCINATED WORKFORCE MEMBERS:

A. Seasonal flu activity can start as early as October and end as late as May. Proof of flu vaccination or exemption will be obtained from October 1st to November 15th. All Workforce members granted an exemption for the influenza vaccination must wear a surgical mask at all times while unvaccinated and while in any ASC patient care or clinical care areas from November 16th of each year through March 31st of the following calendar year. These dates may be modified depending on the circulation of influenza in the community.

B. Workforce members who do not receive vaccination for Measles, Mumps, Rubella, or Varicella will not be allowed to work with high-risk patients.

1. Workforce members who do not receive vaccinations for Measles, Mumps, Rubella, or Varicella will be relieved of their work duties and will be denied access to patient care or clinical care areas should an exposure occur outside or inside the ASC setting.

C. The time of any Workforce member relieved of work duties as set forth herein shall be handled in accordance with the Harris Health System Paid Time Off (PTO) Policy No. 6.03.

VII. COMPLIANCE:

A. Any Harris Health Workforce member who fails to comply with the requirements of this policy may be suspended without pay until the Workforce member complies. If the Workforce member fails to comply with the requirements of this policy after thirty (30) days, the Workforce member may be terminated.

B. Any ASC Medical Staff member who fails to comply with the requirements of this policy shall not be permitted to enter patient care or clinical care areas of the ASC.

VIII. RESPONSIBILITIES:

A. Per the Letter of Agreement between Harris Health and the ASC, Harris Health's EHS shall:

a. Administer and track vaccinations of Workforce members;
b. Accept and review requests for medical exemptions of Workforce members;
c. Notify Harris Health's Human Resources Department of Workforce members receiving medical exemptions;
d. Notify Workforce members who require vaccination through the ASC Administrator;
e. Review the Workforce member's vaccination statuses, immunity statuses, and Qualified Exemptions annually and report annually to the ASC Infection Prevention Manager and to Harris Health's Human Resources Department of non-compliant Workforce members;
f. Evaluate organizational Workforce member vaccination rates and frequency and reasons for vaccine declinations;
g. Establish vaccination requirements; and
h. Maintain written or electronic records of vaccinations, proof of vaccinations, and medical exemptions for all of the Workforce members.

B. Per the Letter of Agreement between Harris Health and the ASC, Harris Health's Human Resources Department shall:

a. Accept, evaluate, and approve requests for religious exemptions of Workforce members;
b. Coordinate with the ASC Administrator disciplinary procedures for Workforce members who do not comply with this policy; and
c. Maintain written or electronic records of religious exemptions for all Workforce members.

C. Medical Staff Services shall:

a. Ensure compliance with this policy by the ASC Medical Staff.

b. Evaluate annually vaccination rates and frequency and reasons for vaccine declinations of the ASC Medical Staff.
c. Review documentation annually of vaccination status, immunity status, and Qualified Exemptions for all ASC Medical Staff.
d. Initiate disciplinary procedures for ASC Medical Staff members who do not comply with this policy.
e. Maintain written or electronic records of vaccinations, proof of vaccinations, and religious and medical exemptions for all ASC Medical Staff.

D. Per the Letter of Agreement between Harris Health and the ASC, Harris Health's Materials Management shall:

a. Ensure compliance with this policy by vendor and supplier representatives;
b. Evaluate annually vendor and supplier representative's vaccination rates and frequency and reasons for vaccine declinations;
c. Review documentation annually of vaccination status, immunity status, and Qualified Exemptions for all vendor and supplier representatives;
d. Initiate disciplinary procedures for vendor and supplier representatives who do not comply with this policy; and
e. Maintain written or electronic records of vaccinations, proof of vaccinations, and religious and medical exemptions for all vendor and supplier representatives through the vendor credentialing system.

IX VACCINE SHORTAGE CONTINGENCY:

A. In the event of a vaccine shortage, the ASC Infection Prevention Manager, Harris Health EHS, and Harris Health's pharmacy department will determine an appropriate distribution plan for the resources available. Required vaccinations will be offered to Workforce members based on job function and risk of exposure to the Vaccine Preventable Diseases.

B. Priority for vaccinations will be given to Workforce who:

1. Provide direct patient care with prolonged face-to-face contact with patients;
2. Care for patients with high risk for complications from a Vaccine Preventable Disease;

3. Have the highest risk of exposure to patients with a Vaccine Preventable Disease; or
4. Are at high-risk for complications from a Vaccine Preventable Disease.

C. Workforce members who meet the requirements for priority for vaccinations during a vaccine shortage shall comply with the provisions of this policy.

D. Workforce members who are not given priority for vaccinations during a vaccine shortage will be required to follow procedures for non-vaccinated Workforce members under Section VI above.

X. PUBLIC HEALTH DISASTER:

In the event of a Public Disaster, Workforce members deemed non-immune or exempt from vaccination for a Vaccine Preventable Disease may not provide direct patient care or work in a patient care or clinical care area of the ASC and will be relieved of their work duties and/or denied access to patient care or clinical care areas. The time of any Workforce member relieved of work duties set forth herein shall be handled in accordance with the Harris Health System Paid Time Off (PTO) Policy No. 6.03.

REFERENCES/BIBLIOGRAPHY:

42 Code of Federal Regulations (C.F.R.) §416.51(b).

American Association for Accreditation of Ambulatory Surgery Facilities §200.055

Tex. Health & Safety Code Ann. §81.003(7).

Tex. Health & Safety Code Ann. §224.002.

Center for Disease Control and Prevention, Morbidity and Mortality Weekly Report, "*Immunization of Health-Care Personnel Recommendations of the Advisory Committee on Immunization Practices (ACIP),"* Vol. 60/No.7, November 25, 2011.

OFFICE OF PRIMARY RESPONSIBILITY:

The Ambulatory Surgical Center (ASC) at LBJ

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APPENDIX 1:
WORKFORCE MEMBERS and ASC Medical Staff

Workforce members and ASC Medical Staff may include, but are not limited to, any of the following:

1. Individuals who primarily serve in a clinical support role and most often receive patients or provide equipment for patient use in the next site of care. Their role requires them to often work in patient care areas and/or provide assistance to or consult with patient care staff.
2. Individuals who serve primarily in a technical support role or product and service sales role. They may provide technical assistance, may occasionally assist with operation of equipment and be in a patient care environment that is not defined as a restricted or sterile area. Their role requires them to often work in patient care areas where other visitors may be present and/or provide assistance to or consult with patient care staff.
    a. This includes vendor and supplier sales representatives that interact with care providers for the purpose of sales, education, and technical support.
    b. Examples may include: DME providers, medical device sales, and pharmacy representatives, representatives calling on departments such as laboratory and radiology, and diagnostic representatives.
3. Individuals who serve primarily in a clinical support or product sales/service role while attending or observing patient procedures. These individuals often provide technical information and serve as a resource for the medical professional by responding to questions regarding the appropriate operation of their medical equipment.
4. Physicians, nurses, nursing assistants, therapists, technicians, emergency medical service personnel, dental personnel, pharmacists, and persons having direct patient contact who may be potentially exposed to infectious agents that can be transmitted to and from patients and others.
5. Examples of non-clinical personnel who may provide services in a patient care or clinical area include, but are not limited to:
    a. Patient Relations & Interpretation Services personnel;
    b. Facilities Management Personnel;
    c. Sterile Processing and Material Services technicians;
    d. Vendor's; and
    e. Environmental Services personnel;

APPENDIX 2:
EXAMPLES OF PATIENT CARE OR CLINICAL CARE AREAS

1. Admissions and Registration;
2. Patient rooms/cubicles;
3. Patient exam rooms/areas;
4. Hallways of the ASC where patients are located;
5. Nursing stations;
6. Procedural/operating rooms and areas;
7. Hallways connecting waiting areas and exam areas or those connecting clinical areas; and
8. Waiting areas.

TITLE: SAFE HANDLING OF NEEDLES AND SHARPS

PURPOSE: To establish procedures for handling needles and sharps that reduces workforce member injuries and exposures to blood and body fluids.

POLICY STATEMENT:

The Ambulatory Surgical Center (ASC) at LBJ is committed to reducing the risk of infection to workforce members by safely handling needles and sharps.

POLICY ELABORATIONS:

I. DEFINITIONS:

A. **WORKFORCE:** Employees, medical staff, trainees, contractors, volunteers, and vendors.

II. GUIDELINES FOR PROPER HANDLING OF NEEDLES AND SHARPS

A. The following guidelines must be followed when handling needles and sharps in the ASC:

1. Disposable needles or sharps must be handled in a manner that will minimize the chance of a puncture, cut, or exposure to blood or bodily fluids.

2. Recapping should never be done by a two-handed method with a cap held in one hand and the needle inserted in the other hand. Rather, recapping should be done by following one of the following single-handed methods:

i. Hemostat Method – Use a hemostat to pick up the cap and recap the stationary needle. The cap may then be tightened with the fingers.

ii. Scoop Method – Place the cap on its side on a clean surface and carefully scoop it up with the needle. The cap may then be tightened with the fingers. The needle should always be considered contaminated by this procedure and should be replaced with a new sterile needle if needed.

iii. Device Assisted Method – Place the cap in the well of a device to hold it for the purpose of recapping.

3. Available engineered safety devices must be activated and used to minimize sharp injuries and reduce exposures to blood and bodily fluids.

4. Contaminated sharps and needles are disposed of immediately in a puncture proof container.

5. All needle disposal boxes are replaced when the boxes are three-fourths (3/4ths) full. Workforce members should never use their hand to push protruding needles or syringes back into the box.

6. Assistance should be obtained when starting an IV, giving an injection, or drawing blood from a patient that is uncooperative, combative or confused.

7. Plastic blood tubes, syringes, and capillary tubes should always be used instead of glass when available

8. Ensure that equipment necessary for performing a procedure is available and accessible.

9. If multiple sharps will be used during a procedure, organize the work area so that the sharp is always pointed away from the Workforce member using the sharp.

10. Identify the location of the sharps container. If the sharps container is movable, place it as near the point of use as appropriate for immediate disposal. If the sharp is reusable, determine in advance where it will be placed for safe handling after use.

11. Do not pass exposed sharps from one person to another. Instead use a predetermined neutral zone or tray for placing and retrieving used sharps.

B. Disposal of sharps and needles should be in accordance with the Sanitary Environment Protocol.

REFERENCES/BIBLIOGRAPHY:

42 Code of Federal Regulations (C.F.R.) §416.51(b).

OFFICE OF PRIMARY RESPONSIBILITY:

The Ambulatory Surgical Center (ASC) at LBJ

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TITLE: COMMUNICABLE DISEASE WORK RESTRICTIONS FOR WORKFORCE MEMBERS

PURPOSE: To provide guidance for work restrictions for Ambulatory Surgical Center (ASC) at LBJ workforce members with a communicable disease or special conditions.

POLICY STATEMENT:

Possible transmission of infection by an Ambulatory Surgical Center (ASC) at LBJ ("ASC") Workforce member poses a risk to patients, visitors, and other workforce members. The route of transmission and likelihood of transmission of infection varies with the specific agent and type of contact. As a result, Workforce members with a communicable disease or infection will be assessed for restrictions.

POLICY ELABORATIONS:

I. DEFINITIONS:

A. **Workforce:** The members of the governing body of the Ambulatory Surgical Center (ASC) at LBJ, employees, Medical Staff, trainees, contractors, volunteers, and vendors.

II. RESPONSIBILITY:

A. All Workforce members with a communicable disease should remain away from work until he or she is no longer contagious. Workforce members are responsible for notifying his or her supervisor if they are ill with a communicable disease. Supervisors are responsible for ensuring that Workforce members are compliant with work restrictions when appropriate.

B. Per the Letter of Agreement between Harris Health System (Harris Health) and the ASC, Harris Health's Employee Health Services is available for consultation when needed.

III. PROCEDURES:

A. Any Workforce members with a fever should stay home until he or she has no fever for twenty-four (24) hours without medication. See the table below for guidelines regarding when to stay home in the setting of an acute respiratory viral illness.

Symptoms	Stay At Home	Return to Work
FEVER • Fever (T38C or 100.4)	• T >38C or 100.4	• No fever for 24 hours(!)
RESPIRATORY SYMPTOMS WITHOUT FEVER • Cough • Sore throat • Nasal congestion / runny nose • Myalgia (body aches)	One or more symptoms on high risk units Two or more symptoms on all other units	• 24 hours after onset of symptoms AND • No fever AND • Symptoms have significantly improved
RESPIRATORY SYMPTOMS WITH FEVER (presumed Influenza) • Fever (T38C or 100.4F) • Cough • Sore throat • Nasal congestion/runny nose • Myalgia (body aches)	T> 38C or 100.4 and at least one symptom	No fever for 24 hours and symptoms have significantly improved

B. A Workforce member who provides patient care and who suspects or knows that he or she is infected with a potential communicable disease shall not engage in any activity that is known to be a risk to others in the ASC.

C. Workforce members who are linked epidemiologically to an increase in bacterial or viral infections caused by a pathogen associated with a carrier state may be

advised to provide samples for microbiology testing, and, if positive, be excluded from patient contact until carriage is eradicated or the risk of disease transmission is eliminated.

D. Workforce members who are infected with a potential communicable pathogen should report their condition to their supervisor. Work restrictions are determined on a case by case basis.

E. For selected conditions, medical clearance by Harris Health Employee Health Services is required prior to return to work. These conditions are set out in Attachment D.

REFERENCES/BIBLIOGRAPHY:

42 Code of Federal Regulations (C.F.R.) §416.51(b).

Bolyard, E.A., et al. The Hospital Infection Control Practices Advisory Committee (1998). *Guidelines for Infection Control in Health Care Personnel,* 1998. American Journal of Infection Control, 26(3), 289-354.

Infectious Disease Guidelines by Type of Infection (2003). Occupational Exposure and Health.

CDC Recommendations for the Amount of Time Persons with Influenza-Like Illness Should be Away from Others. (Oct. 23, 2009).

Henderson, O.K., et al., and the Society for Healthcare Epidemiology of America (2010). SHEA Guidelines for Management of Healthcare Workers Who are Infected with Hepatitis B Virus, Hepatitis C Virus, and/or Human Immunodeficiency Virus. Infection Control and Hospital Epidemiology, 31(3), 203-232.

Updated CDV Recommendations for the Management of Hepatitis B Virus-Infected Health Care Providers and Students. MMWR Recommendations and Reports. Vol. 61, No. 3 (July 6, 2012).

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ATTACHMENT "D"

Disease Problem	Work Restriction	Duration
Conjunctivitis	Restrict from patient contact with patient care environment	Until discharge ceases.
Cytomegalovirus	None	
Diarrhea, acute stage	Restrict from patient contact, contact with patient's environment, or food handling	Until symptoms resolve.
Diarrhea, convalescent stage, Salmonella	Restrict from care of high risk patients*	Until symptoms resolve.
Diphtheria	Exclude from duty	Until antimicrobial therapy concluded and 2 cultures obtained greater or equal to 24 hours apart are negative. **EHS clearance required.**
Enteroviral Infections	Restrict from care of infants, neonates, and immunocompromised patients and their environments	Until symptoms resolve.
Hepatitis A	Restrict from patient contact, contact with patient's environment, or food handling	Until 7 days after jaundice. **EHS clearance required.**
Hepatitis B, acute or chronic surface antigenemia personnel who do not perform exposure prone procedures**	None	**EHS clearance required.**
Hepatitis B, acute or chronic surface antigenemia personnel who perform exposure prone procedures	Expert Panel Review	Expert Panel Review. **EHS clearance required.**
Hepatitis C, personnel who do not perform exposure prone procedures	None	**EHS clearance required.**
Hepatitis C, personnel who perform exposure prone procedures	Expert Panel Review	Expert Panel Review. **EHS clearance required.**
Herpes Simplex, Genital	None	

Herpes Simplex, HADS (Herpetic Whitlow)	Restrict from patient contact and contact with patient care environment	Until lesions heal.
Herpes Simplex, Orofacial	Restrict from care of high risk patients*	Until lesions heal.
Human Immunodeficiency virus, personnel who do not perform exposure prone procedures	None	**EHS clearance required.**
Human Immunodeficiency virus, personnel who do perform exposure prone procedurs	Expert Panel Review	Expert Panel Review. **EHS clearance required.**
Influenza	Exclude from duty	24 hours after resolution of symptoms. **EHS clearance required.**
Measles, active	Exclude from duty	Until 7 days after rash appears.
Measles, post-exposure (susceptible person)	Exclude from duty	From the 5th day after 1st exposure through the 31st day after last exposure and/or 7 days after rash appears. **EHS clearance required.**
Meningococcal	Exclude from duty	Until 24 hours after start of effective therapy.
Mumps, active	Exclude from duty	Until 9 days after onset of parotitis. **EHS clearance required.**
Mumps, post-exposure (susceptible person)	Exclude from duty	From 12th day after 1st exposure through 26th day after last exposure or until 9 days after onset of parotitis. **EHS clearance required.**
Pediculosis (lice)	Restrict from patient contact	Until after one does of effective treatment.
Pertussis, active	Exclude from duty	Until 5 days after start of effective antimicrobial therapy.
Pertussis, post-exposure, asymptomatic	No restrictions, prophylaxis recommended	
Pertussis, post-exposure, symptomatic	Exclude from duty	Until 5 days after start of effective antimicrobial therapy.
Rubella, active	Exclude from duty	Until 5 days after rash appears.

Rubella, post-exposure (susceptible personnel)	Exclude from duty	From 7th day after 1st exposure through 21st day after last exposure. **EHS clearance required.**
Scabies	Restrict from patient contact	Until treated.
Skin lesions that cannot be covered precludes hand washing	Restrict from patient contact	
Staphylococcus aureus infection, active draining skin lesions	Restrict from patient contact with patent care environment or food handling	Until lesions have healed.
Staphylococcus aureus infection, carrier state	No restrictions unless personnel are epidemiologically linked to transmission of organism	
Streptococcal Infection, Group A	Exclude from duty	Until 24 hours after start of effective therapy.
Tuberculosis, active disease	Exclude from duty	Until proved noninfectious. **EHS clearance required.**
Tuberculosis, PPD converter	No restriction	
Varicella, active disease	Exclude from duty	Until all lesions dry and crust.
Varicella, post-exposure (susceptible personnel)	Exclude from duty	From 10th day after 1st exposure through 21st day (28th day if VZIG given after last exposure). **EHS clearance required.**
Zoster, localized in healthy person	Cover lesions; restrict from care of high risk patients*	Until all lesions dry and crust.
Zoster, generalized or localized in immunosuppressed person	Restrict from patient contact	Until all lesions dry and crust.
Zoster, post-exposure (susceptible person)	Restrict from patient contact	From 10th day after 1st exposure through 21st day (28hth day if VZIG given after last exposure). **EHS clearance required.**
Viral upper respiratory infection	Restrict from care of high risk patients*	Until 24 hours after symptoms resolve.

TITLE: COMMUNICABLE DISEASE EXPOSURE EVAULATION

PURPOSE: To prevent the acquisition and/or transfer of a communicable disease to a member of the workforce of the Ambulatory Surgical Center (ASC) at LBJ after exposure by outlining the process for evaluation post exposure.

POLICY STATEMENT:

Center for Disease Control guidelines will be followed for the evaluation and/or treatment of Ambulatory Surgical Center (ASC) at LBJ Workforce members after their occupational exposure to a known communicable disease.

POLICY ELABORATIONS:

I. DEFINITIONS:

A. **WORKFORCE**: The members of the governing body of the Ambulatory Surgical Center (ASC) at LBJ, employees, Medical Staff, trainees, contractors, volunteers, and vendors.

II. RESPONSIBILITIES AND PROCEDURES:

A. The ASC Infection Prevention Manager will be responsible for notifying Harris Health System's ("Harris Health") Employee Health Services of any potential Workforce member exposures related to communicable diseases for events that occur in the ASC. Per the Letter of Agreement between Harris Health and the ASC, Employee Health Services ("EHS") is responsible for contacting the Workforce members, evaluating Workforce members, and treating Workforce members with prophylaxis, if necessary.

B. Procedures:

1. Upon notification of a potential exposure, EHS will validate that the source case is a laboratory confirmed case. Non-laboratory confirmed communicable disease exposure cases will be evaluated on a case-by-case basis using CDC clinical case guidelines, EHS Medical Director review, or Harris Health's Chief of Infection Prevention review.

2. Depending upon the recommendations for the individual communicable disease, the EHS nurse will investigate potential Workforce member exposures. This investigation may include some or all of the following:
   i. Review of Workforce member records for the presence of vaccinations or antibody titers; and
   ii. Interviewing the Workforce member for the nature of exposure and the presence of any symptoms.

3. Depending upon the recommendations for the individual communicable disease, the EHS nurse will follow the order of the EHS Medical Director or Harris Health's Chief of Infection Prevention regarding vaccination, prophylaxis, diagnostic evaluation and treatment, or no additional intervention. Workforce members should be counseled appropriately regarding the exposure and his or her treatment.

4. Depending upon the recommendations for the individual communicable disease, the EHS nurse will consult with the EHS Medical Director to determine if the Workforce member should have any work restrictions or be excluded from duty. Workforce members excluded from duty cannot work in the ASC.

5. Workforce members excluded from duty by EHS for a confirmed occupational exposure will receive pay.

6. All Workforce members excluded from duty require clearance from EHS to return to work.

REFERENCES/BIBLIOGRAPHY:

42 Code of Federal Regulations (C.F.R.) §416.51(b).

Bolyard, E.A., et al., The Hospital Infection Control Practices Advisory Committee (1998).

American Journal of Infection Control, 26(3), 289-354.

OFFICE OF PRIMARY RESPONSIBILITY:

The Ambulatory Surgical Center (ASC) at LBJ

REVIEW/REVISION HISTORY:

Effective Date	Version # (If Applicable)	Review/ Revision Date (Indicate Reviewed or Revised)	Approved by:
6/14/16	1.0		The Ambulatory Surgical Center (ASC) at LBJ Governing Body
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		Reviewed / Approved 02/13/2020	The Ambulatory Surgical Center (ASC) at LBJ Governing Body
		Revised / Approved 02/25/2021	The Ambulatory Surgical Center (ASC) at LBJ Governing Body

TITLE: DETECTION AND MANAGEMENT OF OUTBREAKS

PURPOSE: To delineate the process to verify the existence of an outbreak and initiate infection control practices to interrupt the transmission of disease-causing agents.

POLICY STATEMENT:

The Ambulatory Surgical Center (ASC) at LBJ will use the processes and practices contained in this policy for the detection and management of outbreaks and the transmission of disease causing agents.

POLICY ELABORATIONS:

I. DEFINITIONS:

A. **OUTBREAK**: An excess over the expected level of disease within a specified period of time or in a geographic area, however one case of disease may constitute an outbreak.

B. **WORKFORCE**: Employees, Medical Staff, trainees, contractors, volunteers, and vendors.

II. CONDUCTING AN OUTBREAK INVESTIGATION

A. Initial Investigation: the following steps will be taken during the initial investigation of a possible outbreak:

1. Confirm the presence of an outbreak;
2. Alert key stakeholders about the investigation;
3. Perform a literature review;
4. Establish a preliminary case definition;
5. Develop a methodology for case finding;
6. Prepare an initial line list and epidemic curve;
7. Observe and review potentially implicated patient care activities;
8. Consider environmental sampling; and
9. Implement initial control measures.

B. Follow-up Investigation: the following steps will be taken during the follow-up investigation of an outbreak:
   1. Refine the case definition;
   2. Continue case finding and surveillance;
   3. Review regular control measures; and
   4. Perform an analytic study.

III. PROCEDURES:

A. Establish Diagnosis of Reported Cases:

   1. Develop specific criteria for definition of a case. Initially, this may be a broad definition which is refined as the investigation proceeds (e.g., diarrhea in pediatric patients);
   2. Write case definition that includes information regarding who, what, when, and where;
   3. Characterize the nature of the disease, including signs and symptoms, person, place, and time;
   4. Obtain laboratory specimens to identify specific causative agent;
   5. Develop an outbreak log-listing of patients, location, culture results, procedures, and clinical findings;
   6. Compare current incidence with usual or baseline incidents (calculate rates);
   7. Review existing data to determine if an on-going problem exists; and
   8. Document findings at each investigative step.

B. Institute Appropriate Early Control Measures:

   1. Control measures should be based on the magnitude and nature of the problem;
   2. List all patients in the ASC and their location before moving a single patient;
   3. Divide patients into two categories for isolation and bed assignments:
      i. Affected and probable affected; and
      ii. Exposed
   4. Designate an area for cohorting patients and staff; and
   5. Communicate findings and recommendations frequently to key stakeholders through written reports.

C. Report Additional Cases of the Disease:

1. Immediately report new cases to the Infection Prevention Manager through the following:
   i. Laboratory reports;
   ii. Medical staff;
   iii. Nursing staff; and
   iv. Others as appropriate.
2. Investigate cases that may have occurred retrospectively or concurrently:
   i. Laboratory reports;
   ii. Medical reports;
   iii. Patient charts;
   iv. Physicians and nursing staff;
   v. Public health data; and
   vi. Discharged patients.

D. Investigate Sources of Infection:

1. Consult Infectious Disease Physician and the ASC Medical Director for treatment options for exposed patients. Consult Harris Health System's Employee Health Services, per the Letter of Agreement between Harris Health System and the ASC, for treatment options for exposed Workforce members.
2. Identify practices that are potentially related to the occurrence of the outbreak; and
3. Institute surveillance cultures as stipulated per the Infection Prevention.

E. Evaluate Efficacy of Control Measures:

1. Continue monitoring and surveillance activities to identify new cases;
2. Prepare written Performance Improvement reports; and
3. Distribute final summary reports to Infection Prevention, the Medical Director of the ASC, and the Administrator of the ASC.

F. COVID-19

1. The ASC at LBJ will follow current guidelines from the Centers for Disease Control (CDC) regarding the COVID-19 pandemic and operational safety. (See Attachment A).

REFERENCES/BIBLIOGRAPHY:

42 Code of Federal Regulations (C.F.R.) §416.51(b).

Association for Practitioners in Infection Control, APIC Text, Online 2014.

Mayhall, Glen C., Hospital Epidemiology and Infection Control, 4th Edition, 2012.

APICTEXT http://text.apic.org/item-5/chapter-4-outbreak-investiation.

OFFICE OF PRIMARY RESPONSIBILITY:

The Ambulatory Surgical Center (ASC) at LBJ

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		Reviewed / Approved 02/15/2020	The Ambulatory Surgical Center (ASC) at LBJ Governing Body
		Revised / Approved 02/25/2021	The Ambulatory Surgical Center (ASC) at LBJ Governing Body

Attachment A

Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings

The ASC at LBJ will follow current guidelines from the Centers for Disease Control (CDC) regarding the COVID-19 pandemic and operational safety.

- **Reduce facility risk.** Reduce elective procedures, limit points of entry and manage visitors, screen everyone entering the facility for COVID-19 symptoms, implement source control for everyone entering the facility, regardless of symptoms.
- **Identify symptomatic persons as soon as possible.** Communicate with patients preoperatively to prevent scheduling symptomatic patient. Set up separate screening areas to prevent admission of symptomatic patients, staff and providers to the ASC.
- **Protect healthcare personnel.** Emphasize hand hygiene, install barriers to limit contact with patients at check in, encourage social distancing and prioritize N95 masks for aerosol generating procedures.

This interim guidance has been updated based on currently available information about COVID-19 and the current situation in the United States, which includes community transmission, infections identified in healthcare personnel (HCP), and shortages of facemasks, N95 filtering facepiece respirators (FFRs) (N95 respirators), eye protection, gloves, and gowns.

Please consult the link below for the most up to date guidance from the CDC on these key concepts.

~~https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html?deliveryName=USCDC_425-DM26319#minimize~~Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic

Field Code Changed

1. Recommended routine infection prevention and control (IPC) practices during the COVID-19 pandemic

   Implement Telehealth and Nurse-Directed Triage Protocols

   When scheduling appointments for routine medical care (e.g., annual physical, elective surgery):

   - Advise patients that they should put on their own cloth mask before entering the facility.
   - Instruct patients to call ahead and discuss the need to reschedule their appointment if they have symptoms of COVID-19 within the 10 days prior to their appointment, if they have been diagnosed with SARS-CoV-2 infection within the 10 days prior to their

appointment, or if they have had close contact with someone with suspected or confirmed SARS-CoV-2 infection within 14 days prior to their scheduled appointment.

Screen and Triage Everyone Entering a Healthcare Facility for Signs and Symptoms of COVID-19

- Take steps to ensure that everyone adheres to source control measures and hand hygiene practices while in a healthcare facility
  - Post visual alerts pdf icon (e.g., signs, posters pdf icon) at the entrance and in strategic places (e.g., waiting areas, elevators, cafeterias) to provide instructions (in appropriate languages) about wearing a cloth face covering or facemask for source control and how and when to perform hand hygiene.
  - Provide supplies for respiratory hygiene and cough etiquette, including alcohol-based hand sanitizer (ABHS) with 60-95% alcohol, tissues, and no-touch receptacles for disposal, at healthcare facility entrances, waiting rooms, and patient check-ins.
- Limit and monitor points of entry to the facility.

- Establish a process to ensure everyone (patients, healthcare personnel, and visitors) entering the facility is assessed for symptoms of COVID-19, or exposure to others with suspected or confirmed SARS-CoV-2 infection and that they are practicing source control.
  - Options could include (but are not limited to): individual screening on arrival at the facility; or implementing an electronic monitoring system in which, prior to arrival at the facility, people report absence of fever and symptoms of COVID-19, absence of a diagnosis of SARS-CoV-2 infection in the prior 10 days, and confirm they have not been exposed to others with SARS-CoV-2 infection during the prior 14 days.
    - Fever can be either measured temperature ≥100.4°F or subjective fever. People might not notice symptoms of fever at the lower temperature threshold that is used for those entering a healthcare setting, so they should be encouraged to actively take their temperature at home or have their temperature taken upon arrival.
    - Obtaining reliable temperature readings is affected by multiple factors, including:
      - The ambient environment in which the temperature is measured: If the environment is extremely hot or cold, body temperature readings may be affected, regardless of the temperature-taking device that is used.
      - Proper calibration of the thermometers per manufacturer standards: Improper calibration can lead to incorrect temperature readings.
      - Proper usage and reading of the thermometers: Non-contact infrared thermometers frequently used for health screening must be held at an

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established distance from the temporal artery in the forehead to take the temperature correctly. Holding the device too far from or too close to the temporal artery affects the reading.

- Properly manage anyone with suspected or confirmed SARS-CoV-2 infection or who has had contact with someone with suspected or confirmed SARS-CoV-2 infection:
    - Healthcare personnel (HCP) should be excluded from work and should notify occupational health services to arrange for further evaluation.
    - Visitors should be restricted from entering the facility and be referred for proper evaluation.
- Patients should be isolated in an examination room with the door closed.
- If an examination room is not immediately available, such patients should not wait among other patients seeking care.
    - Identify a separate, well-ventilated space that allows waiting patients to be separated by 6 or more feet, with easy access to respiratory hygiene supplies.
    - In some settings, patients might opt to wait in a personal vehicle or outside the healthcare facility where they can be contacted by mobile phone when it is their turn to be evaluated.
    - Depending on the level of transmission in the community, facilities might also consider designating a separate area at the facility (e.g., an ancillary building or temporary structure) or nearby location as an evaluation area where patients
    - with symptoms of COVID-19 can seek evaluation and care.

Implement Universal Source Control Measures

Source control refers to use of well-fitting cloth face masks or facemasks to cover a person's mouth and nose to prevent spread of respiratory secretions when they are talking, sneezing, or coughing. Because of the potential for asymptomatic and pre-symptomatic transmission, source control measures are recommended for everyone in a healthcare facility, even if they do not have symptoms of COVID-19.

- Patients and visitors should wear their own cloth mask (if tolerated) upon arrival to and throughout their stay in the facility. If they do not have a face covering, they should be offered a facemask or cloth mask
    - Patients may remove their cloth mask when in their rooms but should put it back on when around others (e.g., when visitors enter their room) or leaving their room.
    - Facemasks and cloth masks should not be placed on young children under age 2, anyone who has trouble breathing, or anyone who is unconscious, incapacitated or otherwise unable to remove the mask without assistance.

- Visitors who are not able to wear a cloth mask or facemask should be encouraged to use alternatives to on-site visits with patients (e.g., telephone or internet communication), particularly if the patient is at increased risk for severe illness from SARS-CoV-2 infection.

- HCP should wear a facemask at all times while they are in the healthcare facility, **including in breakrooms or other spaces where they might encounter co-workers**.
  - When available, facemasks are preferred over cloth face masks for HCP as facemasks offer both source control and protection for the wearer against exposure to splashes and sprays of infectious material from others.
    - Cloth masks should NOT be worn instead of a respirator or facemask if more than source control is needed.
  - To reduce the number of times HCP must touch their face and potential risk for self-contamination, HCP should consider continuing to wear the same respirator or facemask (extended use) throughout their entire work shift, instead of intermittently switching back to their cloth mask.
  - HCP should remove their respirator or facemask, perform hand hygiene, and put on their cloth mask when leaving the facility at the end of their shift.
- Educate patients, visitors, and HCP about the importance of performing hand hygiene immediately before and after any contact with their facemask or cloth mask.

Encourage Physical Distancing

Healthcare delivery requires close physical contact between patients and HCP. However, when possible, physical distancing (maintaining at least 6 feet between people) is an important strategy to prevent SARS-CoV-2 transmission.

Examples of how physical distancing can be implemented for patients include:

- Limiting visitors to the facility to those essential for the patient's physical or emotional well-being and care (e.g., care partner, parent).
  - Encourage use of alternative mechanisms for patient and visitor interactions such as video-call applications on cell phones or tablets.
- Scheduling appointments to limit the number of patients in waiting rooms, or creating a process so that patients can wait outside or in their vehicle while waiting for their appointment.
- Arranging seating in waiting rooms so patients can sit at least 6 feet apart.
- Modifying in-person group healthcare activities (e.g., group therapy, recreational activities) by implementing virtual methods (e.g., video format for group therapy) or scheduling smaller in-person group sessions while having patients sit at least 6 feet apart.
  - In some circumstances, such as higher levels of community transmission or numbers of patients with COVID-19 being cared for at the facility, and when healthcare-associated

transmission is occurring, facilities might cancel in-person group activities in favor of an exclusively virtual format.

For HCP, the potential for exposure to SARS-CoV-2 is not limited to direct patient care interactions. Transmission can also occur through unprotected exposures to asymptomatic or pre-symptomatic co-workers in breakrooms or co-workers or visitors in other common areas. Examples of how physical distancing can be implemented for HCP include:

- Reminding HCP that the potential for exposure to SARS-CoV-2 is not limited to direct patient care interactions.
- Emphasizing the importance of source control and physical distancing in non-patient care areas.
- Providing family meeting areas where all individuals (e.g., visitors, HCP) can remain at least 6 feet apart from each other.
- Designating areas and staggered schedules for HCP to take breaks, eat, and drink that allow them to remain at least 6 feet apart from each other, especially when they must be unmasked.

Implement Universal Use of Personal Protective Equipment

- **HCP working in facilities located in areas with moderate to substantial community transmission** are more likely to encounter asymptomatic or pre-symptomatic patients with SARS-CoV-2 infection. If SARS-CoV-2 infection is not suspected in a patient presenting for care (based on symptom and exposure history), HCP should follow Standard Precautions (and Transmission-Based Precautions if required based on the suspected diagnosis).

They should also:

  - Wear eye protection in addition to their facemask to ensure the eyes, nose, and mouth are all protected from exposure to respiratory secretions during patient care encounters.
  - Wear an N95 or equivalent or higher-level respirator, instead of a facemask, for:
    - Aerosol generating procedures (refer to Which procedures are considered aerosol generating procedures in healthcare settings FAQ) and
    - Surgical procedures that might pose higher risk for transmission if the patient has COVID-19 (e.g., that generate potentially infectious aerosols or involving anatomic regions where viral loads might be higher, such as the nose and throat, oropharynx, respiratory tract) (refer to Surgical FAQ).

- **For HCP working in areas with minimal to no community transmission**, HCP should continue to adhere to Standard and Transmission-Based Precautions based on anticipated exposures and suspected or confirmed diagnoses. This might include use of eye protection, an N95 or equivalent or higher-level respirator, as well as other personal protective equipment (PPE). In addition, universal use of a facemask for source control is recommended for HCP if not otherwise wearing a respirator.
- **Consider Performing Targeted SARS-CoV-2 Testing of Patients Without Signs or Symptoms of COVID-19**
- In addition to the use of universal PPE and source control in healthcare settings, targeted SARS-CoV-2 testing of patients without signs or symptoms of COVID-19 might be used to identify those with asymptomatic or pre-symptomatic SARS-CoV-2 infection and further reduce risk for exposures in some healthcare settings. Depending on guidance from local and state health departments, testing availability, and how rapidly results are available, facilities can consider implementing pre-admission or pre-procedure diagnostic testing with authorized nucleic acid or antigen detection assays for SARS-CoV-2.
  Testing results might inform decisions about rescheduling elective procedures or about the need for additional Transmission-Based Precautions when caring for the patient. Limitations of using this testing strategy include obtaining negative results in patients during their incubation period who later become infectious and false negative test results, depending on the test method used.
- **Consider if elective procedures, surgeries, and non-urgent outpatient visits should be postponed in certain circumstances.**
- Facilities must balance the need to provide necessary services while minimizing risk to patients and HCP. Facilities should consider the potential for patient harm if care is deferred when making decisions about providing elective procedures, surgeries, and non-urgent outpatient visits. Refer to the Framework for Healthcare Systems Providing Non-COVID-19 Clinical Care During the COVID-19 Pandemic for additional guidance.

Optimize the Use of Engineering Controls and Indoor Air Quality

- Optimize the use of engineering controls to reduce or eliminate exposures by shielding HCP and other patients from infected individuals. Examples of engineering controls include:
  - Physical barriers and dedicated pathways to guide symptomatic patients through triage areas.
  - Remote triage facilities for patient intake areas.

- If climate permits, outdoor assessment and triage stations for patients with respiratory symptoms.
- Vacuum shrouds for surgical procedures likely to generate aerosols.
- Reassess the use of open bay recovery areas.

- Explore options, in consultation with facility engineers, to improve indoor air quality in all shared spaces.
  - Optimize air-handling systems (ensuring appropriate directionality, filtration, exchange rate, proper installation, and up to date maintenance).
  - Consider the addition of portable solutions (e.g., portable HEPA filtration units) to augment air quality in areas when permanent air-handling systems are not a feasible option.
  - Guidance on ensuring that ventilation systems are operating properly are available in the following resources:
    - Guidelines for Environmental Infection Control in Health-Care Facilities
    - American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE) resources for healthcare facilities external icon, which also provides COVID-19 technical resources for healthcare facilities external icon

Create a Process to Respond to SARS-CoV-2 Exposures Among HCP and Others

Healthcare facilities should have a process for notifying the health department about suspected or confirmed cases of SARS-CoV-2 infection, and should establish a plan, in consultation with local public health authorities, for how exposures in a healthcare facility will be investigated and managed and how contact tracing will be performed. The plan should address the following:

- Who is responsible for identifying contacts (e.g., HCP, patients, visitors) and notifying potentially exposed individuals?
- How will such notifications occur?
- What actions and follow-up are recommended for those who were exposed?

Contact tracing should be carried out in a way that protects the confidentiality of affected individuals and is consistent with applicable laws and regulations. HCP and patients who are currently admitted to the facility or were transferred to another healthcare facility should be prioritized for notification. These groups, if infected, have the potential to expose a large number of individuals at higher risk for severe disease, or in the situation of admitted patients, are at higher risk for severe illness themselves.

Information about when HCP with suspected or confirmed SARS-CoV-2 infection may return to work is available in the Interim Guidance on Criteria for Return to Work for Healthcare Personnel with Confirmed or Suspected COVID-19.

Information about risk assessment and work restrictions for HCP exposed to SARS-CoV-2 is available in the Interim U.S. Guidance for Risk Assessment and Work Restrictions for Healthcare Personnel with Potential Exposure to Coronavirus Disease 2019 (COVID-19).

Healthcare facilities must be prepared for potential staffing shortages and have plans and processes in place to mitigate these, including providing resources ~~resources~~ to assist HCP with anxiety and stress. Strategies to mitigate staffing shortages are available.

Please consult the link below for the most up to date guidance from the CDC on these key concepts.

~~https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html?deliveryName=USCDC_425-DM26319#minimize~~Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic

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Field Code Changed

TITLE: **MANDATORY REPORTING POLICY**

PURPOSE: To set forth the reporting obligations of the Ambulatory Surgical Center (ASC) at LBJ.

POLICY STATEMENT:

It is the policy of the Ambulatory Surgical Center (ASC) at LBJ to comply with all of the reporting requirements set forth by state and federal laws and by its accrediting body, the American Association for Accreditation of Ambulatory Surgery Facilities, Inc. (AAAASF)

POLICY ELABORATIONS:

I. The ASC will comply with all reporting requirements set forth by either state or federal law or by the American Association for Accreditation of Ambulatory Surgery Facilities, Inc.

II. For a detailed description of the ASC's reporting obligations please see Attachments A – C below.

REFERENCES/BIBLIOGRAPHY:

Texas Health and Safety Code §98.103

25 Texas Administrative Code §135.26

25 Texas Administrative Code §200.2

American Association for Accreditation of Ambulatory Surgery Facilities Version 8

https://www.dshs.texas.gov/IDCU/health/infection_control/hai/HAI-Reporting/

http://www.dshs.texas.gov/IDCU/health/preventable-adverse-events/PAE-Reporting.aspx

https://hhs.texas.gov/doing-business-hhs/provider-portals/health-care-facilities-regulation/ambulatory-surgical-centers

OFFICE OF PRIMARY RESPONSIBILITY:

The Ambulatory Surgical Center (ASC) at LBJ

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ATTACHMENT "A"

Reportable Incident	State Reporting Requirement	AAAASF Reporting Requirement
Death of patient under the care of the ASC at LBJ	Report within 10 business of the incident to Texas Department of State Health Services using form in "Attachment D"	Report to AAAASF within 5 business days of incident. *death must also be reported as an Adverse Event (see Attachment "E").
Death of patient within thirty (30) days of surgical procedure	N/A	Report to AAAASF within 5 business days of incident *death must also be reported as an Adverse Event (see Attachment "E").
Patient Safety Data Reporting– including Random Case Review and Adverse Event	N/A	Report to AAAASF within established reporting period using form in Attachment "E"
Patient development of complications within 24 hours of discharge from the ASC resulting in admission to a hospital	Report within 10 business of the incident to Texas Department of State Health Services using form in "Attachment D"	Report to AAAASF within established reporting period using form in Attachment "E""
Transfer of patient to hospital	Report within 10 business of the incident to Texas Department of State Health Services using form in "Attachment D"	Report to AAAASF within established reporting period using form in Attachment "E"
Extended stay of patient – i.e. a patient stay that exceeds 23 hours	Report within 10 business of the incident to Texas Department of State Health Services using form in "Attachment D"	Report to AAAASF within established reporting period using form in Attachment "E""
Fire in the ASC	Report within 10 business of the incident to Texas Department of State Health Services using form in "Attachment D"	N/A
Theft of drugs/diversion of controlled substances	Report within 10 business of the incident to Texas Department of State Health Services using form in "Attachment D"	N/A
Any Unplanned Hospital Admission or Emergency Room visit	N/A	Report to AAAASF within established reporting period using form in Attachment "E"
All adverse events that occur within 30 days of any procedure	N/A	Report to AAAASF within established reporting period using form in Attachment "E" See section 1-F 1-13 AAAASF v. 8.0

Changes in the ASC medical staff – i.e. credentialing new providers	N/A	Report within 30 days of change. *must send copies of the new physician(s): (1) medical license; (2) board certification; and (3) hospital privileges
Any action affecting current professional license of a member of the ASC medical staff	N/A	Report within 10 days of the time the ASC Administrator is aware of the action affecting the professional license.
Reportable Infections/Communicable Diseases	Report within one week any Notifiable Conditions to Texas Department of State Health Services *Harris Health Infection Prevention Department will report on behalf of the ASC pursuant to Letter of Agreement. But ASC must immediately report the notifiable condition to Harris Health Infection Prevention.	Report to AAAASF within established reporting period using form in Attachment "E"
Health Care Associated Infections ("HAI") (including Surgical Site Infections) ***See Attachment B for a list of reportable HAIs.**	Report to the National Healthcare Safety Network. Reports must be made quarterly. The reporting quarters are: Q1: Jan 1 – Mar 31 Q2: Apr 1 – June 30 Q3: July 1 – Sept. 30 Q4: Oct. 1 – Dec. 31 Reports must be made within 60 days of the end of the reporting quarter. Reporting deadlines are: Q1: May 30 Q2: Aug. 30 Q3: Nov. 30 Q4: Feb. 28 *Note: Harris Health System's Quality Department will report this information on behalf of the ASC. However, the ASC must immediately report HAIs to Harris Health System's Quality Department.	N/A

Texas Preventable Adverse Events* ***See Attachment C for a list of Texas Preventable Adverse Events.**	Report to Texas Department of State Health Services *via* Texas Health Care Safety Network. Reports must be made quarterly. The reporting quarters are: Q1: Jan 1 – Mar 31 Q2: Apr 1 – June 30 Q3: July 1 – Sept. 30 Q4: Oct. 1 – Dec. 31 Reports must be made within 60 days of the end of the reporting quarter. Reporting deadlines are: Q1: May 30 Q2: Aug. 30 Q3: Nov. 30 Q4: Feb. 28 *Note: Harris Health System's Quality Department will report this information on behalf of the ASC. However, the ASC must immediately report HAIs to Harris Health System's Quality Department.	N/A
NHSN-reported PAE *****A NHSN-reported PAE is a preventable adverse event defined by the National Quality Forum or CMS.	Reports made by Harris Health's Quality Department on behalf of the ASC.	N/A

ATTACHMENT "B"

TEXAS REPORTABLE HEALTH CARE ASSOCIATED INFECTIONS ("HAIs")

1. Knee Prosthesis Surgical Site Infection;
2. Hip Prosthesis Surgical Site Infection;
3. Coronary Artery Bypass Grafts with Donor Site & Chest Incision Surgical Site Infection;
4. Coronary Artery Bypass Grafts with Chest Incision Only Surgical Site Infection;
5. Vaginal Hysterectomies Surgical Site Infection;
6. Abdominal Hysterectomies Surgical Site Infection;
7. Colon Surgery Surgical Site Infection;
8. Peripheral Vascular Bypass Grafts Surgical Site Infection;
9. Carotid Endarterectomies (CEA) Surgical Site Infection;
10. Abdominal Aortic Aneurysm Repair Surgical Site Infection;

*Please check the below link periodically for updates to the list.

https://www.dshs.texas.gov/IDCU/health/infection_control/hai/HAI-Reporting/

ATTACHMENT "C"

REPORTABLE TEXAS PREVENTABLE ADVERSE EVENTS

1. Surgery on the wrong body part;
2. Surgery performed on the wrong patient;
3. Wrong surgery performed on a patient;
4. Object left in patient after surgery;
5. Death of a health patient after surgery;
6. The release of a patient who cannot make their own decisions to the wrong person;
7. Any event where a medical gas was not given to a patient correctly (no gas, wrong gas, or toxic gas);
8. Abduction of a patient while at the facility;
9. Sexual assault on a patient while at a health care facility;
10. Patient death or serious harm resulting from physical assault that happened at the health care facility;
11. Patient death or severe harm associated with a fall in a health care facility that caused a broken bone;
12. Patient death or severe harm associated with a fall in a health care facility that caused the dislocation of a joint;
13. Patient death or severe harm associated with a fall in a health care facility that caused a head injury;
14. Patient death or severe harm associated with a fall in a health care facility that caused a crushing injury;
15. Patient death or severe harm associated with a fall in a health care facility that caused a burn;
16. Patient death or severe harm associated with a fall in a health care facility;
17. Patient death or severe harm associated with getting blood in an unsafe way;
18. Patient death or severe harm resulting from losing a sample that could not be replaced;
19. Patient death or severe harm resulting from test results were not communicated or followed up on;
20. Patient death or severe harm associated with the use of restraints or bedrails;
21. Patient death or severe harm of a mom or baby during the birth of a child after a health pregnancy;
22. Blood clot in a vein or a blockage in the lungs after knee replacement surgery;
23. Blood clot in a vein or a blockage in the lungs after hip replacement surgery;
24. Lung collapse when a tube is inserted into a vein;
25. A deep bed sore that develops while patient is in a health care facility;
26. Medical order(s) given by a person pretending to be a doctor, nurse, or other provider;
27. Patient commits suicide, attempts suicide, or severely harms themselves in a health care facility;
28. Patient death or severe harm after a patient leaves the health care facility without telling medical staff;
29. Patient death or severe harm associated with an electric shock while in the health care facility;
30. Patient death or severe harm associated with a burn while in the health care facility;
31. Patient death or severe harm associated with taking something metal into the MRI area;
32. An infection after having surgery on the spine;
33. An infection after having surgery on the shoulder;
34. An infection after having surgery on the elbow;
35. An infection after surgery to join the stomach to the intestines;
36. An infection after having surgery to re-direct food around parts of their stomach to reduce the amount of food a patient gets;
37. An infection after having surgery to make the stomach smaller;
38. An infection after implanting an electronic heart device;
39. Artificial insemination with the wrong donor sperm or egg;

40. Coma with low blood sugar;
41. High blood sugar;
42. Coma with high blood sugar and dehydration;
43. High blood sugar due to another condition;
44. High blood sugar and dehydration due to another condition;
45. Patient death or severe harm associated with using contaminated machines or devices;
46. Patient death or severe harm associated with a devices that isn't used properly;
47. Patient death or severe harm in a patient who had an air bubble in the blood while at a health care facility;
48. Patient death or severe harm associated with a medicine error.

Please check the below link periodically for updates to the list.

http://www.dshs.texas.gov/IDCU/health/preventable-adverse-events/PAE-Reporting.aspx

ATTACHMENT "D"

AMBULATORY SURGICAL CENTERS INCIDENT REPORT FORM

https://hhs.texas.gov/laws-regulations/forms/6000-6999/form-6110-ambulatory-surgical-center-facility-incident-report

ATTACHMENT "E"

AMERICAN ASSOCIATION FOR ACCREDITATION OF AMBULATORY SURGERY FACILITIES
Patient Safety Data Reporting DOCUMENTS

https://www.aaaasf.org/documents/outpatient-surgical/

TITLE: BLOODBORNE PATHOGENS

PURPOSE: To minimize the health risk of occupational exposures to blood, potentially infectious materials, or body fluids that may contain bloodborne pathogens at the Ambulatory Surgical Center (ASC) at LBJ facility.

POLICY STATEMENT:

The Occupational Safety and Health Administration ("OSHA") has made a determination that healthcare workers face a significant risk of exposure to bloodborne pathogens, including MRSA, Hepatitis B virus, Hepatitis C virus, and HIV - human immunodeficiency virus. Because the infectious status of patients is often unknown, healthcare workers must practice Standard Precautions when dealing with all patient body materials.

POLICY ELABORATIONS:

I. DEFINITIONS:

A. **BLOODBORNE PATHOGEN**: Means pathogenic microorganisms that are present in human blood and can cause disease in humans. These pathogens include, but are not limited to, Hepatitis B virus (HBV), and human immunodeficiency virus (HIV).

B. **CONTAMINATED**: Means the presence or the reasonably anticipated presence of blood or other potentially infectious materials on an item or surface.

C. **ENGINEERING CONTROLS**: Means controls (e.g., sharps disposal containers, self-sheathing needles, safer medical devices, such as sharps with engineered sharps injury protections and needleless systems) that isolate or remove the Bloodborne Pathogen hazard from the Ambulatory Surgical Center (ASC) at LBJ.

D. **ENGINEERING CONTROLS**: Means controls (e.g., sharps disposal containers, self-sheathing needles, safer medical devices, such as sharps with engineered sharps injury protections and needleless systems) that isolate or remove the Bloodborne Pathogen hazard from the Ambulatory Surgical Center (ASC) at LBJ.

E. **PERSONAL PROTECTIVE EQUIPMENT (PPE)**: A variety of barriers used alone or in combination to protect mucous membranes, skin, and clothing from contact

with infectious agents or organisms. PPE includes gloves, masks, respirators, goggles, face shields, and gowns.

F. **STANDARD PRECAUTIONS:** A group of Infection Prevention Practices that apply to all patients, regardless of suspected or confirmed diagnosis or presumed infection status. Standard Precautions is based on the principle that all blood, body fluids, secretions, excretions except sweat, non-intact skin, and mucous membranes may contain transmissible infectious agents. Standard Precautions includes, but is not limited to, the use of gloves, gown, mask, eye protection, or face shield.

G. **WORKFORCE:** The employees, medical staff, trainees, contractors, volunteers, and vendors.

H. **WORK PRACTICE CONTROLS**: Means controls that reduce the likelihood of exposure by altering the manner in which a task is performed (e.g., prohibiting recapping of needles by a two-handed technique).

II. STANDARD PRECAUTIONS:

A. The Ambulatory Surgical Center (ASC) at LBJ will adhere to the Standard Precautions when caring for patients. Therefore, all human blood and body fluids will be treated by the ASC and Workforce members as if they are known to be infectious. These fluids include, but are not limited to, the following:

1. Amniotic fluid;
2. Blood;
3. Cerebrospinal fluid;
4. Pericardial fluid;
5. Peritoneal fluid;
6. Pleural fluid;
7. Saliva;
8. Semen;
9. Synovial fluid; and
10. Vaginal secretions.

B. To reduce the risk of exposure to Bloodborne Pathogens, Workforce members are prohibited from eating, drinking, applying cosmetics, and handling contact lenses in any area of the ASC where there is a potential for exposure to a Bloodborne Pathogen.

C. All food and drinks must be kept in refrigerators or freezers and not in areas where blood or other potentially infectious materials may be present.

D. Mouth pipetting/suctioning of blood or other infectious materials is prohibited.

E. All procedures involving blood or other infectious materials shall be performed in a manner to minimize splashing, spraying, spattering, and generation of droplets of blood or other infectious materials.

III. CLEANING BLOOD AND BODY FLUID SPILLS:

A. If blood or other bodily fluids are spilled in the ASC, the following cleaning protocol and guidelines must be followed:

1. Gloves must be used when cleaning spills of blood.
2. Blood or body fluid must be removed from the spill site with a paper towel or disposable cloth/towel.
3. After removing the blood or body fluid spill, the area must be Decontaminated and cleaned with an approved germicidal agent that has tuberculocidal activity, such as Phenolic disinfectants, or 1:10 bleach solution. Repeat the application of the disinfectant as many times as necessary to clean the surface or pursuant to the manufacturer instructions.
4. All contaminated waste, including paper towels, disposable towels/cloths, and gloves must be disposed of in the appropriate waste container.

IV. EDUCATION AND TRAINING:

A. All Workforce members who have the potential for exposure to Bloodborne Pathogens will receive training on how to avoid exposure to these pathogens. Specifically, Workforce members who have the potential to be exposed to Bloodborne Pathogens will receive annual training.

B. Pursuant to the Letter of Agreement between Harris Health System ("Harris Health") and the ASC, Harris Health's Learning Resource Center (LRC) will facilitate Bloodborne Pathogen training. At a minimum the LRC will train all ASC Workforce members on the following:

1. Work practice controls, including the use of Personal Protective Equipment;

2. Use of Engineering Controls; and
3. Proper handling of sharps

C. The LRC will be responsible for maintaining a log of all Workforce members who have completed the annual mandatory education regarding Bloodborne Pathogens on behalf of the ASC.

REFERENCES/BIBLIOGRAPHY:

Code of Federal Regulations 42 (C.F.R.) §416.51(a)

American Association for Accreditation of Ambulatory Surgery Facilities Version 8~~7 §800~~

American Association for Accreditation of Ambulatory Surgery Facilities Version 8~~7 §200~~

Harris County Hospital District Exposure Control Plan "Bloodborne Pathogens" Compliance Manual.

2021 Blood Borne Pathogen Exposure Plan
https://apps.hchd.local/sites/dcc/mprm/Manuals%20Plans%20Reference%20Materials/Bloodborne%20Pathogen%20Exposure%20Plan%202021-2022.pdf

~~*2019 Bloodborne Pathogen Exposure Plan,*~~
~~https://apps.hchd.local/sites/dcc/mprm/Manuals%20Plans%20Reference%20Materials/2019%20Bloodborne%20Pathogen%20Exposure%20Plan.pdf~~

OFFICE OF PRIMARY RESPONSIBILITY:

The Ambulatory Surgical Center at LBJ

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HARRISHEALTH
AMBULATORY SURGICAL CENTER AT LBJ

Policy No: ASC-P-6002
Page Number: 1 of 3

Effective Date: 08/05/16
Board Motion No: n/a

TITLE: CRASH CART AND EMERGENCY EQUIPMENT

PURPOSE: To set forth the requirements for the provision and maintenance of crash carts that may be necessary in the event of an emergency situation.

POLICY STATEMENT:

It is the policy of the Ambulatory Surgical Center (ASC) at LBJ to have a crash cart readily available for use in all of the operating rooms of the ASC and Pre-Op/PACU bays in the event of an emergency.

POLICY ELABORATIONS:

I. CONTENTS OF THE CRASH CART:

A. Crash carts (adult and pediatric) are immediately available to all of the ASC operating rooms and Pre-OP/PACU bays.

B. Crash carts include emergency equipment, supplies, and medication that are the most suitable for potential emergencies associated with the types of procedures performed in the ASC and the population of patients the ASC serves. At a minimum, crash carts must include the following:

1. Oxygen tank (in addition to the oxygen delivery system available in the operating/procedure room and patient bays);
2. Mechanical ventilator assistance equipment, including airways, and Ambu bag;
3. Defibrillator or AED;
4. Patient monitor with printer and oxygen saturation;
5. Laryngoscope and endotracheal tubes in addition to the laryngoscope and endotracheal tubes available in the operating/procedure room;
6. Suction equipment, Backboard; and
7. A complete copy of the current ACLS Algorithm.
8. A complete copy of the current PALS Algorithm.

C. Emergency Equipment available in the facility:

1. Emergency airway management kit ("airway box"), including but not limited to a tracheostomy kit and a cricothyroidotomy kit; and

2. Malignant hyperthermia cart.

II. INSPECTION AND MAINTENANCE OF CRASH CART:

A. Registered nurses and/or designee ~~operating room technicians~~ are responsible for performing daily inspection of the crash cart. The inspections consist of the following:

1. Verifying two locks are intact (pharmaceuticals and supplies);

2. Checking expiration dates (pharmaceuticals and cart);

3. Verifying the functionality of the suction machine. Checks operation of suction machine while plugged and unplugged to verify if the battery is charged. Check for presence of negative pressure when turned on;

4. Ensuring that the oxygen tank has greater than or equal to 1800 pounds per square inches (PSI) of pressure. Replace oxygen tank if less than 1800 PSI; and

5. Verifying the functionality of the defibrillator both plugged and unplugged (internal and external).

B. Daily Inspections:

Crash carts are checked daily to ensure the following:

i. The defibrillator is charged, tested in the red plug, and the battery is tested out of the plug, and the plug is removed from the electronic socket;
ii. Locks are intact and locked;
iii. The oxygen tank has greater than or equal to 1,800 pounds square inch pressure;

iv. Suction machine is functioning properly; and
v. EKG leads, defibrillator pads, nasal cannula, O_2 mask, code flow sheet, and Ambu® bag are easily accessible.

C. A comprehensive inspection to ensure that all supplies are present and unexpired shall be performed by the ASC Pharmacy and Harris Health System's Central Supply pursuant to the Letter of Agreement between Harris Health and the ASC and documented in the following circumstances:

1. After each medical emergency;

2. Whenever a lock is found to be broken; and

3. Whenever a cart is expired.

REFERENCES/BIBLIOGRAPHY:

Conditions for Coverage §416.50.

OFFICE OF PRIMARY RESPONSIBILITY:

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TITLE: HAZARDOUS MATERIALS

PURPOSE: To outline the requirements and standards the Ambulatory Surgical Center (ASC) at LBJ must follow to ensure compliance with the Hazardous Communication Act of Texas.

POLICY STATEMENT:

It is the policy of the Ambulatory Surgical Center (ASC) at LBJ to follow the requirements of the Hazardous Communication Act of Texas as it relates to the identification, handling, storage, use, and disposal of hazardous chemical or material substances that are known to cause harm to patients, visitors, and workforce members.

POLICY ELABORATIONS:

I. DEFINITIONS:

A. **HEALTH HAZARD:** a chemical which is classified as posing one of the following hazardous effects: (1) acute toxicity; (2) skin corrosion or irritation; (3) serious eye damage or eye irritation; (4) respiratory or skin sensitization; (5) germ cell mutagenicity; (6) carcinogenicity; (7) reproductive toxicity; (8) specific target organ toxicity; or (9) aspiration hazard.

B. **HAZARDOUS CHEMICAL**: An element, compound, or mixture of elements or compounds that is a physical hazard or health hazard, or a hazardous substance.

C. **PHYSICAL HAZARD**: A chemical that is classified as posing one of the following hazardous effects: (1) explosive; (2) flammable (gases, aerosols, liquids, or solids); (3) oxidizer (liquid, solid, or gas); (4) self-reactive; (5) self-heating; (6) organic peroxide; (7) corrosive to metal; (8) gas under pressure; or (9) in contact with water emits flammable gas.

D. **SAFETY DATA SHEET ("SDS")**: Written or printed material concerning a Hazardous Chemical that is prepared in accordance with the requirements of the OSHA standard for that material.

E. **WORKFORCE:** The members of the governing body of the Ambulatory

Surgical Center (ASC) at LBJ, employees, medical staff, trainees, contractors, volunteers, and vendors.

II. HAZARDOUS CHEMICALS/MATERIALS INVENTORY:

A. Pursuant to the Letter of Agreement between Harris Health System ("Harris Health") and the ASC, Harris Health shall maintain an inventory list of all Hazardous Chemicals and materials located in the ASC that includes:

1. The identity used on the SDS and container for each Hazardous Chemical listed; and

2. The location (room number) where 55 gallons or 500 lbs. of the Hazardous Chemical are stored in the ASC.

B. Harris Health will update this inventory by December 31 of each year and as necessary on behalf of the ASC. Each annual inventory must be dated and signed by the individual responsible for compiling the information.

C. All Workforce members must be aware of the inventory and the inventory must be available to all Workforce members.

D. Pursuant to state law, Harris Health will maintain each annual inventory for the ASC for at least thirty (30) years.

III. SAFETY DATA SHEETS (SDS):

A. Harris Health shall have available a SDS for all Hazardous Chemicals and substances used or stored in the ASC.

B. The SDS's will be made available online via Harris Health's Safety & Environmental Health intranet page.

C. SDS's received by the ASC will be included in the inventory.

IV. LABELS:

A. Workforce members are not permitted to remove labels on an existing

container of a Hazardous Chemical or material.

B. If a label on a container of a Hazardous Chemical or material is illegible, inaccurate, or does not conform to the Occupational Health and Safety Administration standard, then the ASC Administrator must contact Administrative Director – Logistics, EMS, and Ancillary Support Services.

V. EDUCATION PROGRAM:

Pursuant to the Letter of Agreement between the Harris Health and the ASC, Harris Health's Learning Resource Center (LRC) shall provide training to Workforce members that meet the requirements of the Hazard Communication Act of Texas on how to handle hazardous chemicals.

REFERENCES/BIBLIOGRAPHY:

American Association for Accreditation of Ambulatory Surgery Facilities Version 8.0~~7 §400~~

American Association for Accreditation of Ambulatory Surgery Facilities Version 8.0

Texas Health and Safety Code §502.001, *et seq.*

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TITLE: MALIGNANT HYPERTHERMIA

PURPOSE: To establish guidelines for treating patients suspected of having malignant hyperthermia.

POLICY STATEMENT:

The Ambulatory Surgical Center (ASC) at LBJ ("ASC") shall ensure that necessary medications are immediately available to treat suspected or confirmed malignant hyperthermia.

POLICY ELABORATIONS:

I. DEFINITIONS:

A. **MALIGNANT HYPERTHERMIA (MH)**: An uncontrolled increase in skeletal muscle metabolism triggered in susceptible individuals by most inhaled general anesthetics, excluding nitrous oxide, and rarely depolarizing neuromuscular blocker succinylcholine. The signs and symptoms of malignant hyperthermia include increased body metabolism, muscle rigidity, high carbon dioxide production, tachycardia, arrhythmias, diaphoresis, and high fever. Death or brain damage usually results from cardiac arrest. Survivors can experience muscle or internal organ damage. Preventing death or organ damage must include early detection and quick treatment.

B. **WORKFORCE:** The members of the governing body of the Ambulatory Surgical Center (ASC) at LBJ, employees, medical staff, trainees, contractors, volunteers and vendors.

II. GENERAL PROCEDURES:

A. Prior to surgery, patients must be screened for his or her risk for MH. Screening for MH includes examination of the following risk factors:

1. A family history of unexpected death(s) following general anesthesia or exercise;
2. A family history or personal history of MH;
3. A muscular or neuromuscular disorder;
4. A history of high temperatures following exercise;
5. A personal history of muscle spasms;
6. The presence of dark or chocolate-colored urine; and
7. Unanticipated fever immediately following anesthesia or serious exercise.

~~8.~~B. ~~Need to include referral for genetic of CHCT testing if patient risk by Medical Director,~~ counseling and/or Caffeine Halothane Contracture Testing prior to surgical intervention.

~~B.~~C. In addition to an anesthesia machine (if used), electrocardiogram (ECG), temperature monitors, pulse oximeter, and capnometer, the following must be readily accessible when general anesthesia is administered:

1. A MH emergency treatment cart;
2. A MH emergency plan of care visibly posted;
3. The MHAUS Malignant Hyperthermia Algorithms;
4. A means to continuously monitor end-tidal CO_2, blood oxygen saturation, and core body temperature by electronic probe;
5. The Malignant Hyperthermia Association of the United States hotline number, (1-800-644-9737).

~~C.~~D. The ASC pharmacy shall be notified immediately when a MH case is suspected to provide continuum of care and additional items not included in the MH cart.

~~D.~~E. The Anesthesia Technician(s) shall be responsible for inspecting the MH cart daily for:

1. Expired medications;
2. Refrigerator function (maintaining proper temperature);
3. Necessary supplies as outlined in this policy.

~~E.~~F. The following items must be included in the MH cart:

1. Dantrolene - 20mg vial (36 count);
2. Sterile water (no bacteriostatic agent) - 1000mL bag (2 count);
3. Sodium Bicarbonate 8.4% - 50mL (5 count);
4. Dextrose 50% - 50mL vial (2 count);
5. Calcium Chloride 10% - 10mL vial/syringe (2 count);
6. Lidocaine for injection 2% 100mg/5mL or 100mg/10mL syringes (3 count);
7. Charcoal Filters (vapor filter) (2 pairs);
8. Luer Lock syringe - 60mL (5 count);
9. Hypodermic needles - 18G (1.5-inch) (10 count);

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10. Transducer kit (1 count);
11. Large plastic bags (4 count);
12. Pressure bag
13. Test strips (urine hemoglobin); and
14. Foley catheter kit with urine meter (1 count)

~~F.~~G. The following items will **not** be included in the MH cart and must be obtained from the following locations when necessary:

1. Automated Patient Medication System (Pyxis) refrigerator – Regular insulin 100units/mL (1 count);
2. Operating Room Refrigerator- normal saline 0.9% 1000mL intravenous (IV) bag (3 count);
3. Operating Room Refrigerator- normal saline 0.9% bottles (6 count);
4. Operating Room Refrigerator- Disposable ice packs (4 count);
5. Operating Room supply room- Large bucket for ice;
6. OR anesthesia cart - Esophageal or other appropriate core temperate probe;
7. OR anesthesia cart- IV catheters – 16G, 18G, 20G (2-inch), 22G (1-inch), and 24G (0.75-inch);
8. OR anesthesia cart - Nasogastric tubes;
9. Anesthesia Supply room- Cooling machine and Stryker Mul-T-Blanket; and
10. Anesthesia Supply room– spare anesthesia machine, ice, disposable breathing circuit, and sodasorb, blood specimen tubes.

III. TRAINING:

A. The Medical Director and ASC Administrator will ensure that all ASC Workforce members receive proper training to handle Malignant Hyperthermia cases.

B. The ASC will conduct annual drills that will include actual dilution of at least one vial of actual Dantrolene and with staff assigned to their roles prior to the drill.

The ASC Administrator will keep a log documenting the drills.

C.

REFERENCES/BIBLIOGRAPHY:

American Association for Accreditation of Ambulatory Surgery Facilities- version 7 §400

American Association for Accreditation of Ambulatory Surgery Facilities- version 7 §500

42 Code of Federal Regulations (C.F.R.) § 416.44(c)

http://www.mhaus.org/

OFFICE OF PRIMARY RESPONSIBILITY:

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		Reviewed / Approved 02/25/2021	The Ambulatory Surgical Center (ASC) at LBJ Governing Body

TITLE: MANAGEMENT AND ACCOUNTABILITY OF CONTROLLED SUBSTANCES

PURPOSE: To establish guidelines for the storage, security, accountability, and handling of Controlled Substances in the Ambulatory Surgical Center (ASC) at LBJ.

POLICY STATEMENT:

The Ambulatory Surgical Center (ASC) at LBJ is committed to maintaining a safe environment for its patients and the community by enforcing the rules and regulations governing Controlled Substance accountability. Controlled Substance accountability shall be promoted in order to create an environment that prohibits substance abuse and diversion, which ultimately affects the safety of our patients and healthcare professionals. All healthcare disciplines shall work diligently and collaboratively to maintain strict adherence to rules and regulations governing Controlled Substance accountability.

POLICY ELABORATIONS:

I. DEFINITIONS:

A. **AUTHORIZED PERSONNEL**: Any licensed healthcare practitioner or other appropriately credentialed provider with access to Controlled Substances.

B. **AUTOMATED DISPENSING CABINET (ADC):** A mechanical system or device that performs operations or activities relative to the storage and distribution of medications for administration and which collects, controls, and maintains all transaction information (e.g. Pyxis®).

C. **CONTROLLED SUBSTANCE**: Medications classified as Schedule II, III, IV, or V and any unscheduled medications requiring additional controls as regulated by the Texas State Board of Pharmacy (TSBP), Drug Enforcement Agency (DEA), Texas Department of Public Safety, and/or Texas Department of Health.

D. **DISCREPANCY**: A situation resulting when the 'expected count' and the 'actual count' of a Controlled Substance are not identical. A discrepancy may be identified during a manual inventory, medication removal, or medical refill process.

E. **DIVERSION**: The illegal delivery, possession, and/or theft of prescriptions, medications; obtaining prescription medications fraudulently; the unauthorized dispensing of prescription medications.

F. **PHARMACIST-IN-CHARGE (PIC):** The pharmacist designated on a pharmacy license as the pharmacist who has the authority or responsibility for a pharmacy's compliance with laws and rules pertaining to the practice of pharmacy.

G. **QUALIFIED LICENSED PRACTITIONER (QLP):** Any individual permitted by law and by Harris Health to provide care and services, without relevant direction or supervision, within the scope of the individual's license and consistent with individually granted clinical privileges.

H. **WORKFORCE**: Employees (permanent or temporary), Harris Health Board of Trustees, volunteers, trainees, medical staff, and other persons whose conduct, in the performance of work for Harris Health, is under the direct control of Harris Health, whether or not they are paid by Harris Health.

II. DEA REGISTRATION:

The Chief Pharmacy Officer (CPO) overseeing Department of Pharmacy (DOP) Operations shall maintain current registration of Harris Health System pharmacies with the DEA for all necessary activities and will be responsible for all documentation.

III. STORAGE/SECURITY:

A. Only Authorized Personnel shall have access to the ASC's Controlled Substances.

B. Controlled Substances located in patient care areas will be stored in an ADC station.

C. Controlled Substances shall be stored according to the manufacturer's guidelines, in the original container, or an approved pre-packaged container in compliance with regulatory (DEA/TSBP/DPS) and accreditation agencies.

IV. MANAGEMENT OF CONROLLED SUBSTANCES

A. Harris Health System Organization Responsibilities

1. An interdisciplinary Controlled Substances Oversight Committee (CSOC) is established to define, support, guide, and oversee the comprehensive CS diversion monitoring and prevention program.
2. CS data is generated and analyzed
3. The results of CS analysis are shared with the interdisciplinary CSOC to provide oversight to the comprehensive controlled substance diversion prevention program
4. Potential diversion cases shall be investigated as outlined in section VII of this policy
5. Drug diversion response in the organization includes but is not limited to:

    a. Assessment of harm to patients,
    b. Consultation with public health officials when tampering with injectable medication is suspected, and
    c. Prompt reporting to state and federal enforcement agencies.

B. Pharmacy Responsibilities

1. The Pharmacist in Charge (PIC) is responsible for ensuring adequate procedures are in place for handling controlled substances in their areas (Refer to Harris Health System Department of Pharmacy Procedure 3.80 Pharmacy Controlled Substances).

2. Physical Security of the Pharmacy

    a. Entry into the pharmacy shall be monitored via electronic access for all doors.
    b. Camera surveillance will be utilized.
    c. Pharmacy doors are badge-access yet still have lock with key. When applicable, keys to the main pharmacy or medication storage areas shall be clearly stamped with instructions to not duplicate and distribution shall be strictly limited to only essential personnel.

C. Surgical and Procedural Areas

1. CS are secured in the operating room, procedural areas, and anesthesia work areas during and between surgical cases.
2. Syringes prepared from multi-dose vials are labeled and kept under the control of the person preparing the syringes until administered.
3. CS dispensed for a surgical case are reconciled by Pharmacy against the products documented as administered or returned to the pharmacy.

D. Provider Orders/Prescribing

1. CS shall only be ordered/prescribed by licensed providers with DEA authorization.
2. Electronic systems shall be used to order/prescribe and communicate CS orders.
3. If written prescriptions are used, only authorized watermark prescription paper will be used.
4. All verbal orders require authorized prescriber signature.

E. Care Units Responsibilities

1. Only portless tubing shall be used for intravenous administration of CS.
2. ADC shall be used when available for storage/removal of CS upon a valid order.

    a. Medications shall be administered to the patient, returned to stock, or wasted within thirty (30) minutes upon removal.
    Exception: Medications removed in procedural areas shall be removed no more than thirty (30) minutes prior to procedure and returned or wasted immediately after the procedure.
    b. Administration of the medication shall be documented on the appropriate location on the electronic health record.
    c. Wastes and returns to stock shall be documented on the ADC or flowsheet as appropriate.

3. Returning/wasting of CS

    a. All CS medications returned or wasted shall be witnessed by two

(2) licensed professionals (Registered Nurse, Licensed Vocational Nurse, Pharmacist, or Physician).

b. Documentation of the wastage shall be completed at the time the controlled substance is actually wasted.
c. In non-ADC areas, administration and waste shall be documented and reconciled on the MCSAR.
d. Standard operating procedures for wasting common controlled substance dosage forms are outlined in Appendix A of this policy.

4. Inventory

a. Medications shall be inventoried (count verified) during each transaction when CS are removed or added from the cabinet;
b. Two (2) licensed staff members shall inventory CS once a week (each Wednesday);
c. The PIC or designee shall monitor the weekly shift counts and notify the Nurse Manager/Program Manager if the counts are not being completed each week; and
d. The PIC or designee shall notify the respective Director of Nursing if a unit/area fails to complete their weekly controlled substance inventory count timely.
e. The PIC or designee, in consultation with the Chief Nurse Executive (CNE) and CPO, shall jointly discuss and change the frequency of the inventory count in order to consistently comply with the law regulating controlled substance.

V. RECORD KEEPING:

All controlled substance records shall be kept in accordance with the Texas State Board of Pharmacy, Federal law, and Harris Health System Record Control Policy No. 3000.0.

6-D-2: Record Keeping needs to include a dated controlled substance inventory which includes the use of controlled substances on individual patients. Such records must be kept in the form of a secured computer record consistent with state and federal law.

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VI. DISCREPANCY MONITORING:

A. Auditing/Report generation:

1. Routine auditing of CS shall occur on a proactive and retroactive basis using available audit tools and best practices.
2. The Patient Care Area or DOP personnel may also perform random audits of controlled substance administration records for discrepancies.

B. The organization shall utilize reports available in the ADC as well as manual audits as necessary to monitor for diversion and identify discrepancies

C. CS count discrepancies generated at the ADC shall be resolved before the end of the shift.

D. For CS count discrepancies generated at the ADC, the PIC or designee shall:

1. Review all CS discrepancies on a daily basis for validity and timeliness of resolutions;
2. Forward pertinent CS discrepancies (i.e.: discrepancy with questionable resolution or not resolved within twenty-four (24) hours of its occurrence) to the Nurse Manager for review and response; and
3. Forward all pertinent discrepancy documentation to the Nurse Manager upon request.

E. Upon review of available information departmental leadership will be engaged to assist with classifying the identified discrepancies as one of the following:

1. Resolved Discrepancy: Discrepancy in which the explanation provided in a timely manner is plausible and adequate to account for the variation.
2. Unresolved Discrepancy: Discrepancy in which there is no plausible or adequate explanation to account for the discrepancy or where adequate response was not given within 72 hours of notification of the discrepancy.
3. Suspected Diversion: Discrepancy is surmised to be due to diversion without evidence/proof supporting diversion.
4. Known Diversion/Theft: Evidence suggests that the discrepancy is known to be due to diversion.

F. Resolution of individual unresolved discrepancies:

5. Notification of discrepancy is sent to the individuals involved, their immediate supervisor/manager, director, and the PIC or designee.
6. Discrepancies must be resolved within 48 hours from notification.
7. If no response is received within 48 hours from initial notification, the request shall be escalated to the Administrator for the ASC and LBJ (Administrator) .
8. Another 24 hours shall then be granted for resolution (total 72 hours from initial notification).
9. If an advanced practice provider, physician, medical student, or medical resident is involved in discrepancy or diversion, the appropriate medical staff leadership including chief of staff, Chief Medicine Officer (CMO), and Program Director will be notified for timely resolution.

10. Unless extenuating circumstances with a resolution plan are authorized by the Administrator, discrepancies that are not resolved within the allotted 72 hours shall be classified as a loss for reporting purposes as outlined in Section VII and in Appendix B of this policy.

G. Resolved discrepancies shall also be analyzed for patterns with individual users or units to determine if coaching is needed on processes.

VII. DISCREPANCY MONITORING

A. Auditing/Report generation:

1. Routine auditing of CS shall occur on a proactive and retroactive basis using available audit tools and best practices.
2. The Patient Care Area or DOP personnel may also perform random audits of controlled substance administration records for discrepancies.

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3. If no response is received within 48 hours from initial notification, the request shall be escalated to the Administrator.
4. Another 24 hours shall then be granted for resolution (total 72 hours from initial notification).
5. If an advanced practice provider, physician, medical student, or medical resident is involved in discrepancy or diversion, the appropriate medical staff leadership including chief of staff, Chief Medicine Officer (CMO), and Program Director will be notified for timely resolution.
6. Unless extenuating circumstances with a resolution plan are authorized by the Administrator, discrepancies that are not resolved within the

allotted 72 hours shall be classified as a loss for reporting purposes as outlined in Section VII and in Appendix B of this policy.

7. Resolved discrepancies shall also be analyzed for patterns with individual users or units to determine if coaching is needed on processes.

VIII. SUSPECTED/KNOWN DIVERSION

Suspected theft or significant losses of CS shall be reported by the PIC of the affected pavilion or designee to the Harris Health System CS Diversion Response Team for action and investigation in accordance with established procedure (Appendix B).

REFERENCES/BIBLIOGRAPHY:

Texas State Board of Pharmacy(TSBP)
Drug Enforcement Agency (DEA)

Texas Department of Public Safety and Texas Department of Health

84 FR 5816 (40 CFR 261-273)

American Association for Accreditation of Ambulatory Surgery Facilities Version 7 section §500

APPENDICES:

Appendix A: Standard Operating Procedure for Wasting Common Controlled Substance Dosage Forms

Appendix B: Guidelines for Determination of Significant Loss

FORMS:

Harris Health Form 284588 Unit Narcotic Reconciliation Form

Harris Health Form 282139 Perpetual Inventory Record for Controlled Substances

Harris Health Form 282158 Multi-Purpose Controlled Substance Administration

Record (MCSAR)

OFFICE OF PRIMARY RESPONSIBILITY:

Harris Health System Department of Pharmacy Services
Harris Health System Department of Nursing Services

REVIEW/REVISION HISTORY:

Effective Date	Version # (If Applicable)	Review/ Revision Date (Indicate Reviewed or Revised)	Approved by:
9/16/16	1.0	9/16/16	The Ambulatory Surgical Center (ASC) at LBJ Governing Body
		Reviewed / Approved 3/29/18	The Ambulatory Surgical Center (ASC) at LBJ Governing Body
		Reviewed / Approved 02/14/2019	The Ambulatory Surgical Center (ASC) at LBJ Governing Body
		Reviewed / Approved 02/13/2020	The Ambulatory Surgical Center (ASC) at LBJ Governing Body
		Reviewed / Approved 02/25/2021	The Ambulatory Surgical Center (ASC) at LBJ Governing Body

APPENDIX A:

STANDARD OPERATING PROCEDURE FOR WASTING COMMON CONTROLLED SUBSTANCE (CS) DOSAGE FORMS

General Considerations:

- ***** Do not flush or discard medications in the sink (a.k.a. "sewering")*****
- CS medications shall be disposed of in approved non-retrievable containers. If an area begins to accept CS waste, please email Hazardous Materials (HazardousMaterials@harrishealth.org) to set up an approved non-retreivable container in the area for wasting CS.
- Waste shall require authorized WITNESS for verification
- Waste documentation shall include drug name, wasted amount, and witness name
- **Intact containers** of CS medications (i.e., unopened/ unused due to patient refusal, order cancellation, etc.) shall be returned via appropriate return processing
- **Open or PARTIALLY** used CS medication (i.e., seal is broken) shall be wasted based on the dosage form and the guideline below
- Please note that this list is not exhaustive. For questions regarding controlled substances, contact Pharmacy.

DOSAGE FORM	DISPOSAL INSTRUCTIONS
Proper disposal of a **transdermal** patch	• Fold patch so sticky sides are together, being careful not to touch the medication on the patch • Dispose patch in the patch slot of the Cactus sink, using the attached tool to push it through the slot. • Do NOT flush the patch cover
Proper disposal of oral **capsules**	• Drop capsule into the pill maze of the Cactus sink
Proper disposal of oral **tablets**	• Drop tablets into the pill maze of the Cactus sink
Proper disposal of oral **solution**	• Dispose of oral solution into the liquid receptacle of the Cactus sink
Proper disposal of **sublingual film**	• Discard film in the approved non-retrievable container
Proper disposal of **rectal gel**	• **Before** discarding the applicator, dispose any remaining rectal gel (applicator tip is pointed over the approved non-retrievable container, the plunger pulled back then gently depressed until it stops to force gel from the applicator tip into the container) • Dispose the empty applicator in the appropriate biohazard bin
Proper disposal of **injectable medications or infusions**	• Drain the remaining amount into the liquid receptacle of the Cactus sink • Dispose broken vial and/or syringe in the red sharps container • Dispose of empty containers in the regular trash

APPENDIX B
GUIDELINES FOR DETERMINATION OF SIGNIFICANT LOSS

Federal regulations require that registrants notify the DEA Field Division Office in their area, in writing, of the theft or significant loss of any CS within one business day of discovery of such loss or theft. The theft or significant loss of any controlled substance by a pharmacy shall also be reported in writing to the Texas State Board of Pharmacy immediately on discovery of such theft or loss. A pharmacy shall be in compliance with this subsection by submitting to the board a copy of the Drug Enforcement Administration (DEA) report of theft or loss of controlled substances, DEA Form 106, or by submitting a list of all controlled substances stolen or lost.

At Harris Health System, the following definitions shall apply for determining when a loss is reportable:

a. **SIGNIFICANT LOSS**: Any discrepancy that is not resolved within the time defined in Harris Health System policy after investigation shall be considered a significant loss and reported to the DEA and the Texas State Board of Pharmacy.

b. **THEFT**: any loss due to confirmed diversion by any individual while the controlled substance is in the control of the Harris Health System. Any loss due to confirmed diversion, regardless of the amount, shall be reported to the DEA and the Texas State Board of Pharmacy.

The Pharmacist in Charge (PIC) of the area where the theft or significant loss occurred shall complete and submit the DEA Form 106 to the Field Division office in their area and to the Texas State Board of Pharmacy.

TITLE: PATIENT ALLERGIES

PURPOSE: To assure patient safety by establishing a mechanism for the identification, documentation, and communication of patient allergies.

POLICY STATEMENT:

Patient allergies will be documented in the patient's Ambulatory Surgical Center (ASC) at LBJ medical record. A red allergy alert arm band will be placed on the patient with identified allergies and a green arm band for latex allergy. Patient allergies will include, but not be limited to, allergies to medications, food, and latex.

POLICY ELABORATIONS:

I. DEFINITIONS:

A. **ALLERGY**: An immune reaction to an environmental agent that results in a symptomatic reaction.

II. PROCEDURE:

A. Upon admission to the Ambulatory Surgical Center (ASC) at LBJ ("ASC") a registered nurse conducting the pre-surgical assessment will assess the patient's allergies and validate any previously documented allergies listed in the electronic medical record from the comprehensive medical history and physical.

B. A red allergy alert wristband will be placed on patients with identified allergies and a green wristband for latex allergy.

C. The red allergy alert wristband and green wristband should be placed in the same extremity as the patient's identification (ID) band.

D. The current process for reporting adverse drug events will be governed by the Adverse Drug Event Reporting and Monitoring policy (Policy No. 530.0).

E. If there is a change in a patient's listed allergies, the change will be updated in the patient's electronic medical record.

REFERENCES/BIBLIOGRAPHY:

42 Code of Federal Regulations (C.F.R.) §416.52(a) (2).

American Association for Accreditation of Ambulatory Surgery Facilities Version 8.0

Adverse Drug Event Reporting and Monitoring policy (Policy No. 530.0)

OFFICE OF PRIMARY RESPONSIBILITY:

The Ambulatory Surgical Center (ASC) at LBJ

Effective Date	Version # (If Applicable)	Review/ Revision Date (Indicate Reviewed or Revised)	Approved by:
6/14/16	1.0	06/14/16	The Ambulatory Surgical Center (ASC) at LBJ Governing Body
	2.0	Revised / Approved 03/29/2018	The Ambulatory Surgical Center (ASC) at LBJ Governing Body
		Revised / Approved 02/14/2019	The Ambulatory Surgical Center (ASC) at LBJ Governing Body
		Revised / Approved 02/13/2020	The Ambulatory Surgical Center (ASC) at LBJ Governing Body
		Reviewed / Approved 02/25/2021	The Ambulatory Surgical Center (ASC) at LBJ Governing Body

TITLE: OPERATING AND SAFETY PROCEDURES FOR THE MEDICAL USE OF X-RAYS AT THE AMBULATORY SURGICAL CENTER (ASC) AT LBJ.

PURPOSE: To provide guidelines for safe radiation use to all workforce members who use radiation at the Ambulatory Surgical Center (ASC) at LBJ and management in complying with the objectives of the Texas Department of State Health Services, Bureau of Radiation Control regulations and the institutional health and safety policies.

POLICY STATEMENT:

The Texas Administrative Code establishes procedures that serve to minimize radiation exposure to patients and workforce members. These procedures also comply with the rules enforced by the Texas State Health Services (DSHS) Radiation Control. As a result, it is the policy of the Ambulatory Surgical Center (ASC) at LBJ ("ASC") that all workforce members who work with radiation maintain a safe environment by adhering to the Texas Administrative Code's procedures and adhering to DSHS's rules regarding radiation. It is vital that faculty, staff, and students have enough information available to aid them in the safe conduct of their daily work activities relating to radiation. To that end, the Texas Department of State Health Services (TDSHS) has granted a registration to the Harris Health System authorizing the use of radiation producing devices. An essential component of that authorization is the Operating and Safety Procedures Manual for Medical Use of X-rays.

POLICY ELABORATIONS:

I. DEFINITIONS:

A. **IMAGING RECEPTOR:** A device that changes an x-ray beam into a visible image. An image receptor may be a radiographic film and cassette, a phosphorescent screen (used in fluoroscopy or computed radiography), or a special detector placed on a table or upright bucky diaphragm (used in direct digital radiography).

B. **RADIATION SAFETY OFFICER:** The individual responsible for the safe use of radiation and regulatory compliance within the Ambulatory Surgical Center (ASC) at LBJ. This individual has been designated by the Governing Body of the Ambulatory Surgical Center (ASC) at LBJ to assure that all radiologic services are provided in accordance with the requirements of 42 C.F.R. §416.49 and any other applicable state law requirements.

C. **WORKFORCE:** Employees, medical staff, trainees, contractors, volunteers, and vendors.

II. INTRODUCTION

A. The fundamental objective of the use of radiation is to obtain optimum diagnostic information or therapeutic effect with minimum exposure of the patient, the personnel concerned, and the general public.

B. Further advice concerning hazards associated with specific devices and the development of new or unfamiliar activities should be obtained through consultation with the Radiation Safety Officer (RSO).

C. Workforce members operating x-ray producing devices must be familiar with the requirements set forth in this Policy and must conduct their operations in accordance with them.

D. The Operating and Safety Procedures are required by Title 25 of the Texas Administrative Code. This Policy establishes procedures that will minimize radiation exposure to patients and Workforce members. They are provided to comply with rules enforced by the Texas Department of State Health Services (DSHS), Radiation Control.

1. The rules require that each x-ray facility be registered with DSHS, Radiation Control. The certificate of registration contains conditions and restrictions that apply to the operation of the x-ray machines in this facility as well as a listing of the sections of the rules that apply.

2. The rules require that a Radiation Safety Officer (RSO) be designated. The RSO has the responsibility and authority for assuring safe radiation practices and serves as the contact person between the facility and the DSHS, Radiation Control.

3. The name of the current radiation safety officer is provided on the Certificate of Registration that is located in the Radiology

Department at LBJ Hospital. Questions or concerns regarding radiation safety will be directed to the RSO of the ASC.

4. These rules are available for review at http://www.dshs.state.tx.us/radiation/rules.shtm or at the website of the State of Texas Department of State Health Services.

This Policy is designed to inform and educate Workforce members that operate around x-ray producing devices on the safety features and regulatory requirements and to ensure safe radiological working conditions. As such, documentation of annual review and understanding by Workforce members of x-ray producing devices shall be kept on file. The documentation must include the name and signature of the individual, the date, and initials of the RSO.

III. GENERAL RESPONSIBILITIES:

A. All Workforce members who work with radiation shall:

1. Properly wear an assigned radiation monitor while at work, if such a monitor has been assigned to them. ~~Properly monitoring their~~

~~own radiation exposure by wearing an assigned radiation monitor while at work, if such a monitor has been assigned to them.~~

2. ~~Utilizing~~ Utilize all appropriate radiation protection measures including:

   a) Wearing all appropriate personal protective equipment including leaded gloves, lead aprons, or leaded glasses where appropriate;

   b) Using additional protective barriers and other shields when possible;

   c) Using mechanical devices whenever their aid will reduce exposure;

   d) Follow the technique chart provided for each unit;

   e) Complying with requests from the RSO regarding personnel dosimetry and operating procedures;

   f) Verifying appropriate training is completed prior to operating x-ray producing devices; and

   g) Providing signature verification of annual review of these operating and safety procedures.

3. Notifying the Radiation Safety Office of any new radiation producing devices and repairs to existing equipment;

4. Contacting the Radiation Safety Officer for shielding calculations for rooms proposed for a different type of x-ray modality or for a new installation of an x-ray producing device;

5. Notifying the Radiation Safety Office of any stolen or lost x-ray producing devices;

6. Complying with proper procedure when hiring/terminating employment or the use of x-ray producing devices; and

7. Conducting all radiation safety related procedures specific to your particular working environment (for example: portable radiography, CT, fluoroscopy, etc.).

B. The Department of State Health Services' (DSHS) rules require that the ASC designate a Radiation Safety Officer (RSO). The RSO has the responsibility and authority for assuring safe radiation practices occur in the ASC and serves as the contact person between the ASC and DSHS Radiation Control.

C. The Radiation Safety Officer is responsible for:

1. Reviewing all proposals for use of x-ray producing devices and recommending action to the Radiation Safety Committee;

2. Inspecting facilities and equipment through radiation safety evaluations and monitoring all facilities in which radiation-producing equipment resides;

3. Acting as consultant in the design of all new facilities using x-ray producing devices for the purpose of providing protection against radiation exposure;

4. Preparing and disseminating information on radiation safety for faculty, staff, and students as necessary;

5. Providing personnel monitoring services, including the reviewing and recording of commercially processed dosimeter reports;

6. Reviewing and performing, as necessary, lead apron/protective device evaluations and removing any devices that are not in compliance;

7. Reviewing completed medical physics testing and recommending action to the various departments;

8. Preparing registration and certification amendments and technical renewals as well as acting as the primary contact for correspondence with state radiation control authorities on a timely basis;

9. Investigating incidents involving radiation exposures including overexposures, incidents, theft, loss of devices, and accidents;

10. Notifying the Texas Department of State Health Services of all reportable incidents including overexposures, theft, loss of x-ray producing devices and submitting reports as required;

11. Ensuring that radiation doses are maintained as low as (is) reasonably achievable (ALARA); and

12. Maintaining records required by the Texas Department of State Health Services for inspection purposes.

D. The Radiation Safety Committee (RSC) is responsible for:

1. The RSC incorporates multiple departments including the ASC. Attendance at the quarterly RSC meeting can include, but is not limited to: Laboratory, Risk Management, Cardiac Cath Lab, Nursing, Radiation Therapy, PET/CT, Nuclear Medicine and Radiology Administration, and is presided over by the Radiation Safety Officer (RSO) or his/her designee.

2. The RSC provides quarterly review and approval of Radiology departmental policies, Radioactive Materials License amendments, employee radiation monitoring records and other topics as they relate to Radiation Safety within the Harris Health System. Approving policies and practices regarding the registration of radiation producing devices at Harris Health System and the implementation of the approved policies as delegated to the Radiation Safety Officer.

3. Reviewing periodic audits performed by the RSO.

4. Maintaining minutes of the meeting delineating the date, members presence, review actions including committee response, appended

conditions, recommended actions, Audits, RPP, ALARA reviews, and RSO reports.

E. Radiation Protocol Committee (RPC):

1. The Texas Administrative Code 289.227 requires the establishment of a RPC for facilities that perform Fluoro Guided Interventional (FGI) procedures and/or Computed Tomography (CT).

2. The required members for the RPC are the RSO's, radiologists, physicists, Harris Health Administration, and additional staff members deemed necessary.

3. The records of the meeting minutes, Reference Levels, and actions taken by the RPC are kept on a share drive maintained by Harris Health System.

III. APPROVAL AND AUTHORIZATION

A. **Registration**: Harris Health System has been issued a registration to possess radiation producing devices by the Texas Department of State Health Services.

1. The registration, R01642, currently covers the use of radiation producing devices at Ben Taub General Hospital and the Baylor College of Medicine (BCM) affiliated Ambulatory Care Services.
2. The registration, R18411, currently covers the use of radiation producing devices at LBJ Hospital and the University of Texas (UT) affiliated Ambulatory Care Services.

B. **Regulations:** All radiation producing machines are regulated by state and federal laws (e.g. the Texas Administrative Code (TAC) and the Food and Drug Administration. The ASC will comply with the required regulations. This handbook establishes procedures to comply with the regulations enforced by the Texas Department of State Health Services (TDSHS) Bureau of Radiation Control. [25 TAC §289.227(i)(2)].

C. **Procedure for X-ray Producing Devices Authorization:** To be authorized to operate an x-ray producing device, the individual must meet the appropriate operator requirements. Each operator for human use shall meet the appropriate credentialing requirements of rules issued pursuant to Medical Radiologic

Technologist Act Texas Civil Statutes Article 4512m, See[§289.226(t)] Students are defined as individuals enrolled in a radiologic technology program which meets the requirements of the Texas Department of State Health Services, Medical Radiologic Technologists Board, (25 TAC 143.5). Students will NOT work in a radiographic exposure room or operate a mobile unit without the oversight of a supervising staff technologist.

IV. PROCEDURES:

A. Radiologic services will only be provided when integral to procedures performed at the ASC.

B. Credentialing Requirements for Operators of X-Ray Machines:

1. All operators of X-Ray machines, including fluoroscopy, must meet appropriate credentialing requirements of the Medical Radiologic Technologist (MRT) Certification Act, Occupations Code, Chapter 601.

C. **Radiation Exposure Assessment & Dosimeter Application:** Personnel are monitored with commercial dosimeters.

1. Any adult who is likely to receive a dose from occupational exposure to radiation in excess of 500 millirem in a year must use an individual monitoring device.
2. Individual monitoring devices must be worn at the unshielded location of the whole body likely to receive the highest exposure. When a protective apron is worn, the location of the individual monitoring device is typically at the neck (collar).
3. The individual monitoring device shall be assigned to one individual and must be worn only by that individual.
4. Persons working in low exposure areas are furnished with bimonthly or quarterly dosimeters. Monthly dosimeters are assigned to personnel working in higher exposure risk positions (i.e. X-ray technicians, Radiology residents, etc).
5. In accordance with 25TAC §289.202(f), dosimeters will be issued to any person likely to receive greater than 10% of the annual allowable limit.
6. An individual's dosimeter history may be reviewed by the Radiation Safety Officer and if found to be less than 10% of the annual dose for an adult worker, consideration may be given to discontinue the dosimeter.
7. Occupationally exposed individuals are entitled to records of their

radiation exposure and may view their reports at any time. Radiation exposure reports will be posted in a conspicuous location in the relevant departments.

8. When individual monitoring devices are not being worn they will be stored in an area that is away from rooms where radiation machines are in use.
9. The RSO is responsible for the occupational dose records while the department director/manager or designee is responsible for exchanging the individual monitoring devices provided by the RSO. Original dosimetry reports are available from the RSO's office and may be stored on a share drive.
10. If you are working for another employer and receive an occupational dose, you should report that dose to the RSO so that it can be included in your annual record of occupational dose.
11. The RSO or designee will review radiation monitor readings after each cycle of monitoring and note any readings that are in excess of the norm for that person's responsibilities. The RSO will review such findings with the individual and arrange plans to improve radiation management. A note of such findings and the resultant review with the employee will be reported to the PI committee. If an individual's exposure exceeds the annual limits established by State of Texas regulations and for which notification is required, the State will be notified and proper documentation maintained as required by regulation.

D. Individual Monitoring Requirements:

1. The maximum permissible radiation dose limits are found in 25 TAC §289.202(f). Any Workforce member who is likely to receive a dose from

occupational exposure to radiation in excess of 500 millirem in a year, must use an individual monitoring device.

a) Occupationally exposed Workforce members are entitled to records of their radiation exposure and may view their radiation exposure reports at any time. Radiation exposure reports will be posed in a conspicuous location in the ASC.

2. Occupationally exposed pregnant Workforce members must report their pregnancy to the RSO before special protection measures and counseling related to their job responsibilities can be developed to protect the conceptus. Workforce members are encouraged to announce their pregnancy to the RSO as soon as possible. All information regarding a Workforce member's pregnancy will be treated as confidential to the extent the law permits.

3. Individual monitoring devices must be ~~work~~ worn at the unshielded location of the body likely to receive the highest amount of radiation exposure. When a protective apron is worn, the location of the individual monitoring device is typically at the neck (collar).

a) Additional individual monitoring devices that are used to monitor the dose of radiation to the embryo/fetus of a pregnant Workforce member must be located at the level of the uterus or as close as possible to the embryo/fetus ~~wrist~~ under any protective apron being worn by the woman.

4. An individual monitoring device shall be assigned to one individual and must be worn only by that individual.

5. When wearing a protective apron during the fluoroscopy procedures, multiple individual monitoring devices may be worn. When multiple devices are worn, occupational doses shall be determined in accordance with Section 289.231(m)(3)(C) of the Texas Administrative Code.

6. When individual monitoring devices are not being worn, the devices must be stored in an area that is away from rooms where radiation machines are in use.

7. The RSO is responsible for the occupational dose records while the department director/manager or designee is responsible for exchanging the individual monitoring devices provided by the RSO. ~~and is responsible for exchanging the individual monitoring device.~~ Original dosimetry reports are located in the RSO's office.

8. If a Workforce member is also working for an employer that is not the ASC and receives an occupational dose of radiation, that Workforce member must report their dosages to the RSO, so that those dosages may be included in the Workforce member's annual record of occupational doses.

9. The RSO or his or her designee will review radiation monitor readings after each cycle of monitoring and note any readings that are in excess of the norm for that Workforce member's responsibilities. The RSO will review such findings with the Workforce member and arrange plans to improve radiation management. If a Workforce member's exposure exceeds the annual limits established by law, the State will be notified and proper documentation will be maintained as required.

E. Termination of Authorized User/Operator Employment termination includes separation from Harris Health System or the employee terminates operations involving radiation producing devices. Upon termination the designated department personnel must complete the following steps:

1. Notify the Radiation Safety Office as soon as possible of the termination.

2. Return all personnel dosimeters

F. Use of Protective Devices and Apparel

1. Workforce members must use protective devices and apparel, such as lead aprons, gloves, and shields to reduce exposure to an amount that is as low as reasonably achievable. Protective devices must be used or provided in the following situations:

   a) When it is necessary for an individual other than the patient to remain in the room or hold a patient;

   b) When a ~~patient~~ Workforce member must hold the image receptor;

   c) When it is necessary to protect other patients who cannot be moved out of the room; or

   d) When the gonads are within five (5) centimeters of the X-Ray beam, shields must be used unless the use of the shield interferes with the diagnostic procedure.

2. If fluoroscopic procedures are being performed, protective devices (lead drapes, hinged sliding panels) shall be in place unless they interfere with the sterile field. All individuals in the fluoroscopic room must wear protective aprons of 0.5 mm lead equivalent material or must stand behind and equivalently protective shield.

3. Protective devices can be found in a designated location within the ASC.

4. Protective apparel shall be checked annually for defects by the Nursing Clinical Manager or his or her designee shall inspect the apparel for holes, cracks, or tears. This check can be done by visually inspecting the apparel or feeling the protective apparel, or it may be done by X-Raying the items. A record will be kept of this check.

5. If any apparel is found to be defective at the time of the annual check or on any other occasion, the apparel shall be removed from service at the ASC until it has been cleared by additional imaging evaluation. Further evaluation of lead apparel will be supervised by a medical physicist. Apparel that does not pass the annual inspection will be permanently removed from the ASC and documented accordingly on the lead apparel inventory spreadsheet.

6. The ASC hereby adopts and will follow Harris Health System Radiology Department's policy for Lead Apparel Inspection and Inventory. This policy addresses the specifics of the lead apparel inspection process and the guidelines for maintaining inventory.

G. Holding of Patients and/or Image Receptor

1. If a patient or imaging receptor (IR) must be supported during a radiation procedure, Workforce members must use a mechanical holding device when circumstances permit. Mechanical devices cannot be routinely used during situations when the patient is not cooperative or physical barriers to their use prevent their use or when the correct position cannot be achieved.

2. If it becomes necessary for an individual to hold a patient or an IR, the individual should not be pregnant. The individual must wear protective apparel and keep out of the direct beam. If feasible, a non-occupationally exposed individual should hold the patient and/or the IR.

H. Posting Notices:

1. The rooms in the ASC in which the X-Ray machines are located and operated are radiation areas. As a result, access to these areas must be restricted.

2. The radiation area must be designated as such with a sign that states "Caution Radiation Area," or other similar language.

I. Radiation Dose to Operators

1. The occupational dose limits of radiation for Workforce members are set forth in Section 289.231(m) of the Texas Administrative Code.

2. If a Workforce member is pregnant or becomes pregnant, she may voluntarily inform the RSO in writing of the pregnancy, the RSO will ensure that procedures are put in place to restrict the dose to the embryo/fetus to not more than 0.5 rem (500 mrem) during the entire pregnancy. The Workforce member is required to follow the instructions of the RSO to maintain doses within these limits.

3. If a Workforce member suspects that there has been an excessive exposure or a radiation incident, that Workforce member must immediately notify the RSO.

J. Operation of X-Ray Machines:

1. Ordering X-Ray Exams:

a) No X-Ray exam shall be taken unless it is ordered by a physician. The order must be placed in the patient's electronic medical record.

2. Operator Position During Exposure:

a) The operator must be able to continuously view and communicate with the patient.

b) During the exposure, the operator must be positioned so that the operator's exposure is as low as reasonably achievable and he or she must be at least six (6) feet from the machine or be protected by a lead apron, gloves, and/or other shielding.

3. Use of a Technique Chart:

a) Technique charts aide in reducing the exposure of radiation to the operator and patient and should be used for all exposures. ~~Use of a technique chart aides in reducing the exposure to the operator and the patient should be used for all exposures.~~

b) Technique charts should be displayed in the vicinity of the control panel of each X-Ray machine and may be ~~in displayed~~ in writing, electronically, or graphically displayed.

4. Restriction and Alignment of the Beam:

   a) The useful X-Ray beam shall be restricted to the area of clinical interest.

5. Use of Fluoroscopic Machines:

   a) When using the Fluoroscopic machines, Workforce members must reset the five (5) minute cumulative timing device before each fluoroscopic procedure.

   b) For mobile Fluoroscopy (i.e. C-arm) units, a thirty (30) centimeter (cm) source-to-skin (SSD) spacer must be used unless the procedure falls under the conditions of paragraph G(5)(c) below.

   c) A twenty (20) centimeter SSD spacer may be used for mobile fluoroscopy during any procedure in which the thirty (30) centimeter separator device presents a potential obstruction to the procedure as judged by the physician performing the procedure or by the radiologic technologist in charge of the machine. The X-Ray tube will be maintained at a reasonable distance from the patient as is consistent with the procedure.

6. Use of Mobile or Portable Machines:

   a) The operator shall notify other persons within a 10-foot radius that they should remain outside the six-foot zone while the exposure is being made. Stat acquisitions may be acquired if other Workforce members cannot vacate the six-foot zone due to other obligations. The operator must wear a lead apron or be protected by other shielding (e.g., the machine); and should never be in line with the direct beam.

   b) Any person required to assist with holding patients during portable examinations shall be provided with a lead apron and instructed on how to hold the patient or cassette without being directly exposed. Such instructions might include the use of leaded gloves.

c) Each portable x-ray machine will be equipped with the following devices:

(1) A time control cable having a length of at least six feet;

(2) A variable aperture light localizing collimator (cone) which will restrict the x-ray beam; and

(3) A technique chart must be available for all mobile procedures. The technique charts should take into account: (1) the size of the patient; (2) the projection; (3) the kVp; (4) the tube current, if applicable; (5) the mAs, if applicable; and (6) the exposure time if applicable.

7. Alternative Processing Systems:

The ASC uses digital processing techniques. Processing will be done according to the manufacturer's recommendations, which are located in the office of the Quality Control Coordinator for Harris Health.

8. Digital Imaging Acquisition Systems:

The ASC uses a digital imagining acquisition system. Processing will follow the quality assurance/quality control protocol for image processing established by the manufacturer or, if a manufacturer's protocol is not available, by the registrant.

9. Quality Assurance Program:

a) A Quality Assurance Program has been established by Harris Health. Pursuant to the Letter of Agreement between Harris Health and the ASC, the ASC will rely on this program.

b) The Quality Assurance Program requires the commitment of Workforce members to ensure quality diagnostic imaging. Quality Assurance tests will be performed at routine intervals, acceptability limits established, and corrective action taken when applicability limits are exceeded.

c) The Quality Assurance Program also ensures the following:

(1) Radiographic equipment receives an annual preventive maintenance by service personnel. Annually, Harris Health's medical physicist is responsible for performing calibration verification surveys and equipment evaluations. Quality control on radiographic equipment is performed according to schedules specified by the Radiation Safety Officer. Any suspected malfunction or problems identified on with the equipment should be immediately reported to Harris Health's Biomedical Engineering department.

(2) An annual inventory of all radiation machines is maintained by the Radiation Safety Officer.

VIII. X-RAY SYSTEMS NEEDING CORRECTION OR REPAIR

A. In order to achieve compliance with State regulations, the correction or repair shall begin within 30 days following the failure and shall be performed according to a plan designated by the registrant. Correction or repair shall be completed no longer than 90 days from discovery unless authorized by the agency.

B. Records of x-ray system corrections or repairs shall be maintained. These records include the repairs made and any tests, measurements or numerical readings done to verify completion.

C. Digital imaging acquisition system quality control: Our facility uses a digital imaging acquisition system. Processing will follow the quality assurance/quality control protocol for image processing established by the manufacturer or, if no manufacturer's protocol is available, by the registrant.

D. Quality Assurance Program: A QA program has been established and requires the commitment of practitioners and staff to ensure quality diagnostic imaging. QA tests will be performed at routine intervals, acceptability limits established and corrective action will be taken when acceptability limits are exceeded. It is our goal to ensure optimum diagnostic imaging with reduced repeats and

minimal patient exposure.

1. Radiographic equipment receives an annual preventive maintenance by service personnel. Annually, or periodically (depending on the modality), the medical physicist is responsible for performing calibration verification surveys and equipment evaluations. QC, required by regulation, on radiographic equipment is performed according to schedules specified by the RSO. Technologists are to report any suspected malfunction or problems of equipment immediately to Biomedical Engineering.

2. CT Scanners receive preventative maintenance in accordance with the requirements for the machine. Documentation of PM's are maintained in Biomedical Services. Annually, the medical physicist is responsible for performing calibration verification surveys and other equipment evaluations to include dose measurements. Final reports are kept on file. Images for QC are stored in PACS. CT technologists will perform and document weekly quality assurance tests to verify that CT machines are within limits.

REFERENCES/BIBLIOGRAPHY:

42 C.F.R. §416.49(b)(1).

§482.26(b)(1)

https://apps.hchd.local/sites/dcc/Policy/Departmental/Radiology%20Services/G-1%20Operating%20and%20Safety%20Procedures%20for%20Medical%20Use%20of%20X-rays.pdf

American Association for Accreditation of Ambulatory Surgery Facilities Version 8.0

OFFICE OF PRIMARY RESPONSIBILITY:

The Ambulatory Surgical Center (ASC) at LBJ

REVIEW/REVISION HISTORY:

Effective Date	Version # (If Applicable)	Review/ Revision Date (Indicate Reviewed or Revised)	Approved by:
4/13/2017	1.0		The Ambulatory Surgical Center (ASC) at LBJ Governing Body
		Reviewed/Approved 02/14/2019	The Ambulatory Surgical Center (ASC) at LBJ Governing Body
		Reviewed/Approved 02/13/2020	The Ambulatory Surgical Center (ASC) at LBJ Governing Body
		Reviewed / Approved 02/25/2021	The Ambulatory Surgical Center (ASC) at LBJ Governing Body
		Revised 03/23/2021	

TITLE: FIRE WATCH

PURPOSE: To provide guidelines for safely maintaining the Ambulatory Surgical Center (ASC) at LBJ when a fire protection system (fire alarm, sprinkler, fire pump, etc.) is out-of-service for more than four hours in a 24-hour period.

POLICY STATEMENT:

The Ambulatory Surgical Center (ASC) at LBJ shall either evacuate the ASC or establish a fire watch if the center is occupied when any fire protection system (fire alarm, sprinkler, fire pump, etc.) is out-of-service or shut down for maintenance or repair for more than four hours in a 24-hour period.

POLICY ELABORATIONS:

I. GENERAL PROCEDURE:

A. Steps to take when a fire protection system is out of service:

1. Attempt to determine the extent and expected duration of the impairment;
2. If the system is to be shut down for maintenance or upon notification or discovery of a system impairment that is anticipated to last more than four hours, a Fire Watch Procedure will be initiated;
3. The fire department and/or LBJ Engineering Department, and/or other authorities having jurisdiction over the fire protection system will be notified;
4. The out-of-service equipment, fire alarm panel, and fire department connection indicator must be tagged with the appropriate notification;
5. The building or portion of the building affected by the system outage will be evacuated until the system is back in service, or a Fire Watch Procedure is implemented; and
6. The ASC Workforce will be notified of the impairment and implementation of a Fire Watch.

B. Fire Watch Procedure:

1. The Administrator or his or her designee will conduct a Fire Watch Procedure (Fire Watch);

2. The ASC Workforce member assigned to the Fire Watch will be solely dedicated to the Fire Watch and will have no other job duty assignments during the Fire Watch. This Workforce member must have a method of contacting the Houston Fire Department in an emergency. (Landline phone or cell phone);
3. The Workforce member assigned to the Fire Watch will patrol the ASC to ensure that other fire protection features of the building, such as egress routes and other fire protection systems, are available and functioning properly;
4. Fire Watch patrols will be performed periodically throughout the affected areas at random times as determined by the fire marshal;
5. The Workforce member conducting the Fire Watch will patrol a specific/consistent path throughout the affected areas at least hourly;
6. The patrol of affected areas will include all closets, storage areas, janitor closets, utility rooms and other unoccupied areas; and
7. Workforce members will be periodically reminded the facility is on Fire Watch.

C. Fire Watch Procedure if fire or smoke is identified~~:~~ [Refer ASC to policy 6003]

~~1.~~ If a fire or smoke condition is identified, RACE will be initiated Fire Watch personnel will contact the fire department immediately;
~~2.~~1. A Fire Watch documentation form will be completed daily and sent to the Fire Marshal's Office at least once every 24 hours;
~~3.~~2. When fire protection systems become functional the Fire Watch will be terminated;
~~4.~~3. A statement will be sent to the Fire Marshal's office stating the Fire Protection System is restored to normal operation and the has Fire Watch cleared; and
~~5.~~4. A statement of repairs or other documentation of system maintenance will accompany the statement of Fire Protection System restoration.

REFERENCES/BIBLIOGRAPHY:

American Association for Accreditation of Ambulatory Surgery Facilities- Version ~~7 §99999~~8.0

OFFICE OF PRIMARY RESPONSIBILITY:

The Ambulatory Surgical Center (ASC) at LBJ

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		Reviewed / Approved 02/25/2021	The Ambulatory Surgical Center (ASC) at LBJ Governing Body

Facility Safety Manual of the Ambulatory Surgical Center (ASC) at LBJ

Table of Contents

TITLE: FIRE DRILL/ALARM PROCEDURE

PURPOSE: To establish the protocol to be followed in the event of a fire alarm or fire drill at the Ambulatory Surgical Center (ASC) at LBJ.

POLICY STATEMENT:

To protect Workforce members of the Ambulatory Surgical Center (ASC) at LBJ ("ASC"), and patients of the ASC from a fire, the ASC will follow Harris Health System's ("Harris Health") Emergency Preparedness Guide and will treat every fire alarm as a serious event.

I. PROCEDURE:

A. If a fire alarm ("Code Red") is triggered in the ASC or if a fire is identified in the ASC, the following actions must be taken pursuant to recommendations by the Houston Fire Department (**RACE**):
   1. **R**escue patients, evacuate to a safe area;
   2. **A**larm - Pull nearest fire alarm, dial ext. x3-7800, give exact location and announce to the ASC that a "Code Red" exists;
      i. **Note:** if you are unable to contact the operator, dial the Houston Fire Department at 9-911. Do not panic or shout fire.
   3. **C**ontain fire, close doors/windows; and
   4. **E**xtinguish/Evacuate department/unit.

B. When operating the fire extinguisher, workforce members must adhere to the following procedure (**PASS**):

   1. **P**ull the pin;
   2. **A**im at the base of the fire;
   3. **S**queeze the trigger; and
   4. **S**weep from side to side.

C. Documentation Requirements after a Fire Drill or Fire Alarm:

   1. The ASC Administrator must document the ASC's response to a drill or actual fire on the Code Red Form (attached here to as Attachment A).
   2. The ASC Administrator must complete the appropriate form(s) if a patient, visitor, or a Workforce member is injured.

3. If an actual fire incident occurs at the ASC, the Administrator or his or her designee shall submit a Texas Department of State Health Services Ambulatory Surgical Center Incident Reporting Form within ten (10) business days of the incident.

REFERENCES/BIBLIOGRAPHY:

AAAASF Version 7 §400

CFC §416.41(C)

Emergency Preparedness Guide

BTGH Fire Safety Plan Policy FP

HCHD Fire Safety Risks Procedures Policy 7404

Texas Department of State Health Services Ambulatory Surgical Center Incident Reporting Form

OFFICE OF PRIMARY RESPONSIBILITY:

The Ambulatory Surgical Center (ASC) at LBJ

REVIEW/REVISION HISTORY:

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~~ATTACHMENT "A"~~

~~*Link to the Harris Health System Code Red Report form*~~

ATTACHMENT "B"

TEXAS DEPARTMENT OF STATE HEALTH SERVICES AMBULATORY SURGICAL CENTER INCIDENT REPORTING FORM

Name of Facility: _____

Facility License #: _____

Telephone: _____

Contact person(s): _____

Reporting Information – (incidents must be reported within 10 business days):

Date of this report: _____

1. Date of incident: _____

1. Type of incident:

□ Death of a patient while under the care of the ASC

□ The transfer of a patient to a hospital

□ Patient development of complications within 24 hours of discharge from the ASC resulting in admission to a hospital

□ A patient stay exceeding 23 hours

□ Occurrence of fire in the ASC

□ Theft of drugs and/or diversion of controlled drugs

~~4. Summary of reportable incident; what happened and how it was handled *(attach a separate sheet if necessary)*:~~

~~Return this form and any attachments within 10 business days of the incident to~~: ~~Texas Department of State Health Services Regulatory Licensing Unit - Facility Licensing Group Attn: Consolidated Programs Delivery Code 2835 PO Box 149347 Austin, Texas 78714-9347 Fax: (512) 834-451~~

HARRISHEALTH SYSTEM

WASTE DISPOSAL CHART

Regulated Medical Waste Disposal 30 TAC §326
No Pharmaceuticals

BIOHAZARD BAGS

All items saturated with blood or body fluids or Other Potentially Infectious Materials (OPIM) should be discarded as infectious waste. Examples:

- Blood tubing/bags soaked/dripping bloody dressings
- Glass or plastic items/ bottles with blood
- Suction liners/canisters or body fluid/liquid Thoracentesis
- Paracentesis

Never put biohazard bags in regular trash

All liquid infectious waste must be solidified prior to disposal.

- Human or animal body parts and tissues
- Organs
- Large tissue specimens
- Fetuses
- Orthopedic & OB Instruments
- External Fixators
- Non-reusable medical instruments/implants
- Pathological waste

Sharps Disposal and Re-useable Sharps Container Program

SHARPS CONTAINER

Sharps program in place for BT, LBJ, QM Outpatient Center, and Smith Clinic

Examples:

- Needles
- Needles with syringes
- Broken glass
- Broken ampoules
- Blades, Scalpels
- Pasteur pipettes
- Microscope slides
- Any item capable of puncturing the skin

Hazardous Materials

Non-inclusive Hazardous Waste Examples:

- Waste Gases
- Xylene
- Formaldehyde

Amalgam & all mercury containing equipment

Contact the Hazardous Material office for proper disposal guidelines. Never pour chemicals down the drain or sewer

Pharmaceutical Waste: 40 CFR §260
All Waste Medications

NO SHARPS OR DEA CONTROLLED SUBSTANCES

Pharmaceutical (Rx) waste includes all non DEA regulated pharmaceuticals:

- Pills & Tablets
- Medicinal Liquids
- Antiseptics
- Allergenic
- Transdermal Patches
- Gums & Lozenges
- Lotions & Creams
- Ointments & Pastes

Also includes containers which have held hazardous Rx waste. For example:

- Bottles, Vials, IV Bags Gels & Creams, Ampules

RX waste must be disposed of in black hazardous waste containers

All Bulk and Trace Chemo Creditable pharmaceuticals should be returned via the Reverse Distributor

DEA Controlled Substances and Narcotics

CONTROLLED SUBSTANCES

Any DEA scheduled items that requires a witness to waste

Narcotics and Controlled Substances should be witness Wasted per Harris Health Policy 556 and 582

RETURNING AND WASTING MEDICATION:

- Nursing shall waste medication doses if the medication package is not intact per standard operating procedures. Regarding controlled substances, note that:
- The wasting of controlled medications shall be witnessed by two (2) licensed professionals (Registered Nurse, Licensed Vocational Nurse, Pharmacist, or Physician).
- When at all possible, the documentation of the wastage shall be completed at the time the controlled substance is actually wasted.

Low Level Radioactive Waste 25 TAC §289

NUCLEAR MEDICINE

Step 1: Radioactive waste generated during patient treatment shall be disposed of in designated BLUE BAGS LINERS

Step 2: Only the facility Radiation Safety Officer (RSO) can authorize removal of radioactive waste, after authorization is granted the material is placed in RED BIO BAG LINERS for disposal

Nuclear Medicine patient rooms should never be entered while signage is posted on patient room door(s). All waste linens should remain in patient room until cleared for removal by the RSO or Designee.

All BT & LBJ soiled linen and waste - must pass through the Radioactive Waste Portal Monitor to exit facility.

Solid Waste: Clear; Black; White bags

NON-CONTAMINATED ITEMS

No Biohazard bags

- IV bags & tubing
- Non contaminated glass Items; glass/non-glass or containers
- Trash/wrappers
- Dressings
- Diapers & Chux
- Gloves
- Empty Foley bags
- Empty drainage bags
- Disposable patient items

NOTE: If not saturated with blood, body fluid or OPIM, dispose of as regular solid waste

LINEN 25CFR 910.1030

Caution, may contain sharps

Contaminated laundry shall be handled as little as possible with minimum agitation. Contaminated laundry shall be placed and transported in a labeled designated bag. At no time should soiled linen be mixed or placed in red bags, or solid waste.

Revised 10/08/2018

283403 | 03.17

TITLE: SAFE PATIENT HANDLING AND MOVEMENT PRACTICES

PURPOSE: To identify, assess, and develop strategies to minimize the risk of injury to patients and workforce members.

POLICY STATEMENT:

The Ambulatory Surgical Center (ASC) at LBJ ("ASC") is committed to minimizing the risk of injury to patients and workforce members associated with the lifting, transferring, repositioning, or movement of patients.

POLICY ELABORATIONS:

I. DEFINITIONS:

A. **WORKFORCE:** The members of the governing body of the Ambulatory Surgical Center (ASC) at LBJ, employees, medical staff, trainees, contractors, volunteers, and vendors.

II. GUIDELINES:

The following guidelines shall be used, at a minimum, in the ASC to reduce the risk of injury to patients and Workforce members:

A. Analyze the risk of injury to both the patients and Workforce members posed by the patient population served by the ASC;

B. Educate Workforce members regarding the identification, assessment, and reduction of risks of injury during patient handling;

C. Restrict manual patient handling or movement (if feasible with existing equipment and aids) of all or most of a patient's weight to emergency, life-threatening, or otherwise exceptional circumstances;

D. Evaluate alternative ways to reduce risks associated with patient handling, including evaluation of equipment and environment; and

E. Workforce members should discuss concerns that moving a particular patient will expose a patient or the Workforce member to an unacceptable risk of injury.

III. RESPONSIBILITIES:

A. Pursuant to the Letter of Agreement between Harris Health System ("Harris Health") and the ASC, the Harris Health Learning Resource Center shall:

1. Develop and monitor a training program to ensure that all ASC Workforce members involved in patient handling are trained in the use of available equipment; and

2. Provide Workforce members proper education on proper body mechanics associated with the lifting, transferring, and repositioning, or movement of a patient.

B. The ASC Administrator shall:

1. Ensure that lifting equipment and aids are available when necessary to be used in safe patient handling activities;

2. Designate an individual(s) to monitor and evaluate the procedures of safe patient handling;

3. Review the guidelines for proper equipment storage and ensure ASC Workforce members are aware of the guidelines for proper equipment storage; and

4. Monitor Workforce members' ability to use moving equipment.

C. ASC Workforce members shall:

1. Perform a patient assessment, which includes, but is not limited to, the following:

i. The level of assistance the patient requires;

ii. The size of the patient;

iii. The ability of the patient to understand and cooperate; and

iv. Any medical condition(s) that may influence the choice of methods for lifting and positioning.

2. Determine and utilize lifting devices, equipment, and/or additional Workforce members, when necessary, to assist in moving the patient; and

3. Utilize proper body mechanics when moving patients.

REFERENCES/BIBLIOGRAPHY:

Texas Health and Safety Code §2561.001 *et seq.*

AAAASF Version 8~~7 §400~~

Conditions for Coverage §416.50

OFFICE OF PRIMARY RESPONSIBILITY:

The Ambulatory Surgical Center (ASC) at LBJ

REVIEW/REVISION HISTORY:

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		Reviewed / Approved 02/25/2021	The Ambulatory Surgical Center (ASC) at LBJ Governing Body

TITLE: FALLS PREVENTION PROGRAM

PURPOSE: To prevent the risk of patient or visitor fall occurrences at the Ambulatory Surgical Center (ASC) at LBJ through identification and interventions for those who are at risk for falling; and to provide education to patients, families, and staff members on measures to prevent falls and promote safety.

POLICY STATEMENT:

Patients of the Ambulatory Surgical Center (ASC) at LBJ ("ASC") who are at risk for falls will be risk stratified based upon the Ambulatory Care Service (ACS) falls assessment. Patients will receive fall risk education based upon their fall risk assessments.

POLICY ELABORATIONS:

Recognizing that every patient's safety status may potentially be compromised by the nature of his or her illness or by his or her treatment, basic safety issues will be addressed for all patients, and for those patients identified as a higher level of risk, more in-depth prevention interventions will be implemented.

I. DEFINITIONS:

A. **ASSISTED FALL:** A patient's sudden change in status where they are unable to stand and must be lowered to the floor by a person who is unable to safely return the patient to a chair or bed.

B. **FALL:** A sudden, unintentional descent, with or without injury to the patient, that results in the patient coming to rest on the floor, on or against some other surface (e.g., a counter), on another person, or on an object (e.g., a trash can). When a patient rolls off a low bed onto a mat or is found on a surface where you would not expect to find a patient, this is considered a fall. If a patient who is attempting to stand or sit and falls back onto a bed, chair, or commode, this is only counted as a fall if the patient is injured.

C. **MORSE FALL RISK ASSESSMENT SCALE:** A screening tool used to assess a patient's fall risk potential.

D. **UN-WITNESSED FALL:** An un-witnessed fall occurs when a patient is found on the floor and neither the patient nor anyone else knows how he or she got to the floor.

II. FALLS RISK ASSESSMENT:

A. Patients at risk for falls in the ASC will be risk stratified based upon where the patient is located within the ASC. Based upon the assessment, patients will receive fall risk education and/or visual indications of their fall risk.

B. ASC Falls Assessment:

1. Pre-Operative area Assessment by a Workforce member:
   i. Verifies whether the patient has fallen in the last three (3) months;
   ii. A chart review of the patient medications and age;
   iii. An assessment of the patient's gait; and
   iv. Verification of the patient's utilization of an assistive device.

2. Based on the Morse Fall Score a patient in the operating room is at high risk for a fall and is treated accordingly.
3. A patient in the Post Anesthesia Care Unit is assessed using the Morse Fall Scale.

III. ALL ASC WORKFORCE MEMBER FALL SAFETY INTERVENTIONS:

A. ASC Workforce members shall monitor the ASC for environmental safety hazards (e.g., wet floor, tripping hazards, broken equipment, cracked tile, etc.) and report such deficiencies to the appropriate manager or designee.

B. ASC Workforce members must take the following actions to prevent falls:

1. Keep floors un-cluttered, and remove objects that could cause a patient to trip;
2. Clean up spills promptly and notify Harris Health Environmental Services as needed;
3. Keep grab bars and wall rails in bathrooms and hallways clear from obstruction;

4. Remove, tag, and report broken equipment to Engineering (nonclinical) and biomed (clinical);
5. Report broken furniture to Harris Health Environmental Services for removal; and
6. Report and document all patient falls in the Harris Health Electronic Incident Reporting System (eIRS).

IV. MONITORING:

A. ASC Administration will be responsible for:

1. Monitoring and ensuring that Workforce members receive education about the Falls Prevention Program and understand the importance of complying with fall prevention interventions; and

2. Monitoring and evaluating trends and corrective action plan effectiveness.

B. Nursing will be responsible for:

1. Performing post fall unit huddles to:

i. Determine causative factors contributing to the fall;
ii. Identifying measures to prevent fall re-occurrence;
iii. Communicating trends to Workforce members;
iv. Promoting proactive healthcare practices for patient care planning reducing falls risks; and
v. Identifying barriers that create process failures and near failures.

C. Physical Environment Assessments:

Pursuant to the Letter of Agreement between Harris Health and the ASC, the Harris Health Multidisciplinary Fall Prevention Committee will assess the physical environment of the ASC on a pre-scheduled basis. The Harris Health Multidisciplinary Fall Prevention Committee will be responsible for the following:

1. Monitoring and evaluating trends of fall prevention processes, fall rates, and fall-related sentinel events;

2. Promoting proactive healthcare practices for patient care planning, which minimizes the risk for falls;
3. Communicating fall prevention activities and updates to the appropriate ASC committees as required; and
4. Recommending improvement initiatives for fall prevention based upon trends and evidence based practice.

REFERENCES/BIBLIOGRAPHY:

AAAASF Version 8~~7 §400~~

OFFICE OF PRIMARY RESPONSIBILITY:

The Ambulatory Surgical Center (ASC) at LBJ

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		Reviewed / Approved 02/25/2021	The Ambulatory Surgical Center (ASC) at LBJ Governing Body

TITLE: SMOKE-FREE/TOBACCO-FREE ENVIRONMENT

PURPOSE: To provide guidelines for maintaining the Ambulatory Surgical Center (ASC) at LBJ as a smoke-free/tobacco-free environment.

POLICY STATEMENT:

The Ambulatory Surgical Center (ASC) at LBJ ("ASC") desires to provide a healthy, smoke-free/tobacco-free environment for all patients, visitors, contractors, vendors, and employees of the ASC. The ASC designates its facility as a "smoke-free/tobacco-free" facility.

POLICY ELABORATIONS:

I. DEFINITIONS:

A. **SMOKING**: Includes carrying a lighted cigarette, cigar pipe, or electronic cigarette/e-cigarette.

B. **ELECTRONIC CIGARETTE/E-CIGARETTE**: Any electrical device that simulates the act of tobacco smoking.

C. **WORKFORCE:** The members of the governing body of the Ambulatory Surgical Center (ASC) at LBJ, employees, medical staff, trainees, contractors, volunteers, and vendors.

II. SMOKE-FREE/TOBACCO-FREE ENVIRONMENT:

The ASC prohibits smoking and/or the use of tobacco products in its facility, including the lobby, hallways, restrooms, reception area, seating area, elevator, stairwell, parking lots, and walkways on the premises

III. SIGNAGE:

"No Smoking" signs are clearly posted at all prominent areas of the ASC.

IV. COMPLIANCE:

A. All Workforce members must comply with this policy and all non-compliant Workforce members are subject to disciplinary action.

B. All ASC Workforce members must inform a patient, the patient's representative or surrogate, or any other individual who is observed smoking on the ASC facility that smoking and/or the use of tobacco products is prohibited and that the ASC is a smoke-free/tobacco-free facility. The ASC Workforce member should then direct the patient, or the patient's representative or surrogate, or other individual to the designated smoking area.

C. If the patient, the patient's representative or surrogate, or any other individual observed smoking and/or using tobacco products in the ASC refuses to comply with the request to abstain from the use of tobacco products, then the ASC Workforce member will call Harris Health Department of Public Safety and the Harris Health Department of Public Safety will request that the individual stop using tobacco on the ASC and Harris Health premises.

REFERENCES/BIBLIOGRAPHY:

AAAASF Version 87 ~~§200; §400~~

OFFICE OF PRIMARY RESPONSIBILITY:

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		Reviewed / Approved 02/25/2021	The Ambulatory Surgical Center (ASC) at LBJ Governing Body

TITLE: HAZARDOUS MATERIALS

PURPOSE: To outline the requirements and standards the Ambulatory Surgical Center (ASC) at LBJ must follow to ensure compliance with the Hazardous Communication Act of Texas.

POLICY STATEMENT:

It is the policy of the Ambulatory Surgical Center (ASC) at LBJ ("ASC") to follow the requirements of the Hazardous Communication Act of Texas as it relates to the identification, handling, storage, use, and disposal of hazardous chemical or material substances that are known to cause harm to patients, visitors, and workforce members.

POLICY ELABORATIONS:

I. DEFINITIONS:

A. **HEALTH HAZARD:** a chemical which is classified as posing one of the following hazardous effects: (1) acute toxicity; (2) skin corrosion or irritation; (3) serious eye damage or eye irritation; (4) respiratory or skin sensitization; (5) germ cell mutagenicity; (6) carcinogenicity; (7) reproductive toxicity; (8) specific target organ toxicity; or (9) aspiration hazard.

B. **HAZARDOUS CHEMICAL**: An element, compound, or mixture of elements or compounds that is a physical hazard or health hazard, or a hazardous substance.

C. **PHYSICAL HAZARD**: A chemical that is classified as posing one of the following hazardous effects: (1) explosive; (2) flammable (gases, aerosols, liquids, or solids); (3) oxidizer (liquid, solid, or gas); (4) self-reactive; (5) self-heating; (6) organic peroxide; (7) corrosive to metal; (8) gas under pressure; or (9) in contact with water emits flammable gas.

D. **SAFETY DATA SHEET ("SDS")**: Written or printed material concerning a Hazardous Chemical that is prepared in accordance with the requirements of the OSHA standard for that material.

E. **WORKFORCE**: The members of the governing body of the Ambulatory Surgical Center (ASC) at LBJ, employees, medical staff, trainees, contractors, volunteers, and vendors.

II. HAZARDOUS CHEMICALS/MATERIALS INVENTORY:

A. Pursuant to the Letter of Agreement between Harris Health System ("Harris Health") and the ASC, Harris Health shall maintain an inventory list of all Hazardous Chemicals and materials located in the ASC that includes:

1. The identity used on the SDS and container for each Hazardous Chemical listed; and

2. The location (room number) where 55 gallons or 500 lbs. of the Hazardous Chemical are stored in the ASC.

B. Harris Health will update this inventory by December 31 of each year and as necessary on behalf of the ASC. Each annual inventory must be dated and signed by the individual responsible for compiling the information.

C. All Workforce members must be aware of the inventory and the inventory must be available to all Workforce members.

D. Pursuant to state law, Harris Health will maintain each annual inventory for the ASC for at least thirty (30) years.

III. SAFETY DATA SHEETS (SDS):

A. Harris Health shall have available a SDS for all Hazardous Chemicals and substances used or stored in the ASC.

B. The SDS's will be made available online via Harris Health's Safety & Environmental Health intranet page.

C. SDS's received by the ASC will be included in the inventory.

IV. LABELS:

A. Workforce members are not permitted to remove labels on an existing container of a Hazardous Chemical or material.

B. If a label on a container of a Hazardous Chemical or material is illegible, inaccurate, or does not conform to the Occupational Health and Safety Administration standard, then the ASC Administrator must contact Administrative Director – Logistics, EMS, and Ancillary Support Services.

V. EDUCATION PROGRAM:

Pursuant to the Letter of Agreement between the Harris Health and the ASC, Harris Health's Learning Resource Center (LRC) shall provide training to Workforce members that meet the requirements of the Hazard Communication Act of Texas on how to handle hazardous chemicals.

REFERENCES/BIBLIOGRAPHY:

AAAASF Version 7§400

Texas Health and Safety Code §502.001, *et seq.*

OFFICE OF PRIMARY RESPONSIBILITY:

The Ambulatory Surgical Center (ASC) at LBJ

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		Reviewed / Approved 02/25/2021	The Ambulatory Surgical Center (ASC) at LBJ Governing Body

TITLE: HAZARDOUS CHEMICAL SPILLS

PURPOSE: To provide the process for reporting and responding to hazardous chemical spills and to state the how hazardous chemical spills will be managed in the Ambulatory Surgical Center (ASC) at LBJ.

POLICY STATEMENT:

It is the policy of the Ambulatory Surgical Center (ASC) at LBJ ("ASC") to ensure a safe environment for its patients and workforce members by promptly and efficiently responding to and cleaning all spills of hazardous chemicals.

I. DEFINITIONS:

A. **HAZARDOUS CHEMICAL SPILL:** The spilling of any element, compound, or mixture of elements or compounds that is a physical hazard or health hazard, or a hazardous substance.

B. **HEALTH HAZARD:** a chemical which is classified as posing one of the following hazardous effects: (1) acute toxicity; (2) skin corrosion or irritation; (3) serious eye damage or eye irritation; (4) respiratory or skin sensitization; (5) germ cell mutagenicity; (6) carcinogenicity; (7) reproductive toxicity; (8) specific target organ toxicity; or (9) aspiration hazard.

C. **PHYSICAL HAZARD**: A chemical that is classified as posing one of the following hazardous effects: (1) explosive; (2) flammable (gases, aerosols, liquids, or solids); (3) oxidizer (liquid, solid, or gas); (4) self-reactive; (5) self-heating; (6) organic peroxide; (7) corrosive to metal; (8) gas under pressure; or (9) in contact with water emits flammable gas.

D. **SAFETY DATA SHEET ("SDS")**: Written or printed material concerning a Hazardous Chemical that is prepared in accordance with the requirements of the OSHA standard for that material.

E. **WORKFORCE**: The members of the governing body of the Ambulatory Surgical Center (ASC) at LBJ, employees, medical staff, trainees, contractors, volunteers, and vendors.

II. PROCEDURE:

A. Hazardous Chemical Spill incidents that present a direct hazard to the internal environment of the ASC are to be reported to the Page Operator of the Lyndon B. Johnson Hospital by dialing x3-2538 or x6-5566.

B. The emergency code "Condition Yellow" will be announced by the page operator. The page operator will then notify the Hazardous Chemical Response Team (HCRT) that a Condition Yellow exists and the location of the spill event/incident.

C. The designated responders to a Hazardous Chemical Spill include:

1. Laboratory Team Leader;
2. Harris Health's Department of Public Safety;
3. Harris Health's Department of Environmental Services;
4. Harris Health's Engineering Department;
5. Harris Health's Hazardous Materials Department; and
6. Harris Health's Safety Emergency Management and Administration.

D. All Hazardous Chemical Spills will be promptly contained, cleaned, and disposed of in a manner that minimizes risk to Workforce members, patients, and visitors.

1. Hazardous Chemical Spills that are assessed as being manageable and safe will be managed by the Hazardous Chemical Response Team.

2. Larger and unsafe Hazardous Chemical Spills ("Major Spills") will be reported to the Houston Fire Department or HAZMAT authorities with a request for assistance.

3. The following constitute Major Spills:

   i. The spill involves quantities greater than two (2) liters;
   ii. Life-threatening condition exists;
   iii. The condition requires the immediate evacuation of all Workforce members and patients from the ASC;
   iv. The contents of the spilled material are unknown;

v. The spilled material is highly toxic, bio-hazardous, radioactive, or flammable;
vi. Physical symptoms of exposure exist;
vii. The spill requires an immediate onsite intervention from the HCRT;

4. Spills located outside the ASC facility will be managed by the Houston Fire Department or HAZMAT authorities.

5. The Safety Data Sheets shall be used to obtain information about containment of the material, appropriate personal protective equipment that should be worn during containment, and the clean-up and disposal procedures to be used.

E. "Condition Yellow" will remain in effect until the Page Operator receives communication from the Hazard Chemical Response Team that the "Condition Yellow" no longer exists.

F. Spill incidents will be documented on Harris Health System form #280965.

G. Staff education and training programs for the management of Hazardous Chemical Spills will be conducted annually by the Harris Health System Learning Resource Center pursuant to the Letter of Agreement between Harris Health System ("Harris Health") and the ASC. The Learning Resource Center will also provide education and training during new hire orientation.

H. 

REFERENCES/BIBLIOGRAPHY:

AAAASF Version 8.07 ~~§400~~

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TITLE: STANDARD AND TRANSMISSION BASED PRECAUTIONS

PURPOSE: To prevent the transmission of healthcare associated or community acquired organisms and/or infections to patients, visitors, and members of the Ambulatory Surgical Center at LBJ's workforce.

POLICY STATEMENT:

It is the policy of the Ambulatory Surgical Center (ASC) at LBJ ("ASC") that every person is potentially infected or colonized with an organism that could be transmitted in the healthcare setting.

POLICY ELABORATIONS:

I. DEFINITIONS:

A. **AIRBORNE INFECTION ISOLATION ROOM (AIIR):** Formerly, negative pressure isolation room, an AIIR is a single-occupancy patient-care room used to isolate persons with a suspected or confirmed airborne infectious disease. AIIRs should provide negative pressure in the room so that air flows under the door gap into the room; and an air flow rate of 6-12 ACH and direct exhaust of the air from the room to the outside of the building or recirculation of air through a HEPA (high-efficiency particulate air) filter before returning to circulation.

B. **COHORTING**: Applies to the practice of grouping patients infected or colonized with the same infectious agent together to confine their care to one area and prevent contact with susceptible patients. Cohorting patients during outbreaks, Workforce members may be assigned to a cohort of patients to further limit opportunities for transmission to Cohorting staff.

C. **MULTI-DRUG RESISTANT ORGANISM (MDRO):** In general, bacteria, excluding M. Tuberculosis, that are resistant to one or more classes of antimicrobial agents and usually are resistant to all but one or two commercially available antimicrobial agents e.g, MRSA, VRE, Extended Spectrum Beta-Lactamse (ESBL) producing or intrinsically resistant gram negative bacilli, or Carbapenem Resistant Enterobacteriacae (CRE). In addition, organisms of clinical significance or that have special virulent properties such as *Clostridium difficile* will be considered in the same fashion.

D. **OTHER POTENTIAL INFECTIOUS ORGANISMS**: Human body fluids shall be treated as if they are known to be infectious for blood borne pathogens. These fluids include, but are not limited to:

i. Amniotic Fluid;

ii. Pleural Fluid;

iii. Blood;

iv. Saliva (in dental procedures);

v. Cerebrospinal Fluid;

vi. Semen;

vii. Pericardial Fluid;

viii. Synovial Fluid;

ix. Peritoneal Fluid; and

x. Vaginal Secretions

E. **PERSONAL PROTECTIVE EQUIPMENT**: A variety of barriers used alone or in combination to protect mucous membranes, skin, and clothing from contact with infectious agents. PPE includes gloves, masks, respirators, goggles, face shields, and gowns.

F. **QUALIFIED LICENSE PRACTITIONER (QLP):** Any individual permitted by law and by the ASC to provide care and service, without relevant direction or supervision within the scope of the individual's license and consistent with individually granted privileges.

G. **REGULATED MEDICAL WASTE:**

i. A liquid or semi-liquid blood or Other Potentially Infectious Material (OPIM); contaminated items that would release blood in a liquid or semi-liquid state if compressed;

ii. Items that are caked with dried blood or OPIM and are capable of releasing these materials during handling; contaminated sharps; and pathological and microbial wastes containing blood or other potentially infectious materials.

H. **RESPIRATORY HYGIENE/COUGH ETIQUETTE**: A combination of measures designed to minimize the transmission of respiratory pathogens via droplet or airborne routes in healthcare settings.

I. **STANDARD PRECAUTIONS**: A group of infection prevention practices that apply to all patients, regardless of suspected or confirmed diagnosis or presumed infection status. Standard Precautions are based on the principle that all blood, body fluids, secretions, excretions except sweat, non-intact skin, and mucous membranes may contain transmissible infectious agents. Standard Precautions includes hand hygiene, and depending on anticipated exposure, the use of gloves, gowns, masks, eye protection, or face shields.

J. **TRANSMISSION-BASED PRECAUTIONS**:

i. Transmission-Based Precautions are used when the routes of transmission are not completely interrupted by using Standard Precautions alone. There are three (3) categories of Transmission-Based Precautions: (1) Contact Precautions; (2) Droplet Precautions; and (3) Airborne Precautions.

ii. These three categories of Transmission-Based Precautions may be combined together for diseases that have multiple routes of transmission. When used either singularly or in combination, they are to be used in addition to Standard Precautions.

K. **WORKFORCE**: Employees, Medical Staff, trainees, contractors, volunteers, and vendors.

II. GENERAL PROVISIONS:

A. It is safer to "Over-Isolate" than to "Under Isolate." If there is a question regarding isolation, then the more stringent Isolation Precaution should be used until a definitive diagnosis is confirmed.

B. All QLPs, nurses, students, etc., are responsible for complying with Isolation Precautions.

C. Education and training on preventing transmission of infectious agents with healthcare will be provided during orientation to the ASC and thereafter, annually.

D. Identification of MDROs:

   i. The ASC's pre-procedure screening clinic will aid in the coordination of patient care by identifying patients with MDROs so that those patients receive the appropriate level of care, i.e. care at either Lyndon B. Johnson Hospital or Ben Taub General Hospital.

   ii. Harris Health's Laboratory will alert infection prevention and nursing of an MDRO laboratory result pursuant to the Letter of Agreement between Harris Health and the ASC.

E. Nursing will initiate the appropriate isolation immediately.

F. The patient will be placed in the isolation room. The appropriate signage must be placed on the isolation room door and the isolation type should be entered into the patient's medical record.

G. Categories of Standard and Transmission-Based Precautions

   i. Standard Precautions: This presumes that all body substances may carry infectious agents. PPE appropriate to the potential exposure should be worn. PPE may not be worn in hallways, nursing stations, other areas outside of the ASC, or in isolation rooms, when applicable.

   ii. Contact Transmission Precautions: These precautions are based on direct contact with an infected patient or contact with a contaminated environment. Gowns and gloves should be worn by ASC QLP or other personnel to protect against contact with body fluids or contaminated surfaces.

   iii. Droplet: Droplet Transmission Precautions are based on an infectious agent being transmitted from droplets that can reach the respiratory tract of a susceptible host; and

1. Surgical face masks must be work within 3–6 feet of an individual with a respiratory infection;
2. Gowns and gloves should be worn if Workforce members or QLPs are touching surfaces where droplets may have landed.

iv. Airborne Precautions: Airborne transmission occurs by the dissemination of small particles that can remain suspended in the air for considerable time. N95 Respirators are required to be worn by Workforce members and QLPs as an Airborne Precaution.

H. Workforce members will instruct visitors about precautions to be taken while visiting patients in the isolation room. PPE must be worn by all visitors in the isolation room.

I. Patients having the same pathogen may be Cohorted in the absence of private rooms.

III. GUIDELINES FOR THE ISOLATION OF PATIENTS WITH MULTI-DRUG RESISTANT ORGANISMS:

A. Patients colonized or infected with any identified MDRO must be initially placed in the ASC isolation room. Appropriate signage must be placed on the door of the isolation room to alert Workforce members.

B. After the MDRO has been identified, the following steps will be followed:

i. TB Infection:

1. If a patient has TB, that patient will remain in the ASC isolation room the patient's surgery/procedure at the ASC will be cancelled.

ii. Other MDROs:

1. If a patient has another MDRO (MRSA, VRE, VIRE), the ASC's Medical Director, Administrator, and infection Prevention Manager in consultation with the surgeon will make a determination as to whether that patient's scheduled surgery/procedure may continue as scheduled and what precautions, if any, need to be taken.

IV. MANAGEMENT OF THE ENVIRONMENT:

A. Environmental Services: All trash, linen, and cleaning of rooms in the ASC are the same for all patients regardless of whether that patient has been in the isolation room. Privacy curtains must be changed at the patient's discharge.

B. Patient Care Equipment: When possible, equipment should be dedicated. If common equipment is unavoidable, then that equipment must be cleaned and disinfected after each use with an ASC approved product.

C. Patient Supplies: Supplies that are kept in the isolation room should be kept to a minimum and any leftover supplies from the isolation room should be discarded when the patient is discharged.

V. SPECIAL CONSIDERATONS:

A. Surgery and Procedure Rooms: In the event that patients with a communicable disease are scheduled for surgery at the ASC and who are placed in the ASC isolation room, those patients surgeries and/or procedures should be done as the last case of the day with a terminal clean being completed after the procedure concludes. If it is not possible to perform this surgery as the last case of the day, then a terminal clean must be performed on the operating room before the next surgery is performed.

B. Guest Transportation: Patients transported outside the ASC must be transported with appropriate barriers in place, such as surgical masks on patients with a respiratory illness. Workforce members must wear appropriate PPE during the transport.

REFERENCES/BIBLIOGRAPHY:

APIC Text On-Line, Chapter 29 Isolation Precautions-Recommendations.

Siegel JD, Rhinehart E, Jackson M, Chiarello L, and the Healthcare Infection Control Practices Advisory Committee, 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings.

Conditions for Coverage 416.51.

OFFICE OF PRIMARY RESPONSIBILITY:

The Ambulatory Surgical Center (ASC) at LBJ

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TITLE: RECALLS/SAFETY ALERTS/WITHDRAWALS

PURPOSE: To comply with regulatory guidelines requiring the establishment and maintenance of a program for effectively managing safety recalls, alerts, and withdrawal notifications.

POLICY STATEMENT:

The Ambulatory Surgical Center (ASC) at LBJ ("ASC") is committed to ensuring that an active program for the management of safety recalls and alerts is established and maintained.

POLICY ELABORATIONS:

I. DEFINITIONS:

A. ALERT: Issued in situations where a medical device may present an unreasonable risk of harm. In some cases, these situations are also considered recalls.

B. RECALL: Actions taken by a firm to remove a product from the market. Recalls may be conducted on a firm's own initiative, by the Food and Drug Administration (FDA) request, or by FDA order under statutory authority. Recall classification discussion is included below.

C. WITHDRAWALS: Occurs when a product has a minor violation that would not be subject to FDA legal action. The firm removes the product from the market or corrects the violation. A product removed from the market due to tampering, without evidence of manufacturing or distribution problems would be a market withdrawal.

II. RECEIVING A RECALL/ALERT/NOTICE:

A. Harris Health System ("Harris Health") is a member of the National Recall Alert Center and ECRI Alert Tracker Notification Systems.

B. When recalls/alert notices are received through notification channels, the Harris Health manager of the product or medical device will provide notification to the ASC within the time frames established by the notice or regulatory requirement to ensure adequate research and response time and return of status to the notice distributor pursuant to the Letter of Agreement between Harris Health System ("Harris Health") and the ASC.

C. Adherence to the manufacturer, vendor, distributor, or FDA instructions is key to appropriate actions for identified products or devices.

D. Recalls are classified by the FDA as follows:

1. Class I:

   A situation in which there is a reasonable probability that the use of or exposure to a violative product will cause serious adverse health consequences or death

2. Class II:

   A situation in which the use of or exposure to a violative product may cause temporary or medically reversible adverse health consequences or where the probability of serious adverse health consequences is remote

3. Class III:

   A situation in which the use of or exposure to a violative product is not likely to cause adverse health consequences.

III. RESPONSIBILITIES:

A. Primary Distributors of Safety Recall/Alert Notices:

1. The following Harris Health departments have primary responsibility for receiving and distributing safety recall and alert notices to the ASC pursuant to the Letter of Agreement between Harris Health and the ASC:

i. Supply Chain Management;
ii. Pharmacy;
iii. Biomedical Engineering; and
iv. Nutrition Services.

2. Manufacturers may directly contact or send notice to the ASC. In this case, the ASC is responsible for ensuring the appropriate Harris Health commodity or device manager receives a copy of the alert. If a recall/alert notice is received for a product that is not managed by one of the Harris Health departments listed above, the ASC must notify the Safety and Environmental Health Director for Harris Health of the recall/alert.

3. Primary Distributors of safety recall/alert notices will summarize recall information as follows:

   i. Number of recalls/alerts received;
   ii. Classification of recalls (FDA definitions);
   iii. Number of recalls/alerts affecting the organization; and
   iv. The number of recall/alert notices responded to within timeframes established by the notice or regulatory requirement as a proportion of the total number of recall/alert notices received and requiring reply.

4. Summarized information will be provided monthly to the Harris Health Safety and Environmental Health (S&EH) Department within five (5) business days of the month in the format provided by S&EH.

5. This information along with any corrective action plan will be posted to the Harris Health Physical Environment Committee dashboard and presented to the Physical Environment Committee by the primary recall/alert notice distributor or designee when response times are non-conforming or a serious incident has occurred from the affected product/device. This information will be presented directly to the ASC by the primary notice distributor or designee when the ASC is affected.

B. Product User Groups:

1. Investigate for the presence of the device or product described in the safety recall/alert notice;
2. Ensure compliance with reporting time frame requirements as established by the safety recall/alert notice or regulatory requirement; and
3. Report on hand quantities to the recall/alert notice distributor as required by the notice or regulatory requirement.

REFERENCES/BIBLIOGRAPHY:

AAAASF Version 7 §400

OFFICE OF PRIMARY RESPONSIBILITY:

The Ambulatory Surgical Center (ASC) at LBJ

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TITLE: SURGICAL SPECIMENS POLICY

PURPOSE: To outline the procedures to follow and use to properly care for surgical specimens obtained in the Ambulatory Surgical Center (ASC) at LBJ.

POLICY STATEMENT:

It is the policy of the Ambulatory Surgical Center (ASC) at LBJ ("ASC") to properly manage surgical specimens obtained from patients of the ASC.

POLICY ELABORATIONS:

I. DEFINITIONS:

A. **CYTOLOGIC SPECIMEN:** A thin tissue or blood sample that is used to examine the structure, function, multiplication, pathology, and life history of cells for diagnostic purposes.

B. **FROZEN SPECIMEN:** A specimen of tissue that has been frozen to be used for diagnosis.

C. **WORKFORCE:** The members of the governing body of the Ambulatory Surgical Center (ASC) at LBJ, employees, medical staff, trainees, contractors, volunteers, and vendors.

II. SPECIMEN LABELING:

A. ASC Workforce members are responsible for properly labeling all patient specimens after collection.

B. Specimen labels must contain at least the following identifying information:

1. Patient's first and last name;
2. Patient's date of birth;
3. Patient's medical record number; and
4. Collection date, time, and initials of the Workforce member collecting the specimen.

III. PROPER HANDLING OF SURGICAL SPECIMENS:

A. **Specimens placed in Formalin**:

i. The following procedures must be followed when handling surgical specimens that must be put in Formalin and be refrigerated until Harris Health System's Pathology department retrieves the specimen:

i. A patient label that contains the patient's name, date of birth, and medical record number must be placed on the specimen container.

ii. The Workforce member labeling the container must:
a. Write his or her initials on the container;
b. Document the time and date the specimen was taken;
c. Document the name of the specimen;
d. Document the OR location; and
e. Document the attending physician's name.

iii. As a second verification, the scrub nurse must also write his or her initials on the container.

iv. A second patient label containing the date and time that the specimen was taken and the OR location must be placed in the ASC Laboratory's specimen collection log.

v. .

B. **Frozen Specimens**:

1. The following procedures must be followed when handling frozen specimens:

i. Harris Health System's Histology department will be notified of the ASC's need for a frozen section identification prior to a patient's scheduled surgery or procedure, or if not prior to the schedule surgery or procedure, immediately after the attending physician indicates a need. Harris Health System Histology can be contacted by calling 713-566-5286.

ii. Steps (i) – (v) set out above in Section III.A. will be followed for the proper handling of a frozen specimen.

iii. Once steps (i) – (v) are completed, the specimen must be delivered to the 3rd floor of the Lyndon B. Johnson hospital where it must be given to a pathologist or a pathology resident.

C. **Cytologic Specimens**:

1. The following procedures must be followed when handling a Cytologic specimen:

   i. Harris Health System's Cytology department will be notified of the ASC's need for a STAT cytology prior a patient's scheduled surgery or procedure, or if not prior to a patient's scheduled surgery or procedure, as soon as the attending physician indicates a need for a STAT Cytology. Harris Health Cytology department can be contacted by calling 713-566-5286.

   ii. Steps (i) – (v) set out above in Section III.A. will be followed for the proper handling of a cytologic specimen.

   iii. Once steps (i) – (v) are completed the specimen must be delivered to the 3rd floor of the Lyndon B. Johnson hospital where it must be given to a pathologist or a pathology resident.

D. **Special Considerations**:

1. All breast biopsies must be taken with proper documentation to the 3rd floor of the Lyndon B. Johnson hospital, where the biopsy must be given to a pathologist or a pathology resident.

2. Any smaller biopsy (i.e. prostate biopsy) must be placed in Formalin and the process set out in Section III.A. must be followed.

3. If any question arises during the process of collecting and handling a surgical specimen, Harris Health System's Pathology department must be called for assistance. Harris Health's Pathology department's telephone number is 713-566-5260.

REFERENCES/BIBLIOGRAPHY:

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TITLE: EXEMPTION OF SPECIMENS FOR SUBMISSION TO SURGICAL PATHOLOGY FOR LABORATORY EXAMINATION

PURPOSE: To establish the guidelines to be used relating to the standard or automatic examination; or exemption from examination; of specimens derived from invasive procedures.

POLICY STATEMENT:

In accordance with the College of American Pathologists standards, guidelines, and regulations relating to routine standard or automatic examination of specimens derived from invasive procedures, the procedures established herein shall be used the Ambulatory Surgical Center (ASC) at LBJ ("ASC") in determining which specimens may be exempt from analysis.

POLICY ELABORATIONS:

Certain specimens derived from invasive procedures do not warrant routine, standard, or automatic examination by surgical pathology or other laboratory departments. The following lists and guidelines are in accordance with the College of American Pathologists guidelines for determining which specimens may be exempt from analysis.

I. DEFINITIONS:

A. **ANIMATE SPECIMEN:** Any biologic specimen.
B. **INANIMATE SPECIMEN:** Any non-biologic specimen.

II. EXAMINATION EXEMPT SPECIMENS:

A. The following specimens shall be exempt from examination by the laboratory:

1. Intra-Uterine Devices (IUD);
2. Arch bars/dental wires;
3. Chest tube;
4. Gastrostomy tube;
5. Ileo-jejunostomy tube;

6. Pressure Equalizing Tube;
7. Tracheostomy tube;
8. Tenckhoff catheter;
9. Orthopedic hardware, device, and implants;
10. Implants (plastic surgery, ENT-related);
11. Pacemaker batteries;
12. Shunt tubing;
13. Wound drains, wound VACs;
14. Antibiotic beads;
15. Stents;
16. Fragments of apparently normal bone in trauma cases and in orthopedic reconstructive procedures (THA, TKA, bunions, distal clavicle resection for rotator cuff);
17. Bone chips;
18. Clots and thrombi from trauma casts;
19. Fragments from debridement;
20. Foreskin from patients less than fourteen (14) years old;
21. Ocular lenses;
22. Skin scar (except I patients with C-section keloids, or previous history of lesion of site scar), i.e. plastic surgery scars;
23. Clinically normal skin, fat, cartilage, muscle, or bone from cosmetic/plastic/reconstructive surgical cases;
24. Arthroscopy joint surface shavings, menisci, loose bodies;
25. Pterygia;

26. Vaginal/Vulvar tissue from anterior and posterior repair;

27. Fingernails and toenails;

28. Teeth;

29. Liposuction material (fat);

30. Rib (for thoracic access, in patients with non-neoplastic bone disease); and

31. Saphenous Vein segments harvested for CAB.

III. SPECIMENS THAT MUST ALWAYS BE SENT TO PATHOLOGY:

A. Renal calculi (routinely submitted for stone analysis) must always be sent to pathology for examination.

B. Medico-legal specimens (i.e. bullets, foreign bodies, etc.), which require chain of custody to allow the material to be used as evidence in a court of law, should not be sent to pathology but should be handed over to the appropriate peace officer directly after surgical removal from the patient.

REFERENCES/BIBLIOGRAPHY:

AAAASF Version 8.0~~7 §400~~

OFFICE OF PRIMARY RESPONSIBILITY:

The Ambulatory Surgical Center (ASC) at LBJ

REVIEW/REVISION HISTORY:

Effective Date	Version # (If Applicable)	Review/ Revision Date (Indicate Reviewed or Revised)	Approved by:
4/13/2017	1.0		The Ambulatory Surgical Center (ASC) at LBJ Governing Body
		Revised / Approved 02/13/2020	The Ambulatory Surgical Center (ASC) at LBJ Governing Body
		Reviewed / Approved 02/25/2021	The Ambulatory Surgical Center (ASC) at LBJ Governing Body

TITLE: APPROVED PROCEDURES

PURPOSE: To specify the procedures approved to be performed in the Ambulatory Surgical Center (ASC) at LBJ.

POLICY STATEMENT:

The Ambulatory Surgical Center (ASC) at LBJ ("ASC") will maintain a list of procedures approved by the Medical Executive Committee and Governing Body to be performed in the ASC.

POLICY ELABORATION:

A. The approved list of procedures for the ASC contains procedures that may be performed in the ASC. However, the approved list of procedures may include procedures that are not contained on Harris Health System (Harris Health)'s Schedule of Benefits. In those situations, the procedure may not be performed for patients who are a part of Harris Health's financial assistance program, while the procedure may be performed if the patient pays for the procedure in advance or has a guarantor who will pay for the procedure.

B. Only procedures on the approved list of procedures for the ASC will be performed in the ASC.

C. A Medical Staff member of the ASC may make a request to the Medical Executive Committee that a procedure be added to the approved list of procedures for the ASC. If the Medical Executive Committee approves the request, it will be sent to the Governing Body for final approval. If the Governing Body approves, the procedure will be added immediately to the approved list of procedures for the ASC.

D. Any Medical Staff member of the ASC requesting privileges to perform a procedure on the approved list of procedures for the ASC must submit a request for such privileges in accordance with the Medical Staff Bylaws of the ASC.

E. Nursing and other support staff must be trained on all procedures before they may be performed in the ASC. A Practitioner privileged to perform the procedure, as well as appropriate equipment representatives, will conduct the training.

F. Attachments:

1. Attachment A – Approved Procedures for the ASC

OFFICE OF PRIMARY RESPONSIBILITY:

The Ambulatory Surgical Center (ASC) at LBJ

REVIEW/REVISION HISTORY:

Effective Date	Version # (If Applicable)	Review/ Revision Date (Indicate Reviewed or Revised)	Approved by:
9/16/16	1.0	Reviewed / Approved 02/14/2019	The Ambulatory Surgical Center (ASC) at LBJ Governing Body
		Revised / Approved 02/13/2020	The Ambulatory Surgical Center (ASC) at LBJ Governing Body
		Reviewed / Approved 02/25/2021	The Ambulatory Surgical Center (ASC) at LBJ Governing Body

Attachment A

Approved Procedures for the Ambulatory Surgical Center (ASC) at LBJ
~~Approved May~~Approved May **2019**

Anesthesiology
Monitored anesthesia care
General anesthesia
Regional anesthesia (including upper and lower extremity blocks)
Neuraxial analgesia (including epidural, spinal, and combined spinal and epidural)
Blood patch
Topical anesthesia
Local anesthesia

General Surgery
Amputation Digit (toe, finger)
Anorectal Exam
Anoscopy & Biopsy
Axillary Node Dissection
Biopsy – Muscle
Biopsy of rectum
Biopsy or Excision of Lymph Nodes
Breast Biopsy/Lumpectomy/Mass excision
Breast Lumpectomy with wire localization/Sentinel Node Biopsy
Circumcision
Cholecystectomy (Laparoscopic/open)
Colonoscopy
Condylomata fulgeration/excision
Debridement – hand, arm, foot, leg, toes, fingers, abdomen
Destruction anal lesion
Diagnostic Laparoscopy
Dialysis Access Catheter
Endoscopic Sclerotherapy
Esophagogastroduodenoscopy
Excision axillary nodes
Excision of back cyst
Excision of basal cell carcinoma
Excision of Lesions on trunk, rectum, arms, legs, scalp, neck, hands, feet, breast, face or genitalia
Excision of Mass/Cysts (Minor/major)
Excision of submandibular mass
Excision of thyroglossal duct cyst
Excision of tumors of neck, thigh, knee or chest
Fissurectomy/sphincterectomy
Fistulectomy/Fistulotomy/sphincterostomy
Foreign Body removal

Gastrostomy – PEG
Gynecomastia Reduction
Hematoma evacuation
Hemorroidectomy
Hernia repair – inguinal (open or laparoscopic)
Hernia repair – umbilical
Herniorraphy (Laparoscopic/open)
Hydrocelectomy
Incise and debride (minor)
Incise and drain (major/minor)
Incise, irrigate, and debride abscess
Incision and drainage of rectal/perineal abcess
Incision of Anal sphincter
Inguinal, Incisional or Ventral, umbilical, preperitoneal, femoral, epigastric
Insert/Remove Non-tunnel or tunneled CV catheter
Laceration repair
Laparoscopic cholecystectomy intra-operative cholangiograms (IOC)
Laparoscopic hernia repair
Laparoscopic jejunostomy tube placement
Laparoscopic lysis of adhesions
Laparoscopy
Lesion Excision
Lipoma Excision
Lymph node (Neck) excision
Lymphadenedectomy
Mastectomy partial/complete (simple/modified/radical)
Mole removal
Orchiopexy
Percutaneous Endoscopic Gastrostomy (PEG) tube placement with or without laparoscopic assist
Peritoneal dialysis catheter placement
Pilonidal Cystectomy
Placement seton
Port a cath removal/placement
Rectal Fistulectomy
Removal/excision of anal fissure, anal tags, breast tissue, pilonidal cyst, sperm cord lesion, foreign body, hemorrhoids and fistula, rectal obstruction
Repair anal fistula
Skin Grafts (Partial or Full thickness)
Temporal Artery Biopsy
Tracheotomy/Tracheoplasty
Transanal mass/biopsy/excision/polyp resection
Tumor excision
Ulcer Closure
Unilateral Thyroid lobectomy
Wide local excision, sentinel lymph node biopsy

Gastroenterology
Colonoscopy
Colonoscopy with or without Brushing
Colonoscopy with biopsy
Colonoscopy with removal Foreign Body
Colonoscopy with Control of Bleeding
Colonoscopy with polypectomy
Colonoscopy with removal tumor, polyp, or lesion by snare
Colonoscopy with removal tumor, polyp, or lesion by hot biopsy
Colonoscopy with Band Ligation
Flexible Sigmoidoscopy
Sigmoidoscopy with or without brushing
Sigmoidoscopy with biopsy
Sigmoidoscopy with removal foreign body
Sigmoidoscopy with control of bleeding
Sigmoidoscopy with Insertion Stent
Sigmoidoscopy with removal tumor, polyp, or lesion by snare
Sigmoidoscopy with removal tumor, polyp, or lesion by hot biopsy
Sigmoidoscopy with Balloon Dilation
Esophagogastroduodenoscopy
EGD with or without brushing
EGD with biopsy
EGD with trans endoscopic tube or catheter placement
EGD with injection sclerosis of esophageal and/or gastric varices
EGD with Band ligation of esophageal and/or gastric varices
EGD with Dilation of gastric outlet of obstruction
EGD with Directed Placement of percutaneous gastrostomy tube
EGD with Removal of Foreign Body
EGD with Insertion of guide wire followed by dilation of esophagus
EGD with Balloon Dilation of esophagus
EGD with removal tumor, polyp, or lesion by snare
EGD with removal tumor, polyp, or lesion by hot biopsy
EGD with Control of Bleeding Any Method
Push Enteroscopy
Endoscopic Ultrasound
Endoscopic Retrograde CholangioPancreatography
Interventional Radiology
Port-a-cath removal/placement
Central venous access removal/explant
Percutaneous nephrostomy placement/exchange/removal
Percutaneous gastrostomy placement/exchange/removal
Suprapubic catheter placement/exchange/removal
Peritoneal dialysis catheter placement/exchange/removal
PleurX catheter (tunneled pleural and abdominal drain)

Paracentesis
Thoracentesis
IVC filter placement/removal
US-guided biopsies (thyroid, liver, kidney, lymph node, other superficial)
Ablation of varicose veins
Phlebectomy

Obstetrics/Gynecology
Adhesiolysis
Aspiration of simple adnexal cysts
Biopsy of vulva and/or perineum
Chromotubation oviduct
Colpocleisis
Colposcopy
Conization of cervix (cold knife and loop electrode excision)
Destruction of female genital lesions
Diagnostic cystoscopy
Diagnostic laparoscopy
Dilation and curettage (both non-obstetric and obstetric)
Endometrial resection and/or ablation
Examination under anesthesia
Fallopian tube cannulation
Hysterorraphy non-obstetrical
Hysteroscopic adhesiolysis, myomectomy, polypectomy and/or septum resection
Hysteroscopy (both diagnostic and operative)
Incision and drainage of vulvovaginal abscesses
Insertion/removal of intrauterine device
Labia reduction
Laparoscopic or open salpingectomy, cystectomy, and/or oophorectomy
LASER ablation of vagina/vulva
Linear salpingostomy for ectopic pregnancy
Marsupialization bartholin's gland cyst
Midurethral sling procedures
Mini-laparotomy
Neosalpingostomy
Occlusion fallopian tube (both hysteroscopic and laparoscopic_
Ovarian biopsy
Perineorraphy
Repair of rectocele, enterocele, cystocele
Retropubic urethropexy
Total laparoscopic hysterectomy
Urethral bulking agent injection
Vaginal hysterectomy
Vaginal cystectomy
Varicocelectomy

Wide local excision/simple vulvectomy

Ophthalmology
Biopsy of lesions
Glaucoma filtering surgeries
Glaucoma angle surgeries
Cyclophotocoagulation
Cryotherapy
Laser therapy
Intraocular injection of pharmacological agents
Pterygium excision
Other conjunctival lesion excision/biopsy
Conjunctival autograft harvesting and transplantation
Amniotic membrane grafting
Ocular surface reconstruction
Strabismus surgery (including extraocular muscle recession, resection, plication, extirpation, and/or transposition)
Therapeutic use of botulinum toxin chemodenervation (including in extraocular muscles, retrobulbar injection, or periorbital/brow/eyelid injection)
Retrobulbar injection of medication
Therapeutic use of topical antimetabolites (mitomycin-C, 5-fluorouracil, etc)
Eyelid/brow repair/reconstruction
Nasolacrimal duct or other lacrimal surgery
Ptosis repair
Blepharoplasty
Skin graft harvesting and transplantation
Entropion/ectropion repair
Tarsorrhaphy
Enucleation
Evisceration
Orbitotomy
Orbital fracture repair
Brow lift
Cataract extraction with or without IOL placement, simple or complex
Anterior or pars plans vitrectomy
Corneal transplantation
Anterior segment laser
Synechiolysis
Open globe repair
Eyelid laceration repair
Ant vitrectomy, open sky/limbal; partial
Ant vitrectomy, open sky/limbal; subtotal
Posterior sclerostomy
Inj of vit substitute; gas-fluid exchange

Implantation of intravit drug delivery syst.
Injection of intravitreal medications
Pars plan vitrectomy (PPV)
PPV plus endolaser; focal
PPV plus endolaser; PRP
PPV w/ removal of pre-ret memb (ERM)
PPV with ILM peel (includes GFX)
Pars plan lensectomy (PPL)
Repair RD; cryotherapy only
Repair RD; scleral buckle +/-cryo +/- laser
Repair RD; PPV (+/-gas/cryo/laser/SB/PPL)
Repair RD; pneumatic retinopexy only
Repair RD; repeat PPV or SB
Complex RD repair
Removal of Implanted Material (SO)
Release of encircling material
Prophylaxis of RD; cryotherapy
Destroy retinal lesion; cryotherapy
Destroy retinal lesion; laser
Destroy choroidal lesion; laser
Destruction of retinopathy; cryotherapy
Destruction of retinopathy; laser
Phacofra gmentation with aspiration
Surgical posterior capsulotomy

Oral Maxillofacial Surgery
Oral Exam under anesthesia
Diagnostic Local Anesthesia
Taking of Impressions for Casts
Surgical airways
Apicoectomy
Root Amputation
Gingivectomy
Intra- Oral incision and drainage of abscess
Extra-oral incision and drainage of abscess
Alveoloplasty
Surgical repair of oral antral fistula
Removal of foreign body with or without fluoroscopic guidance
Sequestrectomy
Surgical Exposure of un-erupted tooth with/without placement of orthodontic appliance to aid eruption
Transplantation of the teeth or tooth buds
Removal of tori or exostosis
Surgical excision of hyperplastic tissue
Surgical re-positioning of teeth
Vestibuloplasty

Vestibuloplasty with skin or mucosal grafting
Harvesting of Skin Grafts and mucosal grafts
Biopsy of oral hard tissues including but not limited to the Head and Neck
Biopsy of oral soft tissue including but not limited to the Head and Neck
Tracheostomy
Surgical treatment of benign tumors or cysts
Local Facial Flaps
Surgical treatment of malignant tumors
Surgical destruction of lesion by physical methods
Maxillary Sinusotomy for retrieval of tooth or foreign body
Closed reduction of facial fractures
Open reduction of facial fractures
Closed reduction of mandibular dislocation
Temporomandibular Joint manipulation under anesthesia
Temporomandibular Joint Arthroscopy
Temporomandibular Joint Arthrocentesis
Non-surgical management of atypical facial pain
Coronoidectomy
Orthognathic surgical procedures for the Maxilla, Mandible and Chin
Maxillary or mandibular distraction
Alveolar cleft repair
Cleft lip /palate repair
Pharyngoplasty and pharyngeal flap surgery
Surgical rapid palatal expansion
Closure of intraoral soft tissue defect
Closure of extraoral soft tissue defect
Oral Mucosal grafts
Osteoplasty
Surgical nerve repair procedures
Harvesting of Nerve for Nerve Repair
Peripheral neurectomy
Frenectomy / frenoplasty
Cheiloplasty
Sialolithotomy
Sialodochoplasty
Sialendoscopy
Surgical placement of endosseous implant
Surgical placement of subperiosteal implant
Surgical placement of zygoma implant
Osteopromotion with membranes or other osteopromotive material
Autogenous bone graft including harvesting from ilium, tibia, fibula, and oral cavity
Maxillary sinus floor grafting
Ridge augmentation with autogenous bone grafting
Ridge augmentation with allosplastic materials
Alveolar ridge distraction osteogenesis

Rhinoplasty
Septoplasty
Brow and face lift
Blepharoplasty
Chemical peels and dermaabrasions
Use of CO2 (Carbon Dioxide) Laser for oral and facial uses
Submental Lipectomy
Submental Liposuction
Otoplasty

Orthopedic Surgery
Acromioplasty
Amputation finger/toe
Ankle stabiliztion/reconstruction
Application casts/splints (long arm, long leg, short arm, short leg)
Application finger splint
Application/Removal fixation system
Arthrodesis wrist, hand, fingers,ankle,foot, toes
Arthroplasty major/minor
Arthroscopic ACL/PCL repair/reconstruction
Arthroscopy knee, diagnostic
Arthroscopy knee, shoulder, ankle and wrist
Arthroscopy with debridement/shaving of cartilage
Arthroscopy with menisectomy (partial or full) repair or remove
Arthroscopy with removal of loose/foreign bodies
Arthroscopy with synovectomy
Arthrotomy/ loose body removal
Carpal tunnel release
Carpectomy
Chondroplasty
Debridement, extensive ankle
Dupuytren's release
Excision of ganglion - hand, wrist, knee or foot
Excision of lesion of tendon sheath, forearm, ganglion, ankle, hand, leg, foot or wrist
Excision or partial excision bone, bone cyst forearm, wrist or hand
Excision, prepatellar bursa
Hallux valgus correction (bunion repair)
Hardware removal
Incise finger tendon sheath
Lateral release tibial tubercleplasty (fulkerson)
Limited debridement ankle
Limited synovectomy (plica, shelf)
Major synovectomy knee
Manipulation shoulder, elbow, wrist, hand, knee or ankle
Manipulation under anesthesia

Medial and lateral meniscus repair
Medial and lateral menisectomy
Microfracture debridement
Mini open rotator cuff repair
Operation of C-Arm
ORIF clavicle, ulna, humerus, radius, knee (patella), tibula/fibula, ankle, elbow, carpals or metacarpal fractures)
Palmar fasciectomy including skin graft
Partial claviculectomy
Partial synovectomy ankle
Radial nerve decompression/exploration
Removal of prosthesis shoulder, elbow, wrist, hand, leg or ankle
Remove metatarsal spur or heel spur
Remove patellar cyst
Repair achilles tendon
Repair chronic rotator tear cuff, acromioplasty
Repair cruciate or collateral ligament
Repair of hammertoe
Repair nonunion/malunion fracture
Repair of osteochondritis dissecans lesion knee or ankle
Repair of rotator cuff, chronic or acute
Repair of thigh muscle
Repair of wound or lesion
Repair or reconstruct ligaments wrist, hand, fingers, leg, knee or ankle
Repair patellar tendon rupture/quad tendon rupture
Repair ruptured biceps/triceps
Repair tendon hand, wrist, forearm, knee or ankle
Repair wrist or hand joint
Repair/realignment hand tendon
Repair/revise ulna nerve
Repair/revise unstable patellar
Repair/revision elbow
Synovectomy forearm, wrist or hand
Treat clavicle, ulna, humerus, fibula, radius, carpal and metacarpal fractures
Treat lower leg joint
Treat shoulder, hand, arm, kneecap, hip or lower leg dislocation
Ulnar nerve transposition
Wound drainage (incise or irrigate and debridement) arm, elbow, hand, fingers, foot, leg upper and/or lower, toes, knee, ankle
Wrist synovectomy

Otolaryngology
Amputation external ear
CO2 laser ablation of tumor (larynx/pharynx/oral cavity)
Endoscopic sinus surgery

Excision/destruction nasal lesion
Excision lesion external auditory canal
Excision parotid tumor
Excision thyrogloddal duct/cyst/sinus
Excision tumor neck soft tissue
Cartilage graft ear
Cartilage graft nasal
Incision tympanic membrane
Laryngoscopy
Myringoplasty
Myringotomy w/wo tubes
Palatoplasty
Parathyroidectomy
Reconstruct external auditory canal
Remove foreign body auditory canal
Repair nasal vestibule
Resection nasal turbinates
Rhinoplasty major/minor
Septoplasty
Stapedectomy/Stapedotomy
Thyroidectomy
Tympanoplasty w/wo mastoidectomy, w/wo ossicle reconstruction
Tonsillectomy & adenoidectomy

Plastic Surgery
Facial Fracture Repair and Immobilization
Mandibular Fractures: Closed Reduction and Inter-Dental Wiring
Mandibular Fractures: Open Reduction, with or without Inter-Dental Wiring
Maxillary Fractures: Closed Reduction and Inter-Dental Wiring
Maxillary Fractures: Open Reduction with or without Inter-Dental Wiring
Orbital Floor or Rim Fractures: Closed Reduction
Orbital Floor or Rim Fractures: Open Reduction and Fixation with or without Implant or graft
Closed or Open Nasal Bone Reduction

Hand Surgery
Arthrodesis
Arthroplasty with or without Prosthesis
Fingertip Injuries
Nail Bed Injuries
Ablation of Nail/Nail Fold
Fractures: Closed Reduction vs. Open Reduction with Internal or Percutaneous Fixation
Local Flaps or Grafts
Neurolysis/Neurectomy
Osteotomy
Primary or Secondary Nerve Repair

Primary or Secondary Tendon Repair
Sydactyly Release with or without Skingraft
Trigger Finger Release
Carpal Tunnel Release (Open vs. Endoscopic)
Ganglion Cyst Excision
Excision of Tendon Sheath Tumor
Excision of Neoplasm
Revision Amputation
Removal Foreign Body
Tenolysis
Removal of Hardware

Facial Reconstruction
Removal of Hardware
Brow Lift
Rhinoplasty
Scar Revision
Cleft Lip/Nose Revision
Repair Earlobe
Otoplasty
Skin Tag Removal
Excision Neoplasm

Facial Reconstructive Surgery
Chemical Peel or Dermabrasion
Chin Implant
Complete Nasal Reconstruction
Face Lift
Partial Nasal Reconstruction
Rhinoplasty
Septoplasty or Septectomy
Scar Revision
Cleft lip or Nose Revision
Local Flap
Regional Flap
Skin Graft
Resection and Reconstruction for Skin Cancer
Removal Hardware

Breast Reconstruction Surgery
Augmentation Mammoplasty
Breast Biopsy
Mastopexy
Reduction Mammoplasty

Gynecomastia Surgery
Release of Capsular Contracture of Breast secondary to implant
Nipple/Areolar reconstruction
Nipple/Areolar Tattooing
Scar Revision Breast
Removal Breast Implants

Body Contouring
Liposuction Procedures
Brachioplasty
Thigh Lift

Burn Reconstruction
Contracture Release
Syndactyly Release
Full thickness skin graft
Split thickness skin graft
Dermabrasion
CO2 Laser of Scar
Use of Dermal Substitute (Integra)
Dressing Change Under Anesthesia

General Reconstruction
Dressing Change Under Anesthesia
Irrigation and Debridement of Wound
Placement of Wound Vac

Urology
Biopsy of Prostate
Circumcision or Repair of Circumcision
Cystoscopy
Cystoscopy, intravenously botulinum toxin injection
Cystoscopy Retrograde Pyelogram
Cystoscopy Ureteral Stent Placement
Cystoscopy with Biopsy
Cystoureteroscopy with Lithrotripsy
Cystourethroscopy
Cystourethroscopy and/or Resection of Bladder Tumors
Cystourethroscopy with Dilation of Bladder or Dilation of Urethral Stricture with or without Meatotomy
Cystourethroscopy with Fulguration with or without Laser
Cystourethroscopy with Removal of Foreign Body, Calculus/Stone or Ureteral Stent
Diagnostic Laparoscopy
Dilate Urethra
Drainage/Incise Bladder

Excision lesion spermatic cord
Explore Scrotum
Extracorporal Shock Wave Lithotripsy
Fragmenting of Kidney Stone
Hypospadius Repair
Hydrocelectomy
Implant/Revise/Remove Neuroreceiver
Injection of male & female urethra with collagen
Lithotripsy
Laser/Destruction/Biopsy Penis/Testes Lesion
Litholapaxy
Lysis of Labial Lesions
Male and female suburethral slings
Orchiectomy
Orchiopexy
Percutaneous Implantation of Neurostimulator Electrodes
Preputial Stretching
Prostatectomy (TURP)
Pubovascular sling
Relieve Bladder Contracture
Remove Epididymis, Sperm Duct or Hydrocele
Remove/Replace ureteral stent
Repair Bladder Defect
Repair/Reduce Inguinal Hernia
Revise Spermatic Cord Veins
Revise/Repair Sling Repair
Revision of Bladder Neck
Scrotal lesion or mass excision
Spermatocele
Spermatocelectomy
Suprapubic tube placement
Surgery of the Penis
Testicular Prosthesis
Treatment of Urethral Lesion
Ultrasonic Lithotripsy
Ureteral Surgery
Ureteroscopy
Urethral Diverticulectomy
Urethral Surgery
Urethrocutaneous fistula excision
Varicocele Excision
Varicocelectomy
Vas Deferens/Epididymid Surgery

TITLE: EQUIPMENT LIST

PURPOSE: To provide a list of the equipment available in the Ambulatory Surgical Center and that are necessary for Workforce members to carry out his or her responsibilities.

ATTACHMENT "A"

Attached please find a list of equipment that is available in the Ambulatory Surgical Center (ASC) at LBJ.

Biomed #	Description	Manufacturer	Model	Serial #	
60003266	DEFIBRILLATOR LP15	Physio-Control Inc.	V15-2-001608	41558151	
60003283	LASER SURGICAL	Lumenis Inc	VersaPulse	663	
60003284	LIGHT SOURCE 4 PORT MULTI	Sunoptic Technologies	S400T	41629	
60003285	LIGHT SOURCE 4 PORT MULTI	Sunoptic Technologies	S400T	41637	
60003286	LIGHT SOURCE 4 PORT MULTI	Sunoptic Technologies	S400T	41634	
60003287	LIGHT SOURCE 4 PORT MULTI	Sunoptic Technologies	S400T	41636	
60003288	LIGHT SOURCE 4 PORT MULTI	Sunoptic Technologies	S400T	41630	
60003289	LIGHT SOURCE 4 PORT MULTI	Sunoptic Technologies	S400T	41632	
60003290	LIGHT SOURCE 4 PORT MULTI	Sunoptic Technologies	S400T	41631	
60003291	LIGHT SOURCE 4 PORT MULTI	Sunoptic Technologies	S400T	41620	
60003292	LIGHT SOURCE 4 PORT MULTI	Sunoptic Technologies	S400T	41622	
60003293	LIGHT SOURCE 4 PORT MULTI	Sunoptic Technologies	S400T	41635	
60003295	ASPIRATOR URINE	GYRUS ACMI - SUB OF OLYMPUS AM	VC10	N804302-8	
60003300	LASER SYSTEM OMNIGUIDE	Omniguide Inc	FELS-25A	120204	
60003331	ELECTROSURGICAL UNIT	Ethicon Endo-Surgery Inc	GEN11	1111336122	
60003332	ELECTROSURGICAL UNIT	Ethicon Endo-Surgery Inc	GEN11	1111337311	
60003335	ADVANTAGE DRIVE SYSTEM	CONMED Corp	D3000	2013-1243	
60003384	RADIO/FLUORO UNIT/MOBILE	Orthoscan Inc.	1000-0004	5F0632	
60003453	HIGH FLOW INSUFFLATOR	Stryker Endoscopy	0620-040-610	1310CE344	
60003454	HIGH FLOW INSUFFLATOR	Stryker Endoscopy	0620-040-610	1310CE346	
60003455	HIGH FLOW INSUFFLATOR	Stryker Endoscopy	0620-040-610	1310CE342	
60003456	HIGH FLOW INSUFFLATOR	Stryker Endoscopy	0620-040-610	1310CE349	
60003457	HIGH FLOW INSUFFLATOR	Stryker Endoscopy	0620-040-610	1310CE345	
60003458	INFORMATION MANAGEMENT SYSTEM	Stryker Endoscopy	0240060100	13L034214	
60003459	INFORMATION MANAGEMENT SYSTEM	Stryker Endoscopy	0240060100	13L034094	
60003460	INFORMATION MANAGEMENT SYSTEM	Stryker Endoscopy	0240060100	13L034144	
60003461	INFORMATION MANAGEMENT SYSTEM	Stryker Endoscopy	0240060100	14G010214	
60003462	INFORMATION MANAGEMENT SYSTEM	Stryker Endoscopy	0240060100	13L034154	
60003463	CAMERA CONTROL	Stryker Endoscopy	1488010001	13L035224	
60003464	CAMERA CONTROL	Stryker Endoscopy	1488010001	13L038434	
60003465	CAMERA CONTROL	Stryker Endoscopy	1488010001	13L035234	
60003466	CAMERA CONTROL	Stryker Endoscopy	1488010001	13K020504	
60003467	CAMERA CONTROL	Stryker Endoscopy	1488010001	13L038514	
60003468	LIGHT SOURCE	Stryker Endoscopy	0220210000	13L020004	
60003469	LIGHT SOURCE	Stryker Endoscopy	0220210000	13L017474	
60003470	LIGHT SOURCE	Stryker Endoscopy	0220210000	13L024784	
60003471	LIGHT SOURCE	Stryker Endoscopy	0220210000	13L022414	
60003472	LIGHT SOURCE	Stryker Endoscopy	0220210000	13L017484	
60003504	ELECTROSURGICAL UNIT	COVIDIEN	FORCETRIAD	T3H36964EX	
60003505	ELECTROSURGICAL UNIT	COVIDIEN	FORCETRIAD	T3H36963EX	
60003506	ELECTROSURGICAL UNIT	COVIDIEN	FORCETRIAD	T3H36961EX	
60003507	ELECTROSURGICAL UNIT	COVIDIEN	FORCETRIAD	T3H36960EX	
60003508	ELECTROSURGICAL UNIT	COVIDIEN	60-7550-120	G3E2801UX	
60003509	ELECTROSURGICAL UNIT	COVIDIEN	FORCETRIAD	T3H36962EX	
60003546	TOURNIQUET DUAL CHANNEL	Stryker Instruments			
60003547	TOURNIQUET DUAL CHANNEL	Stryker Instruments		1401304723	
60003555	ELECTROSURGICAL UNIT	Smith & Nephew Inc Endoscopy	72202149	D04943	

60003556	HYSTEROFLOW CART	Olympus America Inc	WA40622A	1307CE581	
60003557	HYSTEROFLOW II PUMP	Olympus America Inc	WA40620A	1306CE255	
60003571	VIDEO IMAGE PROCESSOR	Olympus America Inc	OTV-S190	7365245	
60003572	LIGHT SOURCE	Olympus America Inc	CLV-S190	7305064	
60003573	MONITOR LCD 26"	Olympus America Inc	OEV-261H	7356107	
60003574	PRINTER	Olympus America Inc	OEP-5	A312774	
60003575	RECORDER BLUERAY	Olympus America Inc	IMH-20	7341954	
60003576	VIDEO IMAGE PROCESSOR	Olympus America Inc	OTV-S190	7365250	
60003577	LIGHT SOURCE	Olympus America Inc	CLV-S190	7305054	
60003578	MONITOR LCD 26"	Olympus America Inc	OEV-261H	7356148	
60003579	PRINTER	Olympus America Inc	OEP-5	A312695	
60003580	RECORDER BLUERAY	Olympus America Inc	IMH-20	7331732	
60003581	ELECTROSURGICAL UNIT	Olympus America Inc	744000	1321529	
Not in TMS	BOOM EMS CEILING OR #1	STERIS Corp	B605520110	0418413004	
Not in TMS	BOOM EMS CEILING OR #2	STERIS Corp	B605520110	0418413003	
Not in TMS	BOOM EMS CEILING OR #3	STERIS Corp	B605520110	0418413005	
Not in TMS	BOOM EMS CEILING OR #4	STERIS Corp	B605520110	0416413024	
60003586	LIGHT SURGICAL	STERIS Corp	100-240	0417013050	
60003587	LIGHT SURGICAL	STERIS Corp	100-240	0417013045	
60003588	LIGHT SURGICAL	STERIS Corp	100-240	0417013060	
60003589	LIGHT SURGICAL	STERIS Corp	100-240	0417013047	
60003590	LIGHT SURGICAL	STERIS Corp	100-240	0417613038	
60003591	LIGHT SURGICAL	STERIS Corp	100-240	0417613036	
60003592	LIGHT SURGICAL	STERIS Corp	100-240	0417613031	
60003593	LIGHT SURGICAL	STERIS Corp	100-240	0417613034	
60003594	MONITOR LED 26"	STERIS Corp	VTS-26-HD-003	RLM131712553	
60003595	MONITOR LED 26"	STERIS Corp	VTS-26-HD-003	RLM131712556	
60003596	MONITOR LED 26"	STERIS Corp	VTS-26-HD-003	RLM131712552	
60003597	MONITOR LED 26"	STERIS Corp	VTS-26-HD-003	RLM131712555	
60003598	MONITOR LED 26"	STERIS Corp	VTS-26-HD-003	RLM131692538	
60003599	MONITOR LED 26"	STERIS Corp	VTS-26-HD-003	RLM131712550	
60003600	MONITOR LED 26"	STERIS Corp	VTS-26-HD-003	RLM131712554	
60003601	MONITOR LED 26"	STERIS Corp	VTS-26-HD-003	RLM131692539	
60003602	TABLE OPERATING	STERIS Corp	4085	0413013105	
60003603	TABLE OPERATING	STERIS Corp	4085	0413013107	
60003604	TABLE OPERATING	STERIS Corp	4085	0413013104	
60003605	TABLE OPERATING	STERIS Corp	4085	0413013106	
60003606	WARMING CABINET	STERIS Corp	DJ060124331	0416913010	
60003607	WARMING CABINET	STERIS Corp	DJ060124331	041691913011	
60003608	NERVE MONITORING SYS W/CART	MEDTRONIC USA - XOMED - DIV ME			
60003622	ARTHOSCOPIC SHAVER SYSTEM	MEDTRONIC USA - XOMED - DIV ME	EK001		
Not in TMS	BOOM EMS CEILING	STERIS Corp	B605520124	0416413021	
60003626	LIGHT SURGICAL	STERIS Corp	100-240	0405713046	
60003627	LIGHT SURGICAL	STERIS Corp	100-240	0417613035	
60003628	MONITOR VIDEO	STERIS Corp	VTS-26-HD-003	RLM131732560	
60003629	MONITOR VIDEO	STERIS Corp	VTS-26-HD-003	RLM131512511	
60003630	TABLE OPERATING	STERIS Corp	4085	0413713132	
60003633	MICROSCOPE/LIGHT	Carl Zeiss Inc	6636	6636160576	
60003634	CAMERA / VIDEO	Carl Zeiss Inc	308203-3350-000	6904201260	
60003635	RECORDER/TAPE/VIDEO	Carl Zeiss Inc	000000-1521-195	6911102046	
60003636	MICROSCOPE/LIGHT	Carl Zeiss Inc	000000-1154-525	6629320870	
60003637	CAMERA/VIDEO	Carl Zeiss Inc	308203-3350-000	6904201256	
60003641	PUMP CONSOLE ARTHROSCOPY	Stryker Endoscopy	04575100000	14D042324	
60003645	WARMING UNIT BLANKET	STERIS Corp	DJ060124331	0412214099	

60003646	WARMING UNIT BLANKET	STERIS Corp	DJ060124331	0412214100		
60003653	FREEZER LABORATORY	Global Cooling Inc	SU105U	1407.00204		
60003846	CENTURION VISION SYSTEM	Alcon Surgical Inc.	8065751763	1501767001X		
60003958	MICROSCOPE 700 EYE SURGERY	Carl Zeiss Meditec Inc.	6634	6634143803		
60003959	RECORDER EVOLUTION HD 1080	Precision Surgical Inc	EVO.1	EVO-0515-052C		
60003965	STRETCHER EYE SURGERY	STRYKER	1089	1508038384		
60003966	STRETCHER EYE SURGERY	STRYKER	1089	1508038385		
60003967	STRETCHER EYE SURGERY	STRYKER	1089	1508038386		
60004139	RECORDER/TAPE/VIDEO	Carl Zeiss Inc	000000-1521-195	6911101176		
60004234	DIGITAL MOBILE C-ARM	GE HEALTHCARE OEC MEDICAL SYS	OEC9900	E2XXXX05912		
60004235	SHAVER ARTHROSCOPY UTL 02/18	Stryker Endoscopy	0450000000	15G034404		
SN-13L040954	CAMERA HEAD VIDEO ENDOSCOPE	Stryker Endoscopy	1488-210-105	13I1431474		
SN-13L040304	CAMERA HEAD VIDEO ENDOSCOPE	Stryker Endoscopy	1488-210-105	14I017734		
SN-13L040894	CAMERA HEAD VIDEO ENDOSCOPE	Stryker Endoscopy	1488-210-105	13L040894		
SN-13L040404	CAMERA HEAD VIDEO ENDOSCOPE	Stryker Endoscopy	1488-210-105	13L040404		
SN-13L040294	CAMERA HEAD VIDEO ENDOSCOPE	Stryker Endoscopy	1488-210-105	13G055234		
SN-13L035974	CAMERA HEAD VIDEO ENDOSCOPE	Stryker Endoscopy	1488-210-105	13O013554		
SN-13L040374	CAMERA HEAD VIDEO ENDOSCOPE	Stryker Endoscopy	1488-210-105	147023134		
SN-13L031994	CAMERA HEAD VIDEO ENDOSCOPE	Stryker Endoscopy	1488-210-105	13K036694		
SN-13L040974	CAMERA HEAD VIDEO ENDOSCOPE	Stryker Endoscopy	1488-210-105	13I1429074		
SN-13L040384	CAMERA HEAD VIDEO ENDOSCOPE	Stryker Endoscopy	1488-210-105	13K045634		
SN-13L040414	CAMERA HEAD VIDEO ENDOSCOPE	Stryker Endoscopy	1488-210-105	13L040414		
SN-13L040914	CAMERA HEAD VIDEO ENDOSCOPE	Stryker Endoscopy	1488-210-105	13L040914		
SN-846351	URETEROSCOPE RIGID	Stryker Endoscopy	502-880-330	846351		
SN-852916	URETEROSCOPE RIGID	Stryker Endoscopy	502-880-330	852916		
SN-863403	URETEROSCOPE RIGID	Stryker Endoscopy	502-880-330	863403		
SN-853467	URETEROSCOPE RIGID	Stryker Endoscopy	502-880-430	853467		
SN-854146	URETEROSCOPE RIGID	Stryker Endoscopy	502-880-430	854146		
SN-832514	URETEROSCOPE RIGID	Stryker Endoscopy	502-880-430	832514		
SN-H907398	ECTR VIDEO ENDOSCOPE TRAY	MicroAire Surgical Instruments	81025	H907398		
SN-H910799	ECTR VIDEO ENDOSCOPE TRAY	MicroAire Surgical Instruments	81025	H910799		
SN-656532	TELESCOPE 4MM 30 DEGREES AC	Olympus America Inc	A22002A	656532		
SN-654491	TELESCOPE 4MM 30 DEGREES AC	Olympus America Inc	A22002A	654491		
SN-654461	CYSTOSCOPE RIGID 30 DEGREES	Olympus America Inc	A22002A	654461		
SN-657027	CYSTOSCOPE RIGID 70 DEGREES	Olympus America Inc	A22003A	657027		
SN-654239	CYSTOSCOPE RIGID	Olympus America Inc	A22003A	654239		
SN-655213	CYSTOSCOPE RIGID	Olympus America Inc	A22001A	655213		
SN-654250	CYSTOSCOPE RIGID	Olympus America Inc	A22000A	654250		
SN-2353068	URETEROSCOPE FLEXIBLE RENO	Olympus America Inc	URF-V	2353068		
SN-2353070	URETEROSCOPE FLEXIBLE RENO	Olympus America Inc	URF-V	2353070		
SN-2353069	URETEROSCOPE FLEXIBLE RENO	Olympus America Inc	URF-V	2353069		
SN-2301243	CYSTOSCOPE FLEXIBLE NEPHRO	Olympus America Inc	CYF-VH	2301243		
SN-2301247	CYSTOSCOPE FLEXIBLE NEPHRO	Olympus America Inc	CYF-VH	2301247		
SN-2301245	CYSTOSCOPE FLEXIBLE NEPHRO	Olympus America Inc	CYF-VH	2301245		
SN-1200CT	LARYNGOSCOPE RIGID 0 DEG 4MM	Karl Storz Endoscopy-America I	10005AA	1200CT		
SN-1200DE	LARYNGOSCOPE RIGID 0 DEG 4MM	Karl Storz Endoscopy-America I	10005AA	1200DE		
SN-12009V	BRONC/ESAPHAGOSCOPE 30 DEG	Karl Storz Endoscopy-America I	10320BA	12009V		
SN-1200DB	BRONC/ESAPHAGOSCOPE 30 DEG	Karl Storz Endoscopy-America I	10320BA	1200DB		
SN-1200NK	BRONC/ESAPHAGOSCOPE 0 DEG	Karl Storz Endoscopy-America I	10320AA	1200NK		
SN-1200NT	BRONC/ESAPHAGOSCOPE 0 DEG	Karl Storz Endoscopy-America I	10320AA	1200NT		
SN-3402094	PEDI BRONC/ESAPHAGOSCOPE	Karl Storz Endoscopy-America I	10324AA	3402094		
SN-3402132	PEDI BRONC/ESAPHAGOSCOPE	Karl Storz Endoscopy-America I	10324AA	3402132		
SN-670601	CYSTOSCOPE RIGID 30 DEG 4MM	Olympus America Inc	A22002A	670601		

SN-672058	CYSTOSCOPE RIGID 30 DEG 4MM	Olympus America Inc	A22002A	672058	
SN-672100	CYSTOSCOPE RIGID 30 DEG 4MM	Olympus America Inc	A22002A	672100	
SN-672337	CYSTOSCOPE RIGID 30 DEG 4MM	Olympus America Inc	A22002A	672337	
SN-672618	CYSTOSCOPE RIGID 30 DEG 4MM	Olympus America Inc	A22002A	672618	
SN-672849	CYSTOSCOPE RIGID 30 DEG 4MM	Olympus America Inc	A22002A	672849	
SN-673844	CYSTOSCOPE RIGID 30 DEG 4MM	Olympus America Inc	A22002A	673844	
SN-673882	CYSTOSCOPE RIGID 30 DEG 4MM	Olympus America Inc	A22002A	673882	
SN-673884	CYSTOSCOPE RIGID 30 DEG 4MM	Olympus America Inc	A22002A	673884	
SN-671712	CYSTOSCOPE RIGID 70 DEG 4MM	Olympus America Inc	A22003A	671712	
SN-671951	CYSTOSCOPE RIGID 70 DEG 4MM	Olympus America Inc	A22003A	671951	
SN-671953	CYSTOSCOPE RIGID 70 DEG 4MM	Olympus America Inc	A22003A	671953	
SN-671962	CYSTOSCOPE RIGID 70 DEG 4MM	Olympus America Inc	A22003A	671962	
SN-673669	CYSTOSCOPE RIGID 70 DEG 4MM	Olympus America Inc	A22003A	673669	
SN-674376	CYSTOSCOPE RIGID 70 DEG 4MM	Olympus America Inc	A22003A	674376	
SN-670745	CYSTOSCOPE RIGID 12 DEG 4MM	Olympus America Inc	A22001A	670745	
SN-670771	CYSTOSCOPE RIGID 12 DEG 4MM	Olympus America Inc	A22001A	670771	
SN-670880	CYSTOSCOPE RIGID 12 DEG 4MM	Olympus America Inc	A22001A	670880	
SN-674503	CYSTOSCOPE RIGID 12 DEG 4MM	Olympus America Inc	A22001A	674503	
SN-674513	CYSTOSCOPE RIGID 12 DEG 4MM	Olympus America Inc	A22001A	674513	
SN-674517	CYSTOSCOPE RIGID 12 DEG 4MM	Olympus America Inc	A22001A	674517	
SN-670110	CYSTOSCOPE RIGID 0 DEG 4MM	Olympus America Inc	A22000A	670110	
SN-672174	CYSTOSCOPE RIGID 0 DEG 4MM	Olympus America Inc	A22000A	672174	
SN-7401376	CAMERA VIDEO ENDOSCOPE	Olympus America Inc	CH-S190-08-LB	7401376	
SN-7401385	CAMERA VIDEO ENDOSCOPE	Olympus America Inc	CH-S190-08-LB	7401385	
SN-7401391	CAMERA VIDEO ENDOSCOPE	Olympus America Inc	CH-S190-08-LB	7401391	
SN-7401417	CAMERA VIDEO ENDOSCOPE	Olympus America Inc	CH-S190-08-LB	7401417	
SN-1501213753	DRIVER REAMER	Stryker Instruments	6400-099-000	1501213753	
SN-1500704813	SAW SURGICAL BONE	Stryker Instruments	4408-000-000	1500704813	
SN-1500704753	SAW SURGICAL BONE	Stryker Instruments	4408-000-000	1500704753	
61001299	WARMING/COOLING UNITS,PATIENT,CIRCULATING-LIQUID	GAYMAR INDUSTRIES INC DIV STRYKER CORP	MTA7900	MTA7900 H80027	
61003227	HYDROTHERMAL ABLATION SYSTEMS, ENDOMETRIAL	BOSTON SCIENTIFIC CORP	58001	GEN0732	
61005822	REFRIGERATOR	FOLLETT CORP	REF5	E09697-23813	
61005831	COLOR PRINTER	STRYKER ENDOSCOPY DIV STRYKER CORP	0240080230	89696	
61005838	REGULATORS, SUCTION, TRACHEAL	OHIO MEDICAL CORP	6702-1251-908	JGGS14308	
61005846	REGULATORS, SUCTION, TRACHEAL	OHIO MEDICAL CORP	6702-1251-908	JGGS14320	
61005847	REGULATORS, SUCTION, TRACHEAL	OHIO MEDICAL CORP	6702-1251-908	JGGS14317	
61005848	REGULATORS, SUCTION, TRACHEAL	OHIO MEDICAL CORP	6702-1251-908	JGGS14328	
61005849	REGULATORS, SUCTION, TRACHEAL	OHIO MEDICAL CORP	6702-1251-908	JGGS14329	
61005850	REGULATORS, SUCTION, TRACHEAL	OHIO MEDICAL CORP	6702-1251-908	JGGS14316	
61005851	REGULATORS, SUCTION, TRACHEAL	OHIO MEDICAL CORP	6702-1251-908	JGGS14314	
61005852	REGULATORS, SUCTION, TRACHEAL	OHIO MEDICAL CORP	6702-1251-908	JGGS14315	
61005853	REGULATORS, SUCTION, TRACHEAL	OHIO MEDICAL CORP	6702-1251-908	JGGS14319	
61005857	REGULATORS, SUCTION, TRACHEAL	OHIO MEDICAL CORP	6702-1251-908	JGGS14312	
61005858	REGULATORS, SUCTION, TRACHEAL	OHIO MEDICAL CORP	6702-1251-908	JGGS14326	
61005860	REGULATORS, SUCTION, TRACHEAL	OHIO MEDICAL CORP	6702-1251-908	JGGS14318	
61005870	ASPIRATOR/EMERGENCY	SSCOR INC	AE-6975	M25713	
61005871	ASPIRATOR/EMERGENCY	SSCOR INC	AE-6975	M25714	
61006000	CART/INSTRUMENT	OLYMPUS AMERICA INC ENDOS	WM-NP2	21316664	
61006001	CART/INSTRUMENT	OLYMPUS AMERICA INC ENDOS	WM-NP2	21316018	
61006011	PRINTER/VIDEO	SONY ELECTRONICS INC MEDICAL SYS DI	UP-897	297719	
61006055	REGULATORS, SUCTION, TRACHEAL	OHIO MEDICAL CORP	6702-1251-908	JGGT00957	
61006056	REGULATORS, SUCTION, TRACHEAL	OHIO MEDICAL CORP	6702-1251-908	JGGT00956	

61006057 REGULATORS, SUCTION, TRACHEAL OHIO MEDICAL CORP 6702-1251-908 JGGT00958
61006062 ORTHOPEDIC CEMENT/BONE CUTTING/EXTRACTION SYSTEMS, POWERED DRILLING STRYKER INSTRUMENTS 5400-050-000 1405005373
61006063 ORTHOPEDIC CEMENT/BONE CUTTING/EXTRACTION SYSTEMS, POWERED DRILLING STRYKER INSTRUMENTS 5400-050-000 1405005273
61006118 MONITOR/VIDEO CARL ZEISS MICROIMAGING LMD-2110MD 3201629
61006119 CART/INSTRUMENT CARL ZEISS MICROIMAGING 301687-9043-000 001-041178
61006120 MONITOR/VIDEO CARL ZEISS MICROIMAGING LMD-2110MD 3201712
61006121 CART/INSTRUMENT CARL ZEISS MICROIMAGING 301687-9043-000 001-035650
61006124 SCALE/CLINICAL/PRECISION SCALE-TRONIX INC. 4302 ORGAN TISSUE 4302-713
61006125 WARM UNIT/BLOOD/SOLUTION SMITHS MEDICAL ASD INC H-1100 S105A00092
61006265 SMOKE EVACUATION SYS/SURGICAL COVIDIEN SURGICAL SOLUTIONS GROUP DIV COVIDIEN SE3690 VL006543X
61006470 CHAIR/EXAM/TREAT STRYKER INSTRUMENTS SurgiStool II 1508 039809
61006598 LIGHT SOURCE/FIBER BIOMET MICROFIXATION USA DIV BIOMET INC Xe3000 71-OJ 2100
61006723 DETECTOR/BLOOD FLOW/ULTRASONIC KOVEN TECHNOLOGY ES-100X B15110022
61006879 PRINTER/VIDEO STRYKER ENDOSCOPY DIV STRYKER CORP SDP1000 10018
61006945 PRINTER/VIDEO STRYKER ENDOSCOPY DIV STRYKER CORP 240080230 80564
61006946 PRINTER/VIDEO STRYKER ENDOSCOPY DIV STRYKER CORP 240080230 88658
61007102 PRINTER/VIDEO SONY UP-991AA 702929
61007184 REFRIGERATOR FOLLETT CORP REF5P J71327
61007185 PRINTER/VIDEO STRYKER ENDOSCOPY DIV STRYKER CORP SDP1000 80876
62000530 CIRCULATORY/PERIPHERAL COMP/SEQ Compression Therapy Concepts Inc VP500 3950309183
62000986 WARM UNIT/MULTIPURPOSE OR SOLUTIONS INC ORS-2066R-D 51723
62000987 WARM UNIT/MULTIPURPOSE OR SOLUTIONS INC ORS-2066R 49131
62000988 WARM UNIT/MULTIPURPOSE OR SOLUTIONS INC ORS-2066R 40795
62000989 WARM UNIT/MULTIPURPOSE OR SOLUTIONS INC ORS-2066R-F 54961
62000990 WARM UNIT/MULTIPURPOSE OR SOLUTIONS INC ORS-2066R-F 55305
62001066 CIRCULATORY/PERIPHERAL COMP/SEQ Compression Therapy Concepts Inc VP500 121838
62001067 CIRCULATORY/PERIPHERAL COMP/SEQ Compression Therapy Concepts Inc VP500 121839
62001068 CIRCULATORY/PERIPHERAL COMP/SEQ Compression Therapy Concepts Inc VP500 121840
62001069 CIRCULATORY/PERIPHERAL COMP/SEQ Compression Therapy Concepts Inc VP500 121841
62001070 CIRCULATORY/PERIPHERAL COMP/SEQ Compression Therapy Concepts Inc VP500 121842
62001071 CIRCULATORY/PERIPHERAL COMP/SEQ Compression Therapy Concepts Inc VP500 121843
62001143 ASPIRATOR/SURGICALSTRYKER INSTRUMENTS 0408-655-000 1524502453
62001145 ASPIRATOR/SURGICALSTRYKER INSTRUMENTS 0408-655-000 1524502423
62001146 ASPIRATOR/SURGICALSTRYKER INSTRUMENTS 0408-655-000 1524409913
62001147 ASPIRATOR/SURGICALSTRYKER INSTRUMENTS 0408-655-000 1524502443
SN-00001901 HANDPIECE/SURGICAL STRYKER INSTRUMENTS E9010 1901
SN-12000G ENDOSCOPE KARL STORZ ENDOSCOPY-AMERICA INC 7230CVA 12000G
SN-12000K ENDOSCOPE KARL STORZ ENDOSCOPY-AMERICA INC 7230CVA 12000K
SN-12001Y ENDOSCOPE KARL STORZ ENDOSCOPY-AMERICA INC 7230FVA 12001Y
SN-12003Z LARYNGOSCOPE/RIGID KARL STORZ ENDOSCOPY-AMERICA INC 10005BA 12003Z
SN-12005D ENDOSCOPE KARL STORZ ENDOSCOPY-AMERICA INC 7230AA 12005D
SN-1200AZ ENDOSCOPE KARL STORZ ENDOSCOPY-AMERICA INC R7230BVA 1200AZ
SN-1200FD LARYNGOSCOPE/RIGID KARL STORZ ENDOSCOPY-AMERICA INC R10005BA 1200FD
SN-1200QR ENDOSCOPE KARL STORZ ENDOSCOPY-AMERICA INC 7230AA 1200QR
SN-121842 MONITOR/LAB/TEMPERATURE SENSOSCIENTIFIC TPSCPINS 121842
SN-125150 MONITOR/LAB/TEMPERATURE SENSOSCIENTIFIC TPULTP2INS 125150

SN-125460	MONITOR/LAB/TEMPERATURE	SENSOSCIENTIFIC	TPSCPINS	125460	
SN-1501626503X	HANDPIECE/SURGICAL	ALCON SURGICAL INC	8065751761	1501626503X	
SN-1501626504X	HANDPIECE/SURGICAL	ALCON SURGICAL INC	8065751761	1501626504X	
SN-1501626505X	HANDPIECE/SURGICAL	ALCON SURGICAL INC	8065751761	1501626505X	
SN-1501626506X	HANDPIECE/SURGICAL	ALCON SURGICAL INC	8065751761	1501626506X	
SN-1501626507X	HANDPIECE/SURGICAL	ALCON SURGICAL INC	8065751761	1501626507X	
SN-1501626508X	HANDPIECE/SURGICAL	ALCON SURGICAL INC	8065751761	1501626508X	
SN-3400539	ENDOSCOPE	KARL STORZ ENDOSCOPY-AMERICA INC	7230FVA	3400539	
SN-3400801	ENDOSCOPE	KARL STORZ ENDOSCOPY-AMERICA INC	7230BVA	3400801	
SN-5000295147	HYSTEROSCOPE	RICHARD WOLF MEDICAL INSTRUMENTS CORP		8974.412	5000295147
SN-5000312773	HYSTEROSCOPE	RICHARD WOLF MEDICAL INSTRUMENTS CORP		8974.412	5000312773
SN-5000337520	HYSTEROSCOPE	RICHARD WOLF MEDICAL INSTRUMENTS CORP		8974.402	5000337520
SN-608397	HYSTEROSCOPE	RICHARD WOLF MEDICAL INSTRUMENTS CORP		8974.402	608397
SN-611424	HYSTEROSCOPE	RICHARD WOLF MEDICAL INSTRUMENTS CORP		8974.412	611424
SN-614210	HYSTEROSCOPE	RICHARD WOLF MEDICAL INSTRUMENTS CO		8974.412	614210
SN-617694	HYSTEROSCOPE	RICHARD WOLF MEDICAL INSTRUMENTS CO		8974.412	617694
SN-617695	HYSTEROSCOPE	RICHARD WOLF MEDICAL INSTRUMENTS CO		8974.412	617695
SN-617747	HYSTEROSCOPE	RICHARD WOLF MEDICAL INSTRUMENTS CO		8974.402	617747
SN-617749	HYSTEROSCOPE	RICHARD WOLF MEDICAL INSTRUMENTS CO		8974.402	617749
SN-823553	ARTHROSCOPE	STRYKER ENDOSCOPY DIV STRYKER CORP	502-819-010	823553	
SN-830874	ARTHROSCOPE	STRYKER ENDOSCOPY DIV STRYKER CORP	502-927-030	830874	
SN-852589	LAPAROSCOPE	STRYKER ENDOSCOPY DIV STRYKER CORP	0502-539-010	852589	
SN-852645	LAPAROSCOPE	STRYKER ENDOSCOPY DIV STRYKER CORP	0502-539-010	852645	
SN-854305	LAPAROSCOPE	STRYKER ENDOSCOPY DIV STRYKER CORP	0502-539-010	854305	
SN-854313	LAPAROSCOPE	STRYKER ENDOSCOPY DIV STRYKER CORP	0502-539-010	854313	
SN-855719	ARTHROSCOPE	STRYKER ENDOSCOPY DIV STRYKER CORP	502-826-070	855719	
SN-859501	LAPAROSCOPE	STRYKER ENDOSCOPY DIV STRYKER CORP	0502-539-010	859501	
SN-859522	LAPAROSCOPE	STRYKER ENDOSCOPY DIV STRYKER CORP	0502-539-010	859522	
SN-860244	LAPAROSCOPE	STRYKER ENDOSCOPY DIV STRYKER CORP	0502-539-010	860244	
SN-864809	LAPAROSCOPE	STRYKER ENDOSCOPY DIV STRYKER CORP	0502-539-010	864809	
SN-866445	LAPAROSCOPE	STRYKER ENDOSCOPY DIV STRYKER CORP	0502-539-010	866445	
SN-867432	LAPAROSCOPE	STRYKER ENDOSCOPY DIV STRYKER CORP	502-539-045	867432	
SN-867433	LAPAROSCOPE	STRYKER ENDOSCOPY DIV STRYKER CORP	502-539-045	867433	
SN-869906	LAPAROSCOPE	STRYKER ENDOSCOPY DIV STRYKER CORP	502-859-010	869906	
SN-871211	LAPAROSCOPE	STRYKER ENDOSCOPY DIV STRYKER CORP	0502-539-010	871211	
SN-876000	LAPAROSCOPE	STRYKER ENDOSCOPY DIV STRYKER CORP	0502-539-030	876000	
SN-876010	LAPAROSCOPE	STRYKER ENDOSCOPY DIV STRYKER CORP	0502-539-030	876010	
SN-879792	LAPAROSCOPE	STRYKER ENDOSCOPY DIV STRYKER CORP	502-539-045	879792	
SN-881202	LAPAROSCOPE	STRYKER ENDOSCOPY DIV STRYKER CORP	0502-859-045	881202	
SN-881206	LAPAROSCOPE	STRYKER ENDOSCOPY DIV STRYKER CORP	0502-859-045	881206	
SN-881209	LAPAROSCOPE	STRYKER ENDOSCOPY DIV STRYKER CORP	0502-859-045	881209	
SN-881791	LAPAROSCOPE	STRYKER ENDOSCOPY DIV STRYKER CORP	0502-539-030	881791	
SN-881794	LAPAROSCOPE	STRYKER ENDOSCOPY DIV STRYKER CORP	0502-539-030	881794	
SN-882047	LAPAROSCOPE	STRYKER ENDOSCOPY DIV STRYKER CORP	502-859-010	882047	
SN-882056	LAPAROSCOPE	STRYKER ENDOSCOPY DIV STRYKER CORP	502-859-010	882056	
SN-883620	LAPAROSCOPE	STRYKER ENDOSCOPY DIV STRYKER CORP	0502-859-045	883620	
SN-884739	LAPAROSCOPE	STRYKER ENDOSCOPY DIV STRYKER CORP	0502-539-030	884739	
SN-886025	LAPAROSCOPE	STRYKER ENDOSCOPY DIV STRYKER CORP	0502-539-030	886025	
SN-888707	LAPAROSCOPE	STRYKER ENDOSCOPY DIV STRYKER CORP	502-539-045	888707	
SN-888755	LAPAROSCOPE	STRYKER ENDOSCOPY DIV STRYKER CORP	502-539-045	888755	
SN-889476	LAPAROSCOPE	STRYKER ENDOSCOPY DIV STRYKER CORP	502-859-010	889476	

SN-889641	LAPAROSCOPE	STRYKER ENDOSCOPY DIV STRYKER CORP		502-859-010	889641
SN-889988	ARTHROSCOPE	STRYKER ENDOSCOPY DIV STRYKER CORP		502-104-070	889988
SN-889999	ARTHROSCOPE	STRYKER ENDOSCOPY DIV STRYKER CORP		502-104-070	889999
SN-890291	LAPAROSCOPE	STRYKER ENDOSCOPY DIV STRYKER CORP		0502-539-030	890291
SN-890751	LAPAROSCOPE	STRYKER ENDOSCOPY DIV STRYKER CORP		0502-859-045	890751
SN-890753	LAPAROSCOPE	STRYKER ENDOSCOPY DIV STRYKER CORP		0502-859-045	890753
SN-890759	LAPAROSCOPE	STRYKER ENDOSCOPY DIV STRYKER CORP		0502-859-045	890759
SN-891498	LAPAROSCOPE	STRYKER ENDOSCOPY DIV STRYKER CORP		502-859-010	891498
SN-891505	LAPAROSCOPE	STRYKER ENDOSCOPY DIV STRYKER CORP		502-859-010	891505
SN-891536	LAPAROSCOPE	STRYKER ENDOSCOPY DIV STRYKER CORP		502-859-010	891536
SN-891547	LAPAROSCOPE	STRYKER ENDOSCOPY DIV STRYKER CORP		502-859-010	891547
SN-891727	LAPAROSCOPE	STRYKER ENDOSCOPY DIV STRYKER CORP		502-859-010	891727
SN-891821	LAPAROSCOPE	STRYKER ENDOSCOPY DIV STRYKER CORP		0502-539-030	891821
SN-893221	LAPAROSCOPE	STRYKER ENDOSCOPY DIV STRYKER CORP		502-539-045	893221
SN-893530	ARTHROSCOPE	STRYKER ENDOSCOPY DIV STRYKER CORP		502-904-030	893530
sn-893577	ARTHROSCOPE	STRYKER ENDOSCOPY DIV STRYKER CORP		502-904-030	893577
SN-897280	LAPAROSCOPE	STRYKER ENDOSCOPY DIV STRYKER CORP		0502-859-030	897280
SN-897349	LAPAROSCOPE	STRYKER ENDOSCOPY DIV STRYKER CORP		0502-859-030	897349
SN-898232	ARTHROSCOPE	STRYKER ENDOSCOPY DIV STRYKER CORP		502-826-030	898232
SN-898626	LAPAROSCOPE	STRYKER ENDOSCOPY DIV STRYKER CORP		0502-859-030	898626
SN-898871	LAPAROSCOPE	STRYKER ENDOSCOPY DIV STRYKER CORP		502-539-045	898871
SN-899181	LAPAROSCOPE	STRYKER ENDOSCOPY DIV STRYKER CORP		502-539-045	899181
SN-900499	LAPAROSCOPE	STRYKER ENDOSCOPY DIV STRYKER CORP		0502-539-030	900499
SN-901331	LAPAROSCOPE	STRYKER ENDOSCOPY DIV STRYKER CORP		0502-539-030	901331
SN-901679	LAPAROSCOPE	STRYKER ENDOSCOPY DIV STRYKER CORP		0502-859-045	901679
SN-902286	ARTHROSCOPE	STRYKER ENDOSCOPY DIV STRYKER CORP		502-927-070	902286
SN-903694	LAPAROSCOPE	STRYKER ENDOSCOPY DIV STRYKER CORP		0502-859-030	903694
SN-903696	LAPAROSCOPE	STRYKER ENDOSCOPY DIV STRYKER CORP		0502-859-030	903696
SN-903701	LAPAROSCOPE	STRYKER ENDOSCOPY DIV STRYKER CORP		0502-859-030	903701
SN-903782	LAPAROSCOPE	STRYKER ENDOSCOPY DIV STRYKER CORP		0502-859-030	903782
SN-903794	LAPAROSCOPE	STRYKER ENDOSCOPY DIV STRYKER CORP		0502-859-030	903794
SN-904562	LAPAROSCOPE	STRYKER ENDOSCOPY DIV STRYKER CORP		0502-859-030	904562
SN-904573	LAPAROSCOPE	STRYKER ENDOSCOPY DIV STRYKER CORP		0502-859-030	904573
SN-905126	ARTHROSCOPE	STRYKER ENDOSCOPY DIV STRYKER CORP		502-104-030	905126
SN-907277	ARTHROSCOPE	STRYKER ENDOSCOPY DIV STRYKER CORP		502-104-030	907277
SN-910402	ARTHROSCOPE	STRYKER ENDOSCOPY DIV STRYKER CORP		502-904-070	910402
SN-910680	ARTHROSCOPE	STRYKER ENDOSCOPY DIV STRYKER CORP		502-904-070	910680
60003518	MONITOR PATIENT MX700	Philips Medical Systems	865241	DE12521112	
60003519	MONITOR PATIENT MX700	Philips Medical Systems	865241	DE12521114	
60003520	MONITOR PATIENT MX700	Philips Medical Systems	865241	DE12521121	
60003521	MONITOR PATIENT MX700	Philips Medical Systems	865241	DE12521124	
60003522	MONITOR PATIENT MX700	Philips Medical Systems	865241	DE12521107	
60003523	MONITOR PATIENT MX700	Philips Medical Systems	865241	DE12521129	
60003524	MONITOR PATIENT MX700	Philips Medical Systems	865241	DE12521104	
60003525	MONITOR PATIENT MX700	Philips Medical Systems	865241	DE12521117	
60003526	MONITOR PATIENT MX700	Philips Medical Systems	865241	DE12521115	
60003527	MONITOR PATIENT MX700	Philips Medical Systems	865241	DE12521118	
60003528	MONITOR PATIENT MX700	Philips Medical Systems	865241	DE12521119	
60003529	MONITOR PATIENT MX700	Philips Medical Systems	865241	DE12521120	
60003530	MONITOR PATIENT MX700	Philips Medical Systems	865241	DE12521128	
60003531	MONITOR PATIENT MX700	Philips Medical Systems	865241	DE12521106	
60003532	MONITOR PATIENT MX700	Philips Medical Systems	865241	DE12521111	
60003533	MONITOR PATIENT MX700	Philips Medical Systems	865241	DE12521123	
60003534	MONITOR PATIENT MX700	Philips Medical Systems	865241	DE12521113	

60003536 MONITOR PATIENT MX700 Philips Medical Systems 865241 DE12521125
60004579 BLADDER SCANNER Laborie Medical Technologies Corp MD-6000 MD6000.H1111
61005832 REGULATORS, SUCTION, TRACHEAL OHIO MEDICAL CORP 6702-1251-908 JGGS14313
61005833 REGULATORS, SUCTION, TRACHEAL OHIO MEDICAL CORP 6702-1251-908 JGGS14310
61005834 REGULATORS, SUCTION, TRACHEAL OHIO MEDICAL CORP 6702-1251-908 JGGS14304
61005835 REGULATORS, SUCTION, TRACHEAL OHIO MEDICAL CORP 6702-1251-908 JGGS14306
61005836 REGULATORS, SUCTION, TRACHEAL OHIO MEDICAL CORP 6702-1251-908 JGGS14307
61005837 REGULATORS, SUCTION, TRACHEAL OHIO MEDICAL CORP 6702-1251-908 JGGS14305
61005839 REGULATORS, SUCTION, TRACHEAL OHIO MEDICAL CORP 6702-1251-908 JGGS14330
61005840 REGULATORS, SUCTION, TRACHEAL OHIO MEDICAL CORP 6702-1251-908 JGGS14323
61005841 REGULATORS, SUCTION, TRACHEAL OHIO MEDICAL CORP 6702-1251-908 JGGS14321
61005842 REGULATORS, SUCTION, TRACHEAL OHIO MEDICAL CORP 6702-1251-908 JGGS14327
61005843 REGULATORS, SUCTION, TRACHEAL OHIO MEDICAL CORP 6702-1251-908 JGGS14325
61005844 REGULATORS, SUCTION, TRACHEAL OHIO MEDICAL CORP 6702-1251-908 JGGS14311
61005845 REGULATORS, SUCTION, TRACHEAL OHIO MEDICAL CORP 6702-1251-908 JGGS14309
61005854 REGULATORS, SUCTION, TRACHEAL OHIO MEDICAL CORP 6702-1251-908 JGGS14302
61005855 REGULATORS, SUCTION, TRACHEAL OHIO MEDICAL CORP 6702-1251-908 JGGS14303
61005856 REGULATORS, SUCTION, TRACHEAL OHIO MEDICAL CORP 6702-1251-908 JGGS14322
61005859 REGULATORS, SUCTION, TRACHEAL OHIO MEDICAL CORP 6702-1251-908 JGGS14324
61005861 THERMOMETER/ELEC/INFRARED/EAR WELCH ALLYN MEDICAL PRODUCTS DIV
04000-200 04513K08353
61005862 THERMOMETER/ELEC/INFRARED/EAR WELCH ALLYN MEDICAL PRODUCTS DIV
04000-200 04513K08415
61005863 THERMOMETER/ELEC/INFRARED/EAR WELCH ALLYN MEDICAL PRODUCTS DIV
04000-200 04613K01177
61005864 THERMOMETER/ELEC/INFRARED/EAR WELCH ALLYN MEDICAL PRODUCTS DIV
04000-200 04513K08393
61005865 THERMOMETER/ELEC/INFRARED/EAR WELCH ALLYN MEDICAL PRODUCTS DIV
04000-200 04513K08238
61005866 THERMOMETER/ELEC/INFRARED/EAR WELCH ALLYN MEDICAL PRODUCTS DIV
04000-200 04513K08316
61005867 THERMOMETER/ELEC/INFRARED/EAR WELCH ALLYN MEDICAL PRODUCTS DIV
04000-200 04613K00725
61005868 THERMOMETER/ELEC/INFRARED/EAR WELCH ALLYN MEDICAL PRODUCTS DIV
04000-200 04413K09500
61005869 THERMOMETER/ELEC/INFRARED/EAR WELCH ALLYN MEDICAL PRODUCTS DIV
04000-200 04613K00972
61005943 SATELLITE RACK PHILIPS MEDICAL SYS CARDIAC & MONIT 865243 DE12325706
61005944 MOD/PHYSIOLOGIC/MULTI MEASURE PHILIPS MEDICAL SYS CARDIAC & MONIT
M3001A DE9070CZL8
61005945 SATELLITE RACK PHILIPS MEDICAL SYS CARDIAC & MONIT 865243 DE12325663
61005946 MOD/PHYSIOLOGIC/MULTI MEASURE PHILIPS MEDICAL SYS CARDIAC & MONIT
M3001A DE9070CZMD
61005947 SATELLITE RACK PHILIPS MEDICAL SYS CARDIAC & MONIT 865243 DE12325635
61005948 MOD/PHYSIOLOGIC/MULTI MEASURE PHILIPS MEDICAL SYS CARDIAC & MONIT
M3001A DE9070CZNC
61005949 SATELLITE RACK PHILIPS MEDICAL SYS CARDIAC & MONIT 865243 DE12325655
61005950 MOD/PHYSIOLOGIC/MULTI MEASURE PHILIPS MEDICAL SYS CARDIAC & MONIT
M3001A DE9070CZN4
61005951 SATELLITE RACK PHILIPS MEDICAL SYS CARDIAC & MONIT 865243 DE12321941
61005952 MOD/PHYSIOLOGIC/MULTI MEASURE PHILIPS MEDICAL SYS CARDIAC & MONIT
M3001A DE9070CZEL
61005953 SATELLITE RACK PHILIPS MEDICAL SYS CARDIAC & MONIT 865243 DE12325687

61005954 MOD/PHYSIOLOGIC/MULTI MEASURE PHILIPS MEDICAL SYS CARDIAC & MONIT M3001A DE9070CZLW
61005955 SATELLITE RACK PHILIPS MEDICAL SYS CARDIAC & MONIT 865243 DE12325721
61005956 MOD/PHYSIOLOGIC/MULTI MEASURE PHILIPS MEDICAL SYS CARDIAC & MONIT M3001A DE9070CZDD
61005957 SATELLITE RACK PHILIPS MEDICAL SYS CARDIAC & MONIT 865243 DE12322274
61005958 MOD/PHYSIOLOGIC/RECORDER PHILIPS MEDICAL SYS CARDIAC & MONIT M1116B 4227A90210
61005959 MOD/PHYSIOLOGIC/IBP PHILIPS MEDICAL SYS CARDIAC & MONIT M1006B DE805T7200
61005960 MOD/PHYSIOLOGIC/TEMP PHILIPS MEDICAL SYS CARDIAC & MONIT M1029A DE907B3586
61005961 MOD/PHYSIOLOGIC/MULTI MEASURE PHILIPS MEDICAL SYS CARDIAC & MONIT M3001A DE9070CZLV
61005962 MOD/PHYSIOLOGIC/ET CO2 PHILIPS MEDICAL SYS CARDIAC & MONIT M3015A DE13876895
61005963 SATELLITE RACK PHILIPS MEDICAL SYS CARDIAC & MONIT 865243 DE12325628
61005964 MOD/PHYSIOLOGIC/TEMP PHILIPS MEDICAL SYS CARDIAC & MONIT M1029A DE907B3580
61005965 MOD/PHYSIOLOGIC/IBP PHILIPS MEDICAL SYS CARDIAC & MONIT M1006B DE805T7199
61005966 MOD/PHYSIOLOGIC/MULTI MEASURE PHILIPS MEDICAL SYS CARDIAC & MONIT M3001A DE9070CZL2
61005967 SATELLITE RACK PHILIPS MEDICAL SYS CARDIAC & MONIT 865243 DE12322272
61005968 MOD/PHYSIOLOGIC/IBP PHILIPS MEDICAL SYS CARDIAC & MONIT M1006B DE805T7211
61005969 MOD/PHYSIOLOGIC/MULTI MEASURE PHILIPS MEDICAL SYS CARDIAC & MONIT M3001A DE9070CZM8
61005970 SATELLITE RACK PHILIPS MEDICAL SYS CARDIAC & MONIT 865243 DE12322273
61005971 MOD/PHYSIOLOGIC/IBP PHILIPS MEDICAL SYS CARDIAC & MONIT M1006B DE805T7177
61005972 MOD/PHYSIOLOGIC/MULTI MEASURE PHILIPS MEDICAL SYS CARDIAC & MONIT M3001A DE9070CZL9
61005973 SATELLITE RACK PHILIPS MEDICAL SYS CARDIAC & MONIT 865243 DE12321939
61005974 MOD/PHYSIOLOGIC/MULTI MEASURE PHILIPS MEDICAL SYS CARDIAC & MONIT M3001A DE9070CZND
61005975 MOD/PHYSIOLOGIC/TEMP PHILIPS MEDICAL SYS CARDIAC & MONIT M1029A DE907B3572
61005976 MOD/PHYSIOLOGIC/IBP PHILIPS MEDICAL SYS CARDIAC & MONIT M1006B DE805T7201
61005977 SATELLITE RACK PHILIPS MEDICAL SYS CARDIAC & MONIT 865243 DE12325625
61005978 MOD/PHYSIOLOGIC/MULTI MEASURE PHILIPS MEDICAL SYS CARDIAC & MONIT M3001A DE9070CZEF
61005979 SATELLITE RACK PHILIPS MEDICAL SYS CARDIAC & MONIT 865243 DE12325670
61005980 MOD/PHYSIOLOGIC/IBP PHILIPS MEDICAL SYS CARDIAC & MONIT M1006B DE805T7215
61005981 MOD/PHYSIOLOGIC/MULTI MEASURE PHILIPS MEDICAL SYS CARDIAC & MONIT M3001A DE9070CZN7
61005982 SATELLITE RACK PHILIPS MEDICAL SYS CARDIAC & MONIT 865243 DE12325707
61005983 MOD/PHYSIOLOGIC/MULTI MEASURE PHILIPS MEDICAL SYS CARDIAC & MONIT M3001A DE9070CZLF
61005984 MOD/PHYSIOLOGIC/MULTI MEASURE PHILIPS MEDICAL SYS CARDIAC & MONIT M3001A DE9070CZL3

61005985	MOD/PHYSIOLOGIC/ET CO2	PHILIPS MEDICAL SYS CARDIAC & MONIT	M3015A	DE13876878	
61005986	SATELLITE RACK	PHILIPS MEDICAL SYS CARDIAC & MONIT	865243	DE12325629	
61005987	MOD/PHYSIOLOGIC/IBP	PHILIPS MEDICAL SYS CARDIAC & MONIT	M1006B	DE805T7203	
61005988	SATELLITE RACK	PHILIPS MEDICAL SYS CARDIAC & MONIT	865243	DE12325689	
61005989	MOD/PHYSIOLOGIC/MULTI MEASURE	PHILIPS MEDICAL SYS CARDIAC & MONIT	M3001A	DE9070CZLD	
61006004	MOD/PHYSIOLOGIC/RECORDER	PHILIPS HEALTHCARE NORTH AMERICA	862120	US92615766	
61006128	DETECTOR/FETAL HEART/ULTRASONIC	NICOLET VASCULAR VIASYS NEUROCARE	IMEXDOP CT+	CTVN0376	
SN-125430	MONITOR/LAB/TEMPERATURE	SENSOSCIENTIFIC	TPSCPINS	125430	
60003297	STERILIZING UNIT 100NX	Johnson & Johnson Medical Inc	10104	1041130424	
60003298	STERILIZING UNIT STEAM	GETINGE USA INC	433HC	URA050674	
60003325	ULTRASONIC CLEANER	GETINGE USA INC	KR2460RDOOOA	KSJ13081	
60003326	WASHER DECONTAMINATOR	GETINGE USA INC	S-8666913	W50041823	
60003327	WASHER DECONTAMINATOR	GETINGE USA INC	S-8666913	W50041843	
60003328	ULTRASONIC CLEANING SYSTEM	GETINGE USA INC	KR2460RDOOOC	KRF13008	
60003329	STERILIZING UNIT STEAM BULK	GETINGE USA INC	533HC	URA050472	
60003330	STERILIZING UNIT STEAM BULK	GETINGE USA INC	633HC	URA050473	
SN-LAA00639	DRILL BONE	CONMED Corp	E9010	LAA00639	
SN-LAA00641	DRILL BONE	CONMED Corp	E9010	LAA00641	
Not in TMS	WORKSTATION 30 X 60	Bostontec, Inc.	PB3060		
Not in TMS	WORKSTATION 30 X 60	Bostontec, Inc.	PB3060		
Not in TMS	WORKSTATION 30 X 60	Bostontec, Inc.	PB3060		
Not in TMS	WORKSTATION 30 X 60	Bostontec, Inc.	PB3060		
SN-001845	DERMATOME ACCULAN 3TI	Aesculap Inc	GA670	001845	
SN-1405703553	DRIVER HANDPIECE SURGIGAL	Stryker Instruments	6400-099-000	1405703553	
SN-1405703563	DRIVER HANDPIECE SURGICAL	Stryker Instruments	6400-099-000	1405703563	
SN-1405703573	DRIVER HANDPIECE SURGICAL	Stryker Instruments	6400-099-000	1405703573	
SN-1331607513	DRIVER HANDPIECE SURGICAL	Stryker Instruments	4405-000-000	1331607513	
SN-1404404673	DRIVER HANDPIECE SURGICAL	Stryker Instruments	4405-000-000	1404404673	
SN-1404404693	DRIVER HANDPIECE SURGICAL	Stryker Instruments	4405-000-000	1404404693	
SN-1404404703	DRIVER HANDPIECE SURGICAL	Stryker Instruments	4405-000-000	1404404703	
SN-1406303553	DRIVER HANDPIECE SURGICAL	Stryker Instruments	4405-000-000	1406303553	
SN-1406205153	SAW BONE	Stryker Instruments	4408-000-000	1406205153	
SN-1406205283	SAW BONE	Stryker Instruments	4408-000-000	1406205283	
SN-1406304373	SAW BONE	Stryker Instruments	7209-000-000	1406304373	
Not in TMS	BATTERY CHARGER	Stryker Instruments	7110-120-000	1400802243	
Not in TMS	BATTERY CHARGER	Stryker Instruments	7110-120-000	1400802253	
SN-14E012804	SHAVER HAND CONTROL ARTHROSCOP	Stryker Endoscopy	375-708-500	14E012804	
SN-14E012814	SHAVER HAND CONTROL ARTHROSCOP	Stryker Endoscopy	375-708-500	14E012814	
SN-001843	DERMATOME ACCULAN 3TI	Aesculap Inc	GA670	001843	
61003878	HOOD/CHEMICAL FUME	PCI MEDICAL INC	G14KA	35199	
61005891	TESTER	OLYMPUS AMERICA INC ENDOS	MU-1	7046160	
61005892	TESTER	OLYMPUS AMERICA INC ENDOS	MU-1	7046156	
61006849	DEMAGNETIZERS, SURGICAL INSTRUMENT	INTEGRATED MEDICAL SYSTEMS INTERNATIONAL INC (IMS)	EDZ-C2		
61007005	INCUBATOR	3M HEALTH CARE	490H	200993	
61008051	INCUBATOR/TEST TUBE	3M HEALTH CARE	490	113548	
61008062	PACKAGE SEALER	RENNCO INC	LS18D-115	1117-181-8369	

61008298	INCUBATOR/TEST TUBE	3M HEALTH CARE	490	114386	
SN-1403806343	DRILL/BONE	STRYKER INSTRUMENTS	6400-037-000	1403806343	
SN-1405610053	DRILL/BONE	STRYKER INSTRUMENTS	6400-037-000	1405610053	
SN-1405703793	DRILL/BONE	STRYKER INSTRUMENTS	6400-031-000	1405703793	
SN-1405703803	DRILL/BONE	STRYKER INSTRUMENTS	6400-031-000	1405703803	
SN-1416803353	DRILL/BONE	STRYKER INSTRUMENTS	6400-031-000	1416803353	
SN-1417600843	DRILL/BONE	STRYKER INSTRUMENTS	6400-031-000	1417600843	
60003265	DEFIBRILLATOR	Physio-Control Inc.	V15-2-001589	41561633	
60003306	STRETCHER OP AMBULATORY SURG	Stryker Medical	1115	1401030821	
60003307	STRETCHER OP AMBULATORY SURG	Stryker Medical	1115	1401030825	
60003308	STRETCHER OP AMBULATORY SURG	Stryker Medical	1115	1401030828	
60003309	STRETCHER OP AMBULATORY SURG	Stryker Medical	1115	1401030835	
60003310	STRETCHER OP AMBULATORY SURG	Stryker Medical	1115	1401030838	
60003311	STRETCHER OP AMBULATORY SURG	Stryker Medical	1115	1401030824	
60003312	STRETCHER OP AMB SURG	Stryker Medical	1115	1401030831	
60003313	STRETCHER OP AMBULATORY SURG	Stryker Medical	1115	1401030832	
60003314	STRETCHER OP AMB SURG PRE OP	Stryker Medical	1115	1401030826	
60003315	STRETCHER OP AMBULATORY SURG	Stryker Medical	1115	1401030839	
60003316	STRETCHER OP AMBULATORY SURG	Stryker Medical	1115	1401030833	
60003317	STRETCHER OP AMBULATORY SURG	Stryker Medical	1115	1401030822	
60003318	STRETCHER OP AMBULATORY SURG	Stryker Medical	1115	1401030836	
60003319	STRETCHER OP AMBULATORY SURG	Stryker Medical	1115	1401030829	
60003320	STRETCHER OP AMBULATORY SURG	Stryker Medical	1115	1401030823	
60003321	STRETCHER OP AMBULATORY SURG	Stryker Medical	1115	1401030837	
60003322	STRETCHER OP AMBULATORY SURG	Stryker Medical	1115	1401030830	
60003323	STRETCHER OP AMB SURG PRE OP	Stryker Medical	1115	1401030834	
60003324	STRETCHER OP AMBULATORY SURG	Stryker Medical	1115	1401030827	
60003544	STRETCHER CHAIR EYE AMBU SURG	Stryker Medical	5051	1402034215	
60003545	STRETCHER CHAIR EYE AMBU SURG	Stryker Medical	5051	1402034216	
61005821	REFRIGERATOR	FOLLETT CORP	REF5	E09414-23413	
61005825	REFRIGERATOR	FOLLETT CORP	REF5	E09612-23613	
61005826	REFRIGERATOR	FOLLETT CORP	REF5	E10267-241 13	
61005872	ASPIRATOR/EMERGENCY	SSCOR INC	AE-6975	M25724	
61005873	ASPIRATOR/EMERGENCY	SSCOR INC	AE-6975	M25719	
61006127	DETECTOR/FETAL HEART/ULTRASONIC	NICOLET VASCULAR VIASYS NEUROCARE IMEXDOP CT+ CTVN0386			
61006129	SCALE/PATIENT/FLOOR	SCALE-TRONIX INC.	5202	5202-1251	
62000969	WARM UNIT/PATIENT/FORCED-AIR	ARIZANT HEALTHCARE INC A 3M Co	875	45981	
62000970	WARM UNIT/PATIENT/FORCED-AIR	ARIZANT HEALTHCARE INC A 3M Co	875	45998	
62000971	WARM UNIT/PATIENT/FORCED-AIR	ARIZANT HEALTHCARE INC A 3M Co	875	45965	
62000972	WARM UNIT/PATIENT/FORCED-AIR	ARIZANT HEALTHCARE INC A 3M Co	875	45985	
62000973	WARM UNIT/PATIENT/FORCED-AIR	ARIZANT HEALTHCARE INC A 3M Co	875	45993	
62000974	WARM UNIT/PATIENT/FORCED-AIR	ARIZANT HEALTHCARE INC A 3M Co	875	45977	
62000975	WARM UNIT/PATIENT/FORCED-AIR	ARIZANT HEALTHCARE INC A 3M Co	875	45986	
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HARRISHEALTH SYSTEM

ASC Disaster Preparedness Plan

2020-2021

TITLE: DISASTER PREPAREDNESS PLAN

PURPOSE: To provide a safe environment for patients, visitors, and workforce members at the Ambulatory Surgical Center (ASC) at LBJ.

POLICY STATEMENT:

The Ambulatory Surgical Center (ASC) at LBJ has a disaster preparedness plan in place to care for patients, workforce members, and other individuals who are on the ASC's premises when a major disruptive event occurs.

The governing body of the ASC is responsible for the development of this plan.

I. OBJECTIVE

To establish and maintain a program at the ASC that ensures an effective response to probable disasters or emergencies that may affect the ASC physical environment.

II. ELEMENTS OF DISASTER PREPAREDNESS PLAN:

The four phases of the ASC's emergency management activities are:
Mitigation - Measures taken to lessen the severity and impact of a disaster or emergency at the ASC.
Preparedness - Measures taken to ensure readiness and to identify resources that may be used should a disaster occur.
Response - Measures taken during a disaster to ensure the safety of patients, visitors, and Workforce members.
Recovery - Measures taken following a disaster or emergency to return the ASC to normal operations as quickly as possible.

III. HAZARD VULNERABILITY ANALYSIS:

The ASC has identified disaster situations that could affect the operations of the ASC in the Hazard Vulnerability Analysis, *see* Attachment A. Specific procedures are implemented in response to disasters which have been identified as "high probability."

IV. DISASTER PREPAREDNESS PLAN:

A. Activation of Plan:

1. As appropriate, the plan may be activated by the ASC Administrator. The centralized command post will be the nursing station between the pre-op and PACU areas.

2. The ASC command post will have a direct line of communication with LBJ's Incident Command Center (713-566-5105) and the Corporate Incident Command Center during a community or campus-wide disaster that may affect the operations of the ASC.

B. Authority & Responsibilities:

1. The ASC Administrator will serve as the coordinator of all disaster-related activities. If the ASC Administrator is not available, the person of highest authority at the ASC shall assume the role of coordinator, followed by the next person of highest authority.

2. The ASC command post will serve as a central resource for information and assignments regarding the disaster. Supply, space, security, and patient management will be directed from the command post by the ASC Administrator, or person of next highest authority, as appropriate, based on the size, type, and complexity of the emergency or disaster.

3. The ASC Administrator or his or her designee will notify Harris Health System's (Harris Health) Corporate Communications to handle all interactions with the news media regarding the disaster as well as the release of any information to the families of patients and/or victims, pursuant to the Letter of Agreement between Harris Health and the ASC.

(Media On-Call: 713-566-6430).

C. Communications:

1. As with the notification of external authorities, each emergency response procedure, as appropriate, has a method of notifying ASC Workforce members. Alternate methods of communication have been identified in the event there is a loss of telephone service.
These include, but are not limited to, the use of back-up phones, digital pagers, cellular telephones, VOIP phones, etc.

2. In the case of an actual disaster affecting the operations of the ASC, each emergency response procedure, as appropriate, has a method of notifying Harris Health response personnel (e.g., Emergency Alerts & Codes) and external authorities of emergencies. This is done by calling Harris Health Security Dispatcher (713-566-9001) who will notify 911.

3. At the discretion of the ASC Administrator or designee, off-duty Workforce members will be notified to report to the facility as needed. A Disaster Call List will be maintained by the ASC Administrator and designees

for the purposes of notifying off-duty Workforce members should their assistance be necessary.

D. Staff Identification:

1. For security purposes, (e.g., vehicular access, etc.), all ASC Workforce members will be identified as Essential Employees on the back of their ID badges in order to access any Harris Health facility (if safe to do so) during a community disaster. Employees will show their "Essential Personnel" logo on the back of their ID badge to law enforcement.

2. Each ASC Workforce will be designated as a "Recovery" team member at the time of hire.

3. ASC Workforce members will call the Employee Staffing Hotline Number (888-305-2979) to verify the necessity to return to the ASC if they have not been contacted or instructed to return to work by their supervisor.

4. Post-disaster, all Recovery Workforce members will report to the ASC command post for specific assignments.

E. Discontinuation of Services:

In the event of a disaster, the ASC Administrator or designee in consultation with the ASC Medical Director and Harris Health leadership will make the determination as to whether services will be continued, modified, or discontinued as appropriate.

F. Emergency Assets & Resources:

1. Emergency assets and resources are available If specialty items are needed the ASC will contact Harris Health Supply Chain Management department. Harris Health support departments maintain a ninety-six (96) hour supply of assets, including: pharmaceuticals, medical and non-medical supplies, drinking water, and food.

2. In the event of a city-wide disaster, Harris Health's System Incident Command Team will announce steps to be taken to allocate resources.

G. Emergency Response:

1. The ASC response to disasters or emergencies follows an "All Hazards Approach" and is not designed to be all inclusive. If ASC Management can maintain the following "Critical Six" elements of an all hazard approach, the ASC can handle most likely any emergency. The "Critical Six" elements are:

i. Maintain communications;
ii. Maintain safety and security;
iii. Maintain utilities;
iv. Maintain assets and resources;
v. Manage patients; and
vi. Manage staff.

2. Security Threats:

In the event of a civil disturbance or security threat during normal business hours, the Administrator or designee will notify Harris Health's Department of Public Safety who will respond and notify the Houston Police Department. Patients, visitors, and Workforce members will be discouraged from leaving the ASC until the situation is deemed safe by law enforcement. Please see Harris Health System's*, Active Shooter / Armed Intruder Procedures*, attached.

3. Utility/Power Failure:

In the event of a utility/power failure, the ASC is equipped with an auxiliary generator, which is activated by a power failure. Should the auxiliary generator fail, ASC Workforce members should be aware that equipment requiring electricity in the ASC will not be functional except those items on battery back-up. ASC Workforce members will be responsible for reporting the power failure. LBJ Facility Engineering staff will respond and be responsible for repair and notifying and requesting emergency service from utility vendors. Please see Harris Health System's *Facility Alert, Utilities Failure Procedure,* attached.

4. Hurricanes:

The ASC will not be operational during a hurricane. Cancellation of procedures will be the responsibility of the Administrator or designee in conjunction with the Harris Health's Incident Command. Generally, services should be stopped twenty-four (24) to forty-eight (48) hours prior to tropical winds (39 mph) reaching the Houston area. In addition, ASC Workforce

members will be given adequate time to be released to their homes and families.

5. Tornados / Severe Weather:

The areas of concern during severe weather are the waiting area and/or areas that have exposed glass. Once alerted (overhead page, phone call, e-mail), ASC Workforce members shall move all visitors, patients, and fellow Workforce members away from windows and towards interior corridors or protected areas (stairwells). Workforce members will communicate with visitors and patients, lower patient beds to its lowest position, and clear pathways by moving emergency carts and equipment to interior rooms. Please see Harris Health System's*, Weather Alert Procedures, attached.*

6. Pandemic:

Harris Health's Quality department(s) will provide the ASC with continued recommendations in regards to the COVID-19 pandemic (see Attachment B).

H. Shelter-in-Place:

Shelter-in-Place is not intended to be a stand-alone response to an emergency. The ASC Administrator or designee should consider sheltering in place based on the emergent situation. Emergency situations likely to threaten the ASC are external threats such as a chemical release, tornado, ice storm, or severe weather event. All situations could warrant a sheltering place response inside the ASC.

I. Evacuation:

1. When it is determined that the environment cannot support adequate patient care and treatment, after consultation with the ASC Medical Director and Harris Health leadership the ASC will be evacuated.

2. In the event the ASC is evacuated, the Outpatient Center Administration and LBJ Administration will be notified of the evacuation.

3. Types Of Events Requiring Evacuation:

i. Fire/Explosion;
ii. Hazardous Material Incidents;
iii. Structural Damage/Failure;
iv. Extended Utility Failure;
v. Medical Gases Failure;

vi. Infectious Outbreak; and
vii. Tornado/Hurricane.

4. The ASC Evacuation Plan addresses specific procedures to be followed if an evacuation of the ASC is deemed appropriate, as well as alternate roles and responsibilities of key Workforce members.

J. Reoccupation of the ASC after an Event:

1. Harris Health's Engineering/Planning department(s) will provide the ASC Administrator/Medical Director an assessment of damages and status of service operations.

2. Harris Health's Engineering/Planning department(s) will determine the overall readiness and/or operational limitations of the ASC and coordinate with the city of Houston and other appropriate agencies regarding the restoration of utilities and the type of services, if any, that the ASC can provide to the community.

3. All reports of property damage should be directed to Harris Health's Facilities Planning and Development department.

4. Evacuated areas of the ASC can be reoccupied only after thorough inspection and certification by Harris Health's Engineering/Facilities Planning and Development department deems areas safe to occupy.
5. Following an emergency event/disaster, workforce members will be contacted by the ASC Administrator or designee to advise a return-to-work status.

K. Alternate Care Sites:

1. An alternative care site will be identified and utilized when the ASC cannot adequately support patient care and treatment.

2. The specific type of disaster and the conditions in and around the ASC will dictate whether the evacuation, transfer, or relocation of patients to an alternate case site will be necessary.

3. The transfer of patients, staff, equipment, and any patient necessities will be coordinated between the ASC Administrator or his or her designee, the Harris Health Transfer Center, Medical Staff, and Harris Health Leadership.

L. Training:

An orientation program has been established to familiarize ASC Workforce members with the components of the Disaster Preparedness Plan. Orientation is completed by Workforce members upon hire at Harris Health's New Employee Orientation. Additionally, Workforce members must complete annual training on the Disaster Preparedness Plan. Additional training will be completed by Workforce members on an as needed basis and based on reviews of data collected during drills and audits.

M. Drills: Testing, Evaluating, and Updating the Plan:

1. At least once every year the ASC will conduct an exercise to test the effectiveness of the Disaster Preparedness Plan. An exercise that is conducted in concert with State or local authorities qualifies as an annual test. While the exercise drill does not have to test the response to every identified hazard, the drill must test a significant portion of the Disaster Preparedness Plan.

Note: A real disaster event may be used for an exercise.

2. The following table includes the data evaluated in determining the effectiveness of the Emergency Management Plan.

Data	Source	When and Where Reported
Drill Hazard Vulnerability Analysis	Internal OEM	Annually (Quality Council & Gov. Body)
Drill Minutes and Critiques	Internal	Annually (Quality Council and Gov. Body)
Staff Education and Competency	Internal	Quarterly (Quality Council and Gov. Body)
Annual Evaluation of the EM Program	Internal	Annually (Quality Council and Gov. Body)

1. The ASC Administrator must prepare a written evaluation of each annual exercise. The evaluation must address issues identified during the exercise, propose resolutions to those issues, and update the Disaster Preparedness Plan accordingly. Specifically, the following must be evaluated:

i. Emergency preparedness knowledge among Workforce members;
ii. Workforce members' emergency preparedness skills;
iii. Workforce members' participation levels;
iv. Inspection activities;
v. Emergency and incident reporting procedures; and

vi. Testing applicable equipment.

N. Coordination of the Plan:

Because the Southeast Texas Regional Advisory Council (SETRAC) has determined that the ASC will not be integrated into the city-wide disaster response program, the ASC's role in the event of a community-side disaster will be minimal.

REFERENCES/BIBLIOGRAPHY:

American Association for Accreditation of Ambulatory Surgery Facilities Version 7 §400.20

Harris Health Emergency Operations Plan (EOP)

Emergency Alerts, Codes, and Response Policy No. 7100

Harris Health Civil Disturbance Response Plan No. 7112

Emergency Preparedness Guide

LBJGH Fire Safety Plan Policy FP

HCHD Fire Safety Risks Procedures Policy 7404

OFFICE OF PRIMARY RESPONSIBILITY:

The Ambulatory Surgical Center (ASC) at LBJ

REVIEW/REVISION HISTORY:

Effective Date	Version # (If Applicable)	Review/Revision Date (Indicate Reviewed or Revised)	Approved by:
4/13/2017	1.0		The Ambulatory Surgical Center (ASC) at LBJ Governing Body
		Revised / Approved 02/13/2020	The Ambulatory Surgical Center (ASC) at LBJ Governing Body
		Revised / Approved 02/13/2020	The Ambulatory Surgical Center (ASC) at LBJ Governing Body
		Reviewed / Approved 02/25/2021	The Ambulatory Surgical Center (ASC) at LBJ Governing Body

ATTACHMENT A

HAZARD VULNERABILITY ANALYSIS (HVA) RISK RATING

Ambulatory Surgical Center Top 10 Rated Events

20220 HAZARD VULNERABILITY ANALYSIS RISK RATING

Top 10 ASC Scored Events (Average)

Updated January 2022~~12/16/2020~~

	Type Of Event	Risk
Rank	Top Rated Events from ACS HVAs	Relative Threat 0 – 100%
1	Hurricane / Tropical Storm ~~Hurricane / Tropical Storm~~	40% ~~38%~~
2	Epidemic / Pandemic ~~Epidemic / Pandemic~~	29% ~~29%~~
3	Communication / Telephony Failure ~~Flood, External~~	28% ~~28%~~
4	Flood External ~~Communication / Telephony Failure~~	27% ~~27%~~
5	HVAC Failure ~~HVAC Failure~~	27% ~~25%~~
6	Water Disruption / Contamination ~~Water Disruption / Contamination~~	27% ~~25%~~
7	Power Outages ~~Temperature Extremes~~	26% ~~23%~~
8	Information's Systems Failure ~~Power Outages~~	25% ~~23%~~
9	Sewer Failure ~~Information's Systems Failure~~	25% ~~21%~~
10	Temperature Extremes ~~Severe Thunderstorm~~	23% ~~21%~~

TITLE: EVACUATION PLAN AND PROCEDURES

PURPOSE: To establish the protocol to be followed in the event of an evacuation of the Ambulatory Surgical Center (ASC) at LBJ.

POLICY STATEMENT:

In the event of an emergency requiring a complete or partial evacuation of the Ambulatory Surgical Center (ASC) at LBJ, the ASC will follow this protocol to ensure safe and appropriate patient safety during the evacuation.

POLICY ELABORATIONS:

I. DEFINITIONS:

A. **COMPLETE EVACUATION:** The movement of all Workforce members, patients, and visitors from the ASC when the ASC becomes unsafe or a threat poses a danger to all Workforce members, patients, and visitors (e.g., fire, flooding, structural damage). Complete Evacuation usually involves facility shutdown actions.

B. **PARTIAL EVACUATION OR RELOCATION:** The movement of Workforce members, patients, and visitors to either:

1. An area of relative safety in response to a given threat.

2. Staging areas in preparation for evacuation (close proximity to exits).

C. **HORIZONTAL EVACUATION:** The movement of Workforce members, patients, and visitors to a safe location on the same floor (preferably close to an emergency exit and in a different smoke compartment).

D. **VERTICAL EVACUATION:** The movement of Workforce members, patients, and visitors to a safe location on a lower floor when a Horizontal Evacuation is unsafe or cannot meet the safety needs of Workforce members, patients, and visitors.

E. **EVACUATION DEVICES:** Devices used to assist non-ambulatory patients during an evacuation, such as OR tables, beds, stretchers, blanket carriers, Stryker® chair, Paraslyde®*, or MedSled*®.

F. **PRE-EVENT EVACUATION:** An evacuation of Workforce members, patients, and visitors in advance of an impending disaster or when the ASC structure and surrounding environment is not immediately compromised. A Pre-Event Evacuation is appropriate when the ASC Administrator and Harris Health leadership believes the effects of an impending disaster may place Workforce members, patients, and visitors at unacceptable level of risk or when an evacuation after the event is likely to be extremely dangerous or impossible.

G. **POST-EVENT EVACUATION:** The evacuation of Workforce members, patients, and visitors of the ASC when there is no advance warning regarding an event requiring evacuation or after a decision was made to shelter-in-place, but damages or danger has made evacuation necessary.

H. **SEQUENCE OF EVACUATION:** The process of prioritizing the evacuation of patients, visitors, and Workforce members. In an emergent evacuation, priority should be given to those patients, visitors, and Workforce members who are in immediate danger. During a planned or urgent evacuation (<4 hours), evacuate those who need the least resources first (e.g., ambulatory).

I. **SHELTER-IN-PLACE:** The process of securing patients, visitors, and Workforce members from a threat and does not involve evacuation. The decision to Shelter-In-Place is circumstance specific and must be made in relation to the risk to the patient(s), visitor(s), and/or Workforce member(s). It is appropriate to Shelter-In-Place in the following circumstances:

1. When the threat does not permit safe relocation or evacuation;

2. When the movement poses a greater danger than the threat; and

3. When it is not possible to move within a reasonable time frame.

II. EVACUATION PROCEDURES:

A. **In General:**

1. In the event of an internal or external disaster that requires either the Complete Evacuation or Partial Evacuation of the ASC or requires Workforce members, patients, and visitors to Shelter-in-Place, the following steps will be followed by all Workforce members:

a) All Workforce members who are not involved in direct patient care will report to the designated area of the ASC to receive instructions from the ASC Administrator or designee regarding the internal or external disaster. The designated area of the ASC that Workforce members must always report to during a disaster is the Pre-Op/PACU nursing station in the ASC.

b) The ASC Administrator will determine, with the assistance of Harris Health leadership and/or the Houston Fire Department, whether a Complete Evacuation, Partial Evacuation, or Sheltering-In-Place is necessary.

c) Once it is has been determined that the ASC needs to be evacuated or that Workforce members, patients, and visitors need to Shelter-In-Place, the ASC Administrator must report that information to all Workforce members present at the Pre-Op/PACU nursing station.

d) Workforce members will begin executing the ASC Administrator's directions regarding the evacuation of the ASC.

B. **Horizontal Evacuation:**

1. **Lobby:**

a) The Health Unit Coordinator ("HUC") or the Patient Care Coordinator is responsible for receiving instructions from the ASC Administrator regarding the evacuation. The HUC or the Patient Care Coordinator will escort the patients and visitors to the designated area that the ASC Administrator, in consultation with the Houston Fire Department or other proper authorities, has deemed appropriate for Horizontal Evacuation.

2. **Operating Room:**

a) In the event of a fire, tornado, or other environmental disaster requiring Horizontal Evacuation, the following steps must be followed:

(1) The surgeon must close and/or pack wound(s).

(2) After the wound is closed, the surgical technician will remove the drapes from the patient.

(3) The anesthesia provider must secure the patient's airway and ventilate with an Ambu® bag.

(4) The circulating nurse will obtain a stretcher for the patient and move the patient to the designated area for Horizontal Evacuation.

b) In the event of a non-environmental disaster (e.g., active shooter):

(1) The surgeon and the anesthesia provider must secure the patient to the best of his or her ability with consideration given to the specific threat posed.

(2) All Workforce members involved in the patient's care should either (1) Shelter-In-Place or evacuate to a safe area.

3. **Pre-Op/PACU:**

a) In the event of a fire, tornado, or other environmental disaster requiring Horizontal Evacuation:

(1) All pending surgeries will be suspended.

(2) All patients will be transported to the area designated as discharge for Horizontal Transfer.

4. **Discharge Points:**

a) Discharge points in are the areas where patients will either be discharged home or discharged to a hospital during an evacuation of the ASC.

b) During a Horizontal Evacuation, the ASC Administrator will report to Workforce members the specific locations to discharge "homebound" patients and to discharge patients requiring further care.

C. **Vertical Evacuation:**

1. **Lobby:**

a) The HUC or the Patient Care Coordinator is responsible for receiving instructions from the ASC Administrator regarding the evacuation. The HUC or Patient Care Coordinator will escort the patients and visitors to the designated areas that the ASC Administrator, in consultation with the Houston Fire Department or other proper authorities has deemed appropriate for the Vertical Evacuation.

2. **Operating Room:**

a) In the event of a fire, tornado, or other environmental disaster requiring a Vertical Evacuation, the following steps must be followed:

(1) The surgeon must close and/or pack the wound(s).

(2) After the wound is closed, the surgical technician will remove the drapes from the patient.

(3) The anesthesia provider must secure the patient's airway and ventilate with an Ambu® bag.

(4) The circulating nurse will obtain a stretcher for the patient and move the patient to the designated area for the Vertical Evacuation.

b) In the event of a non-environmental disaster (e.g., active shooter):

(1) The surgeon and the anesthesia provider must secure the patient to the best of his or her ability with consideration given to the specific threat posed.

(2) All Workforce members involved in the patient's care should either Shelter-In-Place or evacuate to a safe area.

3. **Pre-Op/PACU:**

a) In the event of a fire, tornado, or other environmental disaster requiring Vertical Evacuation:

(1) All pending surgeries will be suspended.

(2) All patients will be transported to the area designated for Vertical Transfer.

4. **Discharge Points:**

During a Vertical Evacuation, the ASC Administrator will report to Workforce members the specific locations to discharge "homebound" patients and to discharge patients requiring further care.

ATTACHMENT A

HAZARD VULNERABILITY ANALYSIS (HVA) RISK RATING

Ambulatory Surgical Center Top 10 Rated Events

2022~~0~~ HAZARD VULNERABILITY ANALYSIS RISK RATING

Top 10 ASC Scored Events (Average)

Updated January 2022~~12/16/2020~~

	Type Of Event	Risk
Rank	Top Rated Events from ACS HVAs	Relative Threat 0 – 100%
1	Hurricane / Tropical Storm ~~Hurricane / Tropical Storm~~	40% ~~38%~~
2	Epidemic / Pandemic ~~Epidemic / Pandemic~~	29% ~~29%~~
3	Communication / Telephony Failure ~~Flood, External~~	28% ~~28%~~
4	Flood External ~~Communication / Telephony Failure~~	27% ~~27%~~
5	HVAC Failure ~~HVAC Failure~~	27% ~~25%~~
6	Water Disruption / Contamination ~~Water Disruption / Contamination~~	27% ~~25%~~
7	Power Outages ~~Temperature Extremes~~	26% ~~23%~~
8	Information's Systems Failure ~~Power Outages~~	25% ~~23%~~

9	Sewer Failure ~~Information's Systems Failure~~	25% ~~21%~~
10	Temperature Extremes ~~Severe Thunderstorm~~	23% ~~21%~~

REFERENCES/BIBLIOGRAPHY:

American Association for Accreditation of Ambulatory Surgery Facilities Version 8.0~~7 §400~~

OFFICE OF PRIMARY RESPONSIBILITY:

The Ambulatory Surgical Center (ASC) at LBJ

REVIEW/REVISION HISTORY:

Effective Date	Version # (If Applicable)	Review/ Revision Date (Indicate Reviewed or Revised)	Approved by:
4/13/2017	1.0		The Ambulatory Surgical Center (ASC) at LBJ Governing Body
	2.0	Revised / Approved 03/29/2018	The Ambulatory Surgical Center (ASC) at LBJ Governing Body
		Reviewed / Approved 02/14/2019	The Ambulatory Surgical Center (ASC) at LBJ Governing Body
		Revised / Approved 02/13/2020	The Ambulatory Surgical Center (ASC) at LBJ Governing Body
		Revised / Approved 02/25/2021	The Ambulatory Surgical Center (ASC) at LBJ Governing Body

BOARD OF TRUSTEES

HARRISHEALTH SYSTEM

Ambulatory Surgical Center at LBJ Governing Body

Thursday, February 17, 2022

Consideration of Approval of the Harris Health System Medical Staff Bylaws for the Ambulatory Surgical Center at LBJ

Medical Staff Bylaws

February 2021

HARRISHEALTH
AMBULATORY SURGICAL CENTER AT LBJ

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HARRISHEALTH
AMBULATORY SURGICAL CENTER AT LBJ

BYLAWS

OF THE

AMBULATORY SURGICAL CENTER (ASC) AT LBJ HOSPITAL

MEDICAL STAFF

PREAMBLE

WHEREAS The Ambulatory Surgical Center at LBJ, (ASC) is an ambulatory surgical center, as defined in Title 25, Part 1, Chapter 135, of the Texas Administrative Code, as amended; and

WHEREAS, the ASC is wholly owned by the Harris County Hospital District d/b/a Harris Health System (Harris Health), which is organized under the laws of the State of Texas and pursuant to Chapter 281 of the Texas Health and Safety Code Ann. as amended; and

WHEREAS, the ASC is a distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization and in which the expected duration of services will not exceed twenty-four (24) hours following an admission; and

WHEREAS, subject to oversight by the Harris Health Board of Trustees, the ASC Governing Body assumes full legal responsibility for determining, implementing, and monitoring policies governing the ASC's operation, including the quality and safety of the medical care in the ASC, and holding the medical staff accountable to fulfill the ASC's obligations to its patients; and

WHERAS, the ASC Governing Body has approved these ASC Medical Staff Bylaws.

THEREFORE, the Practitioners and Advanced Practice Professionals practicing in the ASC shall carry out the functions delegated to the Medical Staff by the Governing Body in compliance with these Bylaws.

DEFINITIONS

Whenever the context requires, words of masculine gender used herein shall include the feminine and the neuter, and words used in the singular shall include the plural.

1. The term **"ACTIVE STAFF"** shall consist of those Medical Staff members who assume all the functions and responsibilities of membership on the Active staff.
2. The term **"ADVANCED PRACTICE PROFESSIONAL" (APP)** shall be defined as an individual who holds a state license in their profession as well as other educational credentials attesting to training and qualifications to provide services in one or more of the following categories: Physician Assistant (PA), Certified Registered Nurse Anesthetist (CRNA), Nurse Practitioner (NP) or Clinical Nurse Specialist (CNS).

3. The term "**AFFILIATE STAFF"** shall consist of Medical Staff members who may provide patient care and participate in staff activities in a non-voting capacity.

4. The term "**ATTENDING STAFF**" means all Medical Staff holding faculty appointments at The University of Texas Health Science Center at Houston, and/or Baylor College of Medicine and approved by the credentialing mechanisms of the ASC. Medical school faculty appointment status is not required for Practitioners or Advanced Practice Professionals employed by Harris Health, or Contract Practitioners.

5. The term "**BOARD CERTIFIED"** means a designation that the Practitioner is certified in his or her specialty by the American Board of Medical Specialties, American Osteopathic Association, Amercian Board of Dental Specialties, or American Board of Podiatric Medicine.

6. The term "**BOARD ELIGIBLE**" means a designation that the Practitioner has satisfied all requirements to be eligible to take the certification examination(s) in accordance with appropriate certifying board.

6. The term **"CLEAN APPLICATION"** shall mean a completed application in which all aspects of the application are complete; all references have been returned with all questions fully answered as either superior or good; the applicant has not been a party to any malpractice cases, adverse actions involving medical staff membership, clinical privileges or licensure/certification requiring further investigation; and all training, licensure, National Practitioner Data Bank, and OIG database information has been verified, with the results of such verification found to be acceptable. The term "Clean Application" may also be applied to an application from a Medical Staff member requesting new clinical privileges.

7. The term **"CLINICAL PRIVILEGES"** or **"PRIVILEGES"** means the permission granted by the Governing Body to a Practitioner to provide those diagnostic, therapeutic, medical, or surgical services which the Practitioner has been approved to render.

8. The term **"COMPLETED APPLICATION"** shall mean a signed Texas State Standardized Application and ASC Addendum in which all questions have been answered, current copy of licensure (State, DEA, DPS), peer reference letters, delineation of clinical privileges or job description, current appropriate professional liability insurance, National Practitioner Data Bank, OIG, Board Status, hospital affiliations, and verification of any other relevant information from other professional organizations according to the ASC Medical Staff Bylaws and Credentialing Procedures Manual. Additionally, all information and documentation has been provided, and all verifications solicited by the ASC have been received and require no further investigation. A completed application may be determined to be incomplete, based upon the review of Medical Staff Services, the Medical Director, or the Medical Executive Committee.

10. The term "**CONTRACT PRACTITIONER**" means, unless otherwise expressly limited, all physicians, podiatrists, or dentists who are appointed to the Medical Staff and (i) whose patient care services are contracted for by Harris Health and are performed within the ASC; (ii) are not affiliated with Baylor College of Medicine and/or The University of Texas Health Science Center at Houston; and (iii) are not employed by Harris Health to provide healthcare services at designated Harris Health Facilities. All Contract Practitioners will be categorized as Affiliate Staff.

11. The term "**CREDENTIALING PROCEDURES MANUAL"** shall mean the policy containing additional details related to the credentialing process of the ASC, as further detailed in Article XVI of these Bylaws.

12. The term **"DAYS"** shall mean calendar days, including Saturdays, Sundays, and holidays unless otherwise specified herein. Days are counted beginning on the day following the transmittal or receipt of a notice or other required correspondence.

13. The term **"DENTIST"** means an individual with a D.D.S. or equivalent degree licensed or authorized to practice dentistry by the State of Texas.

14. The term **"EXECUTIVE SESSION"** means any meeting or portion of any meeting, of any section, department, or committee of the Medical Staff at which privileged and/or confidential information regarding quality assessment and improvement and/or peer review information is presented or discussed.

15. The term **"EX-OFFICIO"** shall mean service as a member of a body by virtue of an office or position held and, unless otherwise expressly provided, refers to a position without voting rights.

16. The term **"FEDERAL HEALTH CARE PROGRAM"** shall mean any plan or program that provides health benefits whether through insurance or otherwise, which is funded directly in whole or in part by the United States government or a state health program (with the exception of the Federal Employees Health Benefits program). The most significant federal health care programs are Medicare, Medicaid, Blue Cross Federal Employees Program (FEP)/Tricare/CHAMPUS and the veterans' programs.

17. The term **"FELLOW"** means a physician who has completed his or her residency training and is engaged in further training in a specialized area under the direct supervision of a specialized member of the Medical Staff.

18. The term **"GOOD STANDING"** means that, at the time of his or her most recent appointment, this individual was deemed to have met the following requirements: satisfactory clinical competence, satisfactory technical skill/judgment, satisfactory results of Quality Assurance activity, satisfactory adherence to ASC Medical Staff Bylaws, satisfactory medical records completion, satisfactory physical mental health completion, satisfactory relationships to peers and status.

19. The term **"GOVERNING BODY"** means the Governing Body of the ASC.

20. The term **"HARRIS HEALTH"** shall mean the Harris County Hospital District d/b/a Harris Health System, a group of general, tertiary care, clinics, and teaching hospital campuses located in Harris County, Texas, including the Ben Taub General Hospital campus, the Quentin Mease Community Hospital campus, the Lyndon B. Johnson General Hospital campus, the Ambulatory Surgery Center at LBJ Hospital, and other locations licensed or accredited as part of Harris Health, including the clinics of the Ambulatory Care Services (collectively, "Harris Health Facilities").

20. The term **"INELIGIBLE PERSON"** means any individual or entity that: (i) is currently excluded, debarred, suspended, or otherwise ineligible to participate in any federal and/or state health care programs or in federal and/or state procurement or nonprocurement programs (this includes persons who are on the List of Excluded Individuals or Entities of the Inspector General, List of Parties Excluded from Federal Programs by the General Services Administration or the Medicaid Sanction List); or (ii) has been convicted of a criminal offense related to the provision of a health care program that falls within the ambit of 42 U.S.C. §1320a-7(a), but has not yet been excluded, debarred, suspended, or otherwise declared ineligible.

21. The term **"MEDICAL EXECUTIVE COMMITTEE"** means the committee with authority to exercise ASC-wide functions on behalf of the Medical Staff.

22. The term **"MEDICAL STAFF"** means all physicians, dentists, podiatrists and oral-maxillofacial surgeons who are appointed to the Medical Staff to provide healthcare services at designated Harris Health facilities and who either (i) hold a faculty appointment at Baylor College of Medicine and/or The University of Texas Health Science Center at Houston, (ii) are employed by Harris Health, or (iii) are Contract Practitioners. Medical school faculty appointment status is not required for Practitioners or Advanced Practice Professionals employed by Harris Health or Contract Practitioners.

23. The term "**PEER**" shall mean an individual who practices in the same profession as the Practitioner under review. The level of subject-matter expertise required to provide meaningful evaluation of a Practitioner's performance will determine what "practicing in the same profession" means on a case-by-case basis. For example, for quality issues related to general medical care, a physician may review the care of another physician. For specialty-specific clinical issues, such as evaluating the technique of a specialized surgical procedure, a peer is an individual who is well-trained and competent in that specific surgical specialty. The Medical Executive Committee shall determine the degree of subject matter expertise required on a case-by-case basis.

24. The term "**PEER REVIEW**" shall mean the evaluation of medical and healthcare services, including evaluation of the qualifications and professional conduct of professional healthcare practitioners and of patient care provided by those Practitioners. The Practitioner is evaluated based on generally recognized standards of care. The Medical Executive Committee conducts a peer review with input from one or more Practitioner colleagues (peers).

25. The term **"PHYSICIAN"** means an individual with an M.D., D.O. or equivalent degree currently licensed to practice medicine in the State of Texas.

26. The term **"PODIATRIST"** means an individual with a D.P.M. or equivalent degree licensed to practice podiatry by the State of Texas.

27. The term **"PRACTITIONER"** means, unless otherwise expressly limited, any Physician, Podiatrist or Dentist holding a current license to practice in the State of Texas.

28. The term **"RESIDENT/INTERN/HOUSESTAFF/FELLOW"** means an individual who, licensed as appropriate, is a graduate of a medical, dental, osteopathic, or podiatric school and who is appointed to the ASC's professional graduate training program and who participates in patient care under the direction of Medical Staff members who have Clinical Privileges for the services provided by the Housestaff.

29. The term **"SPECIAL NOTICE"** shall mean written notification sent by certified or registered mail, return receipt requested, or by personal or e-mail delivery with a receipt of delivery or attempted delivery obtained.

30. The term **"STATE"** shall mean the State of Texas.

31. The term **"STATE BOARD"** shall mean, as applicable, the Texas Medical Board, the State Board of Dental Examiners, the State Board of Podiatric Examiners, or such other licensing board that may license individuals who have clinical privileges at the ASC.

ARTICLE I — NAME

The name of this organization governed by these Bylaws shall be The Ambulatory Surgical Center (ASC) at LBJ (hereinafter referred to as the "ASC").

ARTICLE II — PURPOSE

The purposes of this organization are:

1. To operate a licensed, certified, and accredited ambulatory surgery center;
2. To provide the best possible care for all patients admitted to or treated in any of the facilities, departments, or services of the ASC;
3. To provide the community with a facility in which medical and surgical procedures can be safely carried out on a short-stay basis;
3. To ensure a high level of professional performance of all Medical Staff members authorized to practice in the ASC through appropriate delineation of the clinical privileges that each Medical Staff member may exercise (see Article VII) and through an ongoing review and evaluation of each Medical Staff member's performance;
4. To provide an appropriate educational setting for Medical Staff members that will maintain medical and scientific standards that will lead to continuous advancement in professional knowledge and skill;
5. To initiate and maintain ASC Medical Staff Bylaws for self-governance of the Medical Staff;
6. To provide a means for communication and conflict resolution regarding issues that are of concern to the Medical Staff and the ASC.

ARTICLE III — MEDICAL STAFF MEMBERSHIP

Section 1. Nature of Medical Staff Membership

Membership on the Medical Staff of the ASC is a privilege which shall be extended, without discrimination as to race, sex, religion, disability, national origin, or age only to professionally competent individuals who continuously meet the qualifications, standards and requirements set forth in these Bylaws, and does not in any way imply or preclude employment status by Harris Health. Membership on the Medical Staff shall confer only such clinical privileges as have been granted by the Governing Body in accordance with these Bylaws.

Section 2. Scope

Only Practitioners qualified to practice in the following specialties are to be granted membership on the Medical Staff of the ASC:

- Anesthesiology;
- General Surgery;
- Obstetrics and Gynecology;
- Ophthalmology;
- Oral Maxillofacial Surgery;
- Orthopedic Surgery;
- Otorhinolaryngology;
- Plastic Surgery; and

- Urology.

Section 3. Qualifications for Membership

a. Only individuals who have no health problems that could affect his or her ability to perform the privileges requested and can document their background, experience, training and demonstrated competence, their adherence to the ethics of their profession, their good reputation, and their ability to work with others so as to assure the Medical Staff and ASC Governing Body that patients treated by them will be given a high quality of medical care, shall be qualified for membership on the Medical Staff.

b. Only individuals who have and continue to maintain current unrestricted admitting privileges, in Good Standing, at Harris Health.

c. Only individuals who are Board Certified or Board Eligible in his or her specialty practice area.

d. Only individuals who have current licenses and certificates. Medical Staff members must have unrestricted licenses and certificates, with no past adverse licensure actions(s) (e.g. probation, suspension, revocation). Past adverse licensure action(s) do not include action(s) taken for administrative reasons, such as failure to timely pay licensure fees. Required licenses and certificates include:

- State of Texas license to practice medicine, osteopathy, podiatry, or dentistry;
- United States and Texas Controlled Substances Registration Certificates (DEA/DPS), with exceptions approved by the Credentials Committee;
- National Provider Identifier (NPI); and
- Professional liability insurance covering the exercise of all requested privileges, except for Physicians employed by Harris Health, whose liability is governed by the Texas Tort Claims Act.

e. Only Practitioners who have no record of denial, revocation, relinquishment or termination of appointment or clinical privileges at any other healthcare facility for reasons related to professional competence or conduct.

d. No Practitioner shall be entitled to membership on the Medical Staff or to the exercise of particular clinical privileges in the ASC merely by virtue of the fact that he or she is duly licensed to practice medicine, osteopathy, podiatry, or dentistry in this State or in any other state, or that he or she is a member of any professional organization, or that he or she had in the past, or presently has, such privileges at another ambulatory surgical center.

e. Acceptance of membership on the Medical Staff shall constitute the staff member's agreement that he or she will strictly abide with all provisions of these ASC Medical Staff Bylaws.

f. The Practitioner will remain in Good Standing so long as he or she is a member of the Medical Staff.

g. The Practitioner is required to be eligible to participate in federal and/or State healthcare programs. The Practitioner may not currently be an Ineligible Person and shall not become an Ineligible Person during any term of membership. The Practitioner must also have no record of conviction of Medicare, Medicaid or insurance fraud and abuse.

(1) A Practitioner is required to disclose immediately any debarment, exclusion, or other event that makes the person an Ineligible Person.

(2) An Ineligible Person is immediately disqualified for membership to the Medical Staff or the granting of clinical privileges or practice prerogatives.

h. A Practitioner who does not meet one or more of the qualifications for membership described above may request the Medical Director to waive one or more of the qualifications for membership. The Medical Director's determination not to waive one or more of the qualifications for membership is not a denial of the Practitioner's application for Medical Staff membership, is not reportable to the National Practitioner Databank, and does not entitle the Applicant to the fair hearing rights as described in Article IX of these Bylaws.

Section 3. Basic Responsibilities of Medical Staff Membership

The following responsibilities shall govern the professional conduct of Medical Staff members and failure to meet these responsibilities shall be cause for suspension of privileges or dismissal from the Medical Staff:

a. The principal objective of the Medical Staff is to render service to humanity with full respect for the dignity of each person. Medical Staff members should merit the confidence of patients entrusted to their care, rendering to each a full measure of service, devotion and continuity of care. Medical Staff members are responsible for the quality of the medical care provided to patients.

b. Medical Staff members should strive continually to improve medical knowledge and skill, and should make available to their patients and colleagues the benefits of their professional qualifications.

c. Medical Staff members should observe all laws, uphold the dignity and honor of their profession and accept self-imposed disciplines. They should report without hesitation, illegal or unethical conduct by other Medical Staff members and self-report their own illegal or unethical conduct. Reports should be made to the Administrator or Medical Director, who will report the information to Medical Staff Services.

d. Medical Staff members should self-report any physical, behavioral or mental impairment that could affect his or her ability to perform his or her clinical privileges, or treatment for the impairment that occurs at any point during his or her Medical Staff membership. Reports should be made to the Administrator or Medical Director, who will report the information to Medical Staff Services.

e. In an emergency, Medical Staff members should render services to the best of their abilities. Having undertaken the care of a patient, a Medical Staff member may not neglect him or her.

f. Medical Staff members should not solicit patients.

g. Medical Staff members should not dispense of their services under terms or conditions that tend to interfere with or impair the free and complete exercise of their professional judgment and skill or tend to cause a deterioration of the quality of their care.

h. Medical Staff members should seek consultation upon request, in doubtful or difficult cases, or whenever it appears that the quality of service may be enhanced thereby.

i. Medical Staff members may not reveal the confidences entrusted to them in the course of professional attendance unless they are required to do so by law or unless it becomes necessary in order to protect the welfare of an individual or of the community.

k. Medical Staff members must abide by the ASC Medical Staff Bylaws, Rules and Regulations, and Medical Staff and applicable ASC and Harris Health policies and procedures.

l. Medical Staff members must participate cooperatively in quality review and peer evaluation activities, both as a committee member and in conjunction with evaluation of his or her own performance or professional qualifications.

m. Medical Staff members must prepare and complete medical records in a timely fashion for all patients to whom the member provides care in the ASC.

n. Medical Staff members are accountable to the Governing Body.

Section 4. Conditions and Duration of Appointment

a. Initial appointments and reappointments to the Medical Staff shall be made by the Governing Body. The Governing Body shall act on appointments, reappointments, or revocation of appointments after there has been a recommendation from the Medical Executive Committee.

b. Initial appointments shall be acted upon following submittal of a Completed Application.

c. All appointments to the Medical Staff shall be for a period of not more than two years.

e. Appointment or reappointment to the Medical Staff confers on the appointee only such clinical privileges as have been approved by the Governing Body.

f. Each application for Medical Staff appointment shall be signed by the applicant and shall contain the applicant's specific acknowledgement of a Medical Staff member's obligations to provide continuous care and supervision of their patients, to abide by the ASC Medical Staff Bylaws, Rules and Regulations, to accept committee assignments and to accept staff assignments in the ASC. All Medical Staff members shall carry an appropriate level of professional liability insurance as determined by the Governing Body of the ASC.

g. Appointments and reappointments to the Medical Staff shall always conform to applicable State and Federal laws.

Section 5. Leave of Absence

a. Requesting a Leave of Absence. A Practitioner may submit a written request to Medical Staff Services for a leave of absence 30 days prior to the requested leave, unless related to a Medical Leave of Absence. Upon favorable recommendation by the Medical Director, the Medical Executive Committee may consider a voluntary leave of absence for up to one (1) year. An additional one (1) year may be granted for good cause in accordance with policy. During the period of the leave, the Practitioner shall not exercise clinical privileges at the ASC, and the Practitioner's rights and responsibilities shall be inactive. All medical records must be completed prior to granting a leave of absence unless circumstances would not make this feasible.

b. Termination of Leave. At least 45 days prior to the termination of the leave of absence, or at any earlier time, the Practitioner may request reinstatement of privileges by submitting a written notice to Medical Staff Services along with a summary of relevant activities during the leave. The Practitioner's request, activity summary and verification, if applicable, shall be presented to the Medical Director. The Medical Director will review the documentation and provide a recommendation to the Medical Executive Committee. Reactivation of membership and clinical privileges previously held shall be subject to quality review as determined by the Medical Executive Committee following recommendation by the Medical Director. If the practitioner is scheduled for reappointment during the approved leave, the practitioner's application for reappointment must be finalized in accordance with Article VII, Section 4 prior to the practitioner's return.

c. Failure to Request Reinstatement. Failure, without good cause, to request reinstatement shall be deemed a voluntary resignation from the Medical Staff and shall not give rise to the right to a fair hearing. A request for Medical Staff membership received from a practitioner subsequent to termination shall be submitted and processed in the manner specified for applications for initial appointments.

d. Medical Leave of Absence. Following recommendation by the Medical Director, the Medical Executive Committee shall determine the circumstances under which a particular practitioner shall be granted a leave of absence for the purpose of obtaining treatment for a medical condition or disability. Unless accompanied by a reportable restriction of privileges, the leave shall be deemed a voluntary medical leave of absence and will not be reported to the National Practitioner Data Bank.

e. Military Leave of Absence. Requests for leave of absence to fulfill military service obligations shall be granted upon appropriate notice to Medical Staff Services and will be provided to the Medical Executive Committee for information only.

ARTICLE IV — CATEGORIES OF THE MEDICAL STAFF

Section 1. The Active Staff

a. Qualifications. The Active staff shall consist of members who:

(1) Meet the general qualifications for membership set forth in Article III, Section 3;

(2) Meet the minimum case requirement by performing at least (50) cases during the prior (12) month period and performing at least one hundred (100) cases within the prior two (2) year appointment period; and

(3) Hold faculty appointments from Baylor College of Medicine or The University of Texas Health Science Center at Houston or are employed by Harris Health or are Contract Practitioners.

b. Prerogatives. Except as otherwise provided, the prerogatives of an Active staff member shall be:

(1) Exercise of all clinical privileges that are granted to the member pursuant to Article VII;

(2) Attend and vote on matters which are presented at general and special meetings of the Medical Staff or any meeting of any specialty or committee of the ASC of which such person is a member;

(3) Participate in Medical Staff Satisfaction surveys;

(4) Hold any office for which the member is qualified; and

(5) Serve as a voting member on any committee to which such person is duly appointed or elected.

c. Reclassification. Failure of an Active Staff member to meet the requirements of Article IV, Section 1(a) at the time of reappointment shall result in reclassification as Affiliate Staff.

Section 2. The Affiliate Staff

a. Qualifications. The Affiliate Staff shall consist of members who:

(1) Meet the general qualifications for membership set forth in Article III, Section 3;

(2) Meet the minimum case requirement by performing at least ten (10) cases during the prior (12) month period and performing at least twenty (20) cases within the prior two (2) year appointment period; and

(3) Hold faculty appointments from Baylor College of Medicine or The University of Texas Health Science Center at Houston or are employed by Harris Health or are Contract Practitioners.

b. Prerogatives. Except as otherwise provided, the prerogatives of an Active staff member shall be:

(1) Exercise of all clinical privileges that are granted to the member pursuant to Article VII; and

(2) Attend, in a non-voting capacity, general and special meetings of the Medical Staff or any meeting of any specialty or committee of the ASC of which such person is a member.

Section 3. The Provisional Staff

a. All Practitioners and APPs who have been granted an initial appointment to the Medical Staff will be assigned to the Provisional Staff for a three (3) month period during the first year of his or her initial appointment. During the provisional period, the Practitioner or APP must perform or assist with at least ten (10) cases. At the end of the provisional period, the Medical Executive Committee will determine if they will or will not recommend placing the individual in the Active or Affiliate category of Medical Staff.

b. Membership on the Provisional Staff is probationary and does not create any right or expectation on the part of any such Practitioner or APP of continued membership on the Medical Staff or of advancement to any other category of Medical Staff.

c. The probationary period may be extended by the Medical Executive Committee for a period not to exceed twelve (12) months after the initial appointment of privileges.

d. The Medical Executive Board and Governing Body may required that a Practitioner be placed in this category of Medical Staff at any time, such as when privileges are granted between appointments or when privileges are granted for new procedures.

ARTICLE V — INTERNS, RESIDENTS, AND FELLOWS (HOUSESTAFF)

Housestaff are not members of the Medical Staff. Housestaff shall not be eligible for independent clinical privileges or Medical Staff membership, and shall not be entitled to any of the rights, privileges, or to the hearing or appeals rights under these Bylaws. Housestaff shall be credentialed by the sponsoring medical school or training program in accordance with provisions in a written affiliation agreement between the ASC and the school or program; credentialing information shall be made available to the ASC upon request and as needed by the Medical Staff in making any training assignments and in performance of their supervisory function. In compliance with federal laws, the ASC shall not submit a query to the National Practitioner Data Bank prior to permitting Housestaff to provide services at ASC. All interns, residents, and fellows will be required to obtain a Texas Medical Board training license, if not otherwise licensed in Texas, and a National Provider Identifier (NPI), prior to beginning training at the ASC. Verification of this licensure will be accomplished through the Graduate Medical Education Offices at the respective Accreditation Council for Graduate Medical Education sponsoring institutions. Housestaff may render patient care services at ASC only pursuant to and limited by the following:

a. Applicable provisions of the professional licensure requirements of this State;

b. A written affiliation agreement between the ASC and the sponsoring medical school or training program; such agreement shall identify the individual or entity responsible for providing professional liability insurance coverage for a Housestaff Practitioner.

c. The protocols established by the Medical Executive Committee, in conjunction with the sponsoring medical school or training program regarding the scope of a Housestaff authority, mechanisms for the direction and supervision of Housestaff, and other conditions imposed upon Housestaff by the ASC.

d. While functioning in the ASC, Housestaff shall abide by all provisions of state and Federal law, rules and regulations; requirements of Accrediting Bodies; the ASC Medical Staff Bylaws, Rules and Regulations; and ASC and Medical Staff policies and procedures.

e. Housestaff may perform only those services set forth in the training protocols developed by the applicable training program to the extent that such services do not exceed or conflict with the Rules and Regulations of the Medical Staff or ASC policies, and to the extent approved by the Governing Body.

f. Housestaff shall be responsible and accountable at all times to an assigned member of the Medical Staff and shall be under the supervision and direction of that member of the Medical Staff. Housestaff may be invited or required to attend meetings of the Medical Staff, Medical Staff Services, Sections, or Committees, but shall have no voting rights.

g. The ASC will promptly notify Baylor College of Medicine or The University of Texas Health Science Center at Houston (sponsoring institutions) Graduate Medical Education (GME) Offices when or if the ASC becomes aware of potentially inappropriate action taken by Housestaff. Upon notification of such a request, the sponsoring institution will promptly investigate the inappropriate actions. The ASC will cooperate and consult with the sponsoring institution and will permit the sponsoring institution reasonable time to conduct its investigation prior to the ASC taking any adverse action against the Housestaff member, except as otherwise provided in this Section. Regardless, after consultation with the Medical Director and/or Program Director, Harris Health's CEO may in his or her sole discretion determine that the Housestaff member not continue his or her training at the ASC until the investigation is complete. At the conclusion of the sponsoring institution's investigation, the sponsoring institution will notify the ASC of the results of the investigation and proposed corrective or rehabilitative action, or reason(s) for inaction. If Harris Health's CEO is not satisfied with the sponsoring institution's investigation, proposed corrective or rehabilitative action, or reason(s) for inaction, and a mutually agreed resolution cannot be reached, Harris Health's CEO will notify the ASC's Governing Body and the ASC's Governing Body may, in its sole discretion, remove the Housestaff member's ability to continue his or her training at the ASC.

h. If a sponsoring institution requests to reinstate a Housestaff member who was previously removed from the ASC, the sponsoring institution will notify the ASC of the circumstances that warrant reinstatement. Harris Health's CEO will consult with the sponsoring institution that made the request, as well as with the Medical Director and the ASC's Governing Body. If Harris Health's CEO does not agree with the sponsoring institution's request to reinstate, Harris Health's CEO will notify the ASC's Governing Body and the ASC's Governing Body may, in its sole discretion, deny the request to reinstate.

i. Nothing in these Bylaws shall be interpreted to entitle Housestaff to the fair hearing rights as described in Article IX of these Bylaws.

ARTICLE VI — ADVANCED PRACTICE PROFESSIONALS

Section 1. Membership

Advanced Practice Professionals are not members of the Medical Staff, but provide clinical services to ASC patients.

Section 2. Qualifications

APPs include those non-Medical Staff members whose license or certificate permits, and the ASC authorizes, the individual provision of patient care services without direction or supervision within the scope of the APP's individually delineated clinical privileges. APPs must:

(1) Meet all applicable standards related to licensure, training and education, clinical competence and health status as described in these Bylaws, Medical Staff Rules and Regulations, and Medical Staff and ASC policies and procedures;

(2) Be assessed, credentialed, and monitored through existing ASC credentialing, quality assessment, and performance improvement functions;

(3) Maintain an active and current credential file and hold delineated clinical privileges approved by the Medical Executive Committee and Governing Body;

(4) Complete all proctoring requirements as may be established by the Medical Executive Committee; and

(5) Not admit patients or assume primary patient care responsibilities.

APPs include those categories of individuals identified in the Definitions Section of these Bylaws.

Section 3. Prerogatives

1. By virtue of their training, experience and professional licensure, APPs are allowed by the ASC to function within the scope of their licensure and delineated clinical privileges but may not admit patients. All APPs shall be under the supervision of a sponsoring physician, who is member of the Medical Staff and has clinical privileges in the same surgical specialty as the APP, who is responsible for delineating the applicant's clinical privileges. If the sponsoring physician's Medical Staff membership is terminated, then the APP's ability to perform clinical services shall be suspended for a period of up to ninety (90) days or until an alternative supervising physician can be secured. If the suspension lasts longer than ninety (90) days or if there is any change in the APP's privileges, then the APP shall complete the initial application procedure. Each APP must notify Medical Staff Services immediately upon loss of required sponsorship or supervision.
2. APPs holding clinical privileges shall have their privileges or practice prerogatives reviewed and approved through the same mechanism described in Article VII of these Bylaws unless otherwise determined by the Medical Executive Committee.
3. The clinical privileges and/or practice prerogatives which may be granted to specific APPs shall be defined by the Medical Staff. Such prerogatives may include:

   (a) The provision of specific patient care services pursuant to established protocols, either independently or under the supervision or direction of a physician or other member of the Medical Staff. The provision of such patient care services must be consistent with the APP's licensure or certification and delineated clinical privileges or job description;

(b) Participation by request on Medical Staff and/or administrative committees or teams; and

(c) Attendance by request at Medical Staff and/or administrative meetings.

4. Participating in quality assessment and performance improvement activities as requested by the Quality Review Council, Medical Executive Committee, or any other committee of the Medical Staff or Governing Body. Failure of an APP to participate in quality assessment or performance improvement activities when requested by the Medical Staff or Governing Body shall result in responsive action, including the possible revocation or suspension of all privileges or practice prerogatives.

Section 4. Review

Nothing in these Bylaws shall be interpreted to entitle APPs to the fair hearing rights as described in Article IX of these Bylaws. An APP shall, however, have the right to challenge any action that would adversely affect the APP's ability to provide patient care services in the ASC. Under such circumstances, the following procedures shall apply:

(1) Notice. Special Notice of the adverse recommendation or action and the right to a hearing shall be promptly given to the APP subject to the adverse recommendation or action. The notice shall state that the APP has thirty (30) days in which to request a hearing. If the APP does not request a hearing within thirty (30) days, the APP shall have waived the right to a hearing.

(2) Hearing Panel. The Medical Director shall appoint a hearing panel that will include at least three members. The panel members shall include the Medical Director, another member of the Medical Staff, and if possible, a peer of the APP, except that any peer review of a nurse shall meet the panel requirements of the Texas Nursing Practice Act. None of the panel members shall have had a role in the adverse recommendation or action.

(3) Rights. The APP subject to the adverse recommendation or action shall have the right to present information but cannot have legal representation or call witnesses.

(4) Hearing Panel Determination. Following presentation of information and panel deliberation, the panel shall make a determination:

i. A determination favorable to the APP shall be reported in writing to the body making the adverse recommendation or action.

ii. A determination adverse to the APP shall result in notice to the APP of a right to appeal the decision to the Chairperson of the Governing Body.

(5) Final Decision. The decision of the Chairperson of the Governing Body shall be the final appeal and represent the final action in the matter.

ARTICLE VII – PROCEDURE FOR APPOINTMENT AND REAPPOINTMENT

Section 1. Burden of Producing Information

In connection with all applications for appointment, reappointment, advancement, or transfer, the applicant shall have the burden of producing sufficient information of clinical and professional performance to permit an adequate evaluation of the applicant's qualifications and suitability for the clinical privileges and staff category requested, to resolve any reasonable doubts about these matters, and to satisfy any request for such information. Failure of a Practitioner to produce required

information related to an authorized Medical Staff peer review, quality assessment, performance improvement, or credentialing activity in a timely manner shall result in automatic suspension of all clinical privileges until such time as the required information has been provided. Initial applicants who fail to produce all appropriate information and/or documents as requested may withdraw their application prior to review by the Medical Executive Committee.

Section 2. Application for Appointment

a. All applications for appointment to the Medical Staff shall be signed by the applicant, and shall be submitted on a form prescribed by the State of Texas. The application shall include the following detailed information:

- evidence of current licensure;
- evidence of current Board Certification or current Board Eligible status;
- evidence of current United States and Texas Controlled Substances Registration Certificates (DEA/DPS);
- evidence of current National Provider Identifier (NPI);
- evidence of appropriate professional liability insurance, as determined by the Governing Body;
- privileges requested;
- Evidence of appropriate Basic Life Support (BLS), except for those board certified or board eligible in Anesthesiology (ACLS is required);
- relevant training and/or experience;
- current competence;
- physical and mental health status attestation;
- previously successful or currently pending challenges to any licensure or registration (state or district, Drug Enforcement Administration);
- voluntary or involuntary relinquishment of any licensure or registration (state or district, Drug Enforcement Administration);
- voluntary or involuntary termination of Medical Staff membership or voluntary or involuntary decrease of privileges at any other hospital or institution;
- suspension or revocation of membership in any local, state or national medical society;
- suspension or revocation of license to practice any profession in any jurisdiction
- any claims, lawsuits, settlements, or judgments against the applicant in a professional liability action, including consent to the release of information from the present and past malpractice insurance carrier(s);
- loss of clinical privileges;
- a clear, legible copy of a government-issued photo identification, e.g., valid driver's license or passport;
- three professional peer references; and
- evidence of continuing medical education satisfactory to the Medical Executive Committee.

b. The applicant shall have the burden of producing adequate information for a proper evaluation of their competence, character, ethics and other qualifications, and for resolving any doubts about such qualifications.

c. Upon the receipt of a Completed Application, Medical Staff Services shall verify the applicant's information on behalf of the Medical Executive Committee. Harris Health, on pursuant to the Letter of Agreement with the ASC, shall consult primary sources of information about the applicant's credentials. It is the applicant's responsibility to resolve any problems Harris Health may have in obtaining information from primary sources. Verifications of licensure, controlled substances registrations (state and federal), specialty board certification or eligibility, and professional liability claims history, query of the National Practitioner Data Bank, and queries to ensure the applicant is not an Ineligible Person shall be completed. Verification may be made by a letter or computer printout obtained from the primary source, verbally, if documented, or electronically if transmitted directly from the primary source to Harris Health. For new applicants, information about the applicant's membership status and/or work history shall be obtained from all organizations where the applicant currently has membership or privileges and/or is employed, and where the applicant has held membership or has been granted clinical privileges and/or has been employed during the previous five years. Associated details on the credentialing process are set forth in Harris Health's Credentialing Procedures Manual.

d. The application and verifications shall be forwarded to Medical Staff Services for review. After review by Medical Staff Services for completeness, the application and all supporting materials shall be transmitted to the Medical Executive Committee for evaluation.

e. By applying for appointment to the Medical Staff, applicants thereby signify their willingness to appear for interviews in regard to the application; authorize the ASC to consult with members of Medical Staffs of other health care organizations with which the applicant has been associated and with others, including past and present malpractice insurance carriers, who may have information bearing on the applicant's competence, character and ethical qualification; consent to Harris Health and the ASC's inspection of all records and documents that, in the opinion of the Medical Executive Committee, may be material to an evaluation of professional qualifications and competence to carry out the clinical privileges requested, as well as moral and ethical qualifications for staff membership; releases from any liability all representatives of the ASC, Harris Health and its Medical Staff for their acts performed in good faith and without malice in connection with evaluation of the applicant and his or her credentials; and releases from any liability all individuals and organizations who provide information to Harris Health and the ASC in good faith and without malice concerning the applicant's competence, ethics, character and other qualifications for staff appointment and clinical privileges, including otherwise privileged or confidential information.

f. Each applicant shall sign and return a statement that he or she has received and read the ASC Medical Staff Bylaws and that he or she agrees to be bound by the terms thereof relating to consideration of the application and, if the applicant is appointed, to all terms thereof.

Section 3. Appointment Process

a. Medical Staff Services shall transmit Completed Applications to the Medical Executive Committee at its next regularly scheduled meeting following completion of verifications tasks and receipt of all relevant materials.

b. Within one hundred and twenty days (120) days after receipt of the Completed Application, the Medical Executive Committee shall report its review and recommendation to the Governing Body. Prior to making this report, the Medical Executive Committee shall

examine the evidence of the character, professional competence, physical and mental health status, qualifications and ethical standing of the applicant and shall determine, through information contained in references given by the applicant, and from any other sources available to the committee, whether the applicant has established and meets all of the necessary qualifications for the category of staff membership and the clinical privileges requested.

c. Within sixty (60) days of receipt of the recommendation from the Medical Executive Committee, the Governing Body shall determine whether to accept or reject the recommendation. The Governing Body may only make a decision contrary to the recommendation of the Medical Executive Committee if the applicant meets all of the requirements for Medical Staff membership and the Medical Executive Committee's recommendation is unreasonable or not based on sound judgment. If the Governing Body makes a decision contrary to the recommendation of the Medical Executive Committee, the Governing Body must document its rationale for doing so.

d. A decision by the Governing Body to accept a recommendation resulting in an applicant's appointment to the Medical Staff shall be considered a final action. Within twenty (20) days of the Governing Body's final action, the ASC shall provide notice of all appointments approved by the Governing Body by Special Notice to each new Medical Staff member. All such notices shall include a delineation of approved privileges and appointment dates.

e. The time periods specified in Section 3(b) and (c) above are for guidance only and do not create any right for for the applicant to have his or her application processed within those time periods.

f. When the recommendation of the Governing Body is adverse to the applicant, either in respect to appointment or clinical privileges, the Medical Director shall notify the applicant by Special Notice within fifteen (15) days, as described in Article IX of these Bylaws. No such adverse recommendation shall be forwarded to the Governing Body until after the applicant has exercised his or her right to a hearing as provided in Article IX of these Bylaws. If the applicant fails to act within thirty (30) days of receipt of the Special Notice, the applicant will have waived his or her right to a hearing as provided in Article IX of these Bylaws.

g. If, after the Medical Executive Committee has considered the report and recommendations of the hearing committee and the hearing record, the Medical Executive Committee's reconsidered recommendation is favorable to the applicant, it shall be processed in accordance with subparagraph "b" of this section. If such recommendation continues to be adverse, the Medical Director shall promptly so notify the applicant by Special Notice. The Medical Director shall so forward such recommendation and documentation to the Governing Body.

h. The Governing Body shall send notice of its final decision regarding any such review under Article IX of these Bylaws through the Medical Director to the applicant.

Section 4. Reappointment Process

a. It is the responsibility of Active and Affiliate members and Advanced Practice Professionals to request reappointment to the Medical Staff in accordance with the "Reappointment and Renewal of Clinical Privileges Procedure" in the Credentialing Procedures Manual. Reappointment to the Medical Staff shall be based on the applicant's maintaining qualifications for Medical Staff membership, as described in Section 2 of this Article, current competence, and consideration of the results of quality assessment activities as determined by the Medical Executive Committee. Failure to submit a completed reappointment application form with required supporting documentation no less than sixty (60) days prior to the expiration of the Practitioner's then current appointment shall constitute a resignation from

the Medical Staff and all privileges will terminate upon expiration of said appointment. Such termination shall not give rise to the right to a hearing pursuant to Article IX of these Bylaws.

Reappointment shall occur every two (2) years. Medical Staff Services will transmit the necessary reapplication materials to the Practitioner not less than 120 days prior to the expiration date of their then current appointment.

All claims, lawsuits, settlements, or judgments against the applicant in a professional liability action, either final or pending, since the last appointment or reappointment must be reported.

b. Each recommendation concerning the reappointment of a staff member and the clinical privileges to be granted upon reappointment shall take into consideration the following characteristics:

- the practitioner's ASC-specific case record, including measures employed in the ASC's quality assurance/performance improvement program, including but not limited to emergency transfers to hospitals, post-surgical infection rates, other surgical complications, etc.
- professional competence and clinical judgment in the treatment of patients;
- ethics and conduct;
- relations with other Medical Staff members;
- general attitude toward patients, the ASC, and the public;
- documented physical and mental health status;
- evidence of continuing medical education that is related, at least in part, to the Practitioner or APP's clinical privileges;;
- previously successful or currently pending challenges to any licensure or registration (state or district, Drug Enforcement Administration);
- voluntary or involuntary relinquishment of such licensure or registration;
- voluntary or involuntary termination of Medical Staff membership; and
- voluntary or involuntary decrease of privileges at any other hospital.

c. Thereafter, the procedure provided in Sections 2 and 3 this Article relating to recommendations on applications for initial appointment shall be followed.

d. Members of the Medical Staff shall maintain current licensure and certifications, as described in Article III, Section 3 of these Bylaws. Members of the Medical Staff must notify the ASC whenever their license to practice in any jurisdiction has been voluntarily/involuntarily limited, suspended, revoked, denied, or subjected to probationary conditions, or when proceedings toward any of those ends have been instituted. Those without current licensure and certifications will be subject to loss of privileges as described in Article VIII, Sections 3 and 4 of these Bylaws.

e. The appointment of any Practitioner who fails to submit an application for reappointment~~,~~ or who loses faculty appointment at Baylor College of Medicine and/or The University of Texas Health Science Center at Houston or ceases to be employed by or have a contractual relationship with the ASC shall automatically expire at the end of his or her faculty appointment or employment. A Practitioner whose appointment has expired must submit a new application, which shall be processed without preference as an application for initial appointment.

f. When the final action has been taken, the Medical Director shall give written notice of the reappointment decision to the Practitioner.

Section 5. Application for Clinical Privileges

Every initial application for staff appointment to the Medical Staff and each reappointment application must contain a request for the specific clinical privileges desired by the applicant. The evaluation of such request shall be based upon the applicant's education, clinical training, experience, current competence, references, judgment, and other relevant information. The applicant shall have the burden of establishing his or her qualifications and competency to be granted the clinical privileges requested.

Section 6. Clinical Privileges

a. Every Medical Staff member practicing within the ASC by virtue of Medical Staff membership or otherwise, shall, in connection with such practice, exercise only those clinical privileges specifically approved, ratified, and affirmed to him or her by the Governing Body.

b. Clinical privileges will be limited to those activities deemed the responsibility of the specialty area to which the applicant is appointed.

Section 7. Privileges in More Than One Specialty

Practitioners or APPs may be awarded clinical privileges in one or more specialty in accordance with their education, training, experience, and demonstrated competence.

Section 8. Temporary Privileges

a. Upon the basis of information then available, which may reasonably be relied upon as to the competence and ethical standing of the applicant, the Medical Executive Committee may grant temporary clinical privileges to the applicant. Temporary privileges of the applicant shall persist until the next meeting of the Governing Body (not to exceed 120 days) and shall cease at the time of official action upon his or her application for Medical Staff membership.

b. Termination. Temporary clinical privileges may be terminated by the Medical Director.

c. Neither termination of temporary clinical privileges nor failure to grant them shall constitute a Final Hearing Review Action and neither is an Adverse Recommendation or Action.

Section 9. Emergency Clinical Privileges

In the case of an emergency, any current Medical Staff member, to the degree permitted by his or her license and regardless of service or staff status, shall be permitted and assisted to do everything possible to save the life of a patient using the appropriate resources of the ASC, including the calling for any consultation necessary or desirable. For the purpose of this section, an "emergency" is defined as a condition in which a patient is in immediate danger of serious permanent harm or loss of life, and any delay in administering treatment could add to that danger.

Section 10. Confidentiality of the Credentials File

A Medical Staff member or other individual exercising clinical privileges shall be granted access to his or her own credentials file, subject to the following provisions:

a. A request for access must be submitted in writing to the Chairperson of the Medical Executive Committee.

b. The individual may review, and receive a copy of, only those documents provided by or addressed personally to the individual. All other information, including peer review committee findings, letters of reference, proctoring reports, complaints, and other documents shall not be disclosed.

c. The review by the individual shall take place in Medical Staff Services during normal work hours with an officer or designee of the Medical Staff present.

ARTICLE VIII - CORRECTIVE ACTION

Section 1. Procedure

a. Whenever the activities, professional conduct or health status of any Medical Staff member are considered to be lower than the standards or aims of the Medical Staff or to be disruptive to the operations of the ASC, corrective action against such Medical Staff member may be requested by the Medical Director or by the Governing Body. All such requests shall be in writing, shall be made to the Medical Executive Committee, and shall be supported by reference to the specific activities or conduct, which constitute the grounds for the request. The Medical Director or designee must meet with the member to discuss the issues that are the basis for the request either prior to submission or no later than 72 hours after receipt of a copy of the request. In the event that the member who is the subject of the request for corrective action is the Medical Director, another voting member of the Medical Executive Committee must conduct the meeting. The party conducting the meeting shall send a letter to the staff member immediately following the meeting confirming that the meeting was held and the matters discussed. The letter must be sent to the staff member via Special Notice procedures with a copy to Medical Staff Services.

b. Whenever the corrective action could be a reduction or suspension of clinical privileges, the Chairperson of the Medical Executive Committee shall immediately appoint an ad hoc committee to investigate the matter.

c. Within thirty (30) days after the ad hoc committee's receipt of the request for corrective action, it shall make a report of its investigation to the Medical Executive Committee. If in the reasonable view of the Medical Executive Committee more than thirty (30) days is needed to complete the investigation, the Medical Executive Committee shall grant an extension to the ad hoc committee. Prior to the making of a report, the Medical Staff member against whom corrective action has been requested shall have an opportunity for an interview with the ad hoc investigating committee. At such interview, the Medical Staff member shall be informed that the meeting shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules provided in these Bylaws with respect to hearing shall apply thereto. A record of such interview shall be made by the ad hoc committee and included with its report to the Chairperson of the Medical Executive Committee.

d. Within thirty (30) days following the receipt of the report of the ad hoc investigating committee, the Medical Executive Committee shall take action upon the request. If the corrective action could involve a reduction or suspension of clinical privileges, or a suspension or expulsion from the Medical Staff, the affected Medical Staff member shall be permitted to make an appearance before the Medical Executive Committee prior to its taking action on such request, and none of the procedural rules provided in these Bylaws with respect to hearings shall apply thereto. A record of such appearance shall be made by the Medical Executive Committee.

e. The Medical Executive Committee shall take such action as deemed justified as a result of these investigations.

f. Any recommendations by the Medical Executive Committee to the Governing Body for reduction or revocation of clinical privileges, or expulsion from the Medical Staff shall entitle the affected Medical Staff member to the procedural rights provided in Article IX.

g. All decisions resulting from investigations of a Medical Staff member in a medical administrative position shall be reviewed by the Governing Body following the process as outlined in Article IX.

h. When the Medical Executive Committee or Governing Body has reason to question the physical and/or mental status of a Medical Staff member, the latter shall be required to submit an evaluation of their physical and/or mental health status by a physician or physicians acceptable to the Medical Executive Committee and the affected physician as a prerequisite to further consideration of: (1) their application for appointment or reappointment, (2) their exercise of previously granted privileges, or (3) their maintenance of a Medical Staff appointment.

Section 2. Summary Suspension

Whenever there is a reasonable belief that a Member's conduct or condition requires that immediate action be taken to protect life or to reduce the likelihood of injury or damage to the health or safety of patients, workforce members, or others, summary action must be taken as to all or any portion of the Member's clinical privileges, and such action shall become effective immediately upon imposition.

The Chairperson of the Medical Executive Committee, the Medical Executive Committee itself, the Medical Director, Harris Health's Chief Executive Officer, or the Governing Body shall have the authority, whenever action must be taken immediately in the best interest of patient care at the ASC, to suspend summarily all or any portion of the clinical privileges of a Medical Staff member, and such summary suspension shall become effective immediately upon imposition.

The Medical Staff member must be immediately notified by Special Notice from the Medical Director. A suspended member's patients in the ASC must be assigned to another member by the applicable specialty, considering the wishes of the patient, where feasible, in choosing a substitute practitioner.

As soon as possible, but within ten (10) working days after a summary suspension is imposed, the Medical Executive Committee shall convene to review and consider the action taken. In its sole discretion, the Medical Executive Committee may provide the member the opportunity to meet with the Medical Executive Committee, which may recommend modification, continuation or termination of the terms of the suspension. A Medical Executive Committee recommendation to continue the extension or to take any other adverse action as defined in Article IX entitles the Medical Staff member, upon timely and proper request, to the procedural rights contained in Article IX.

Section 3. Automatic Suspension

Occurrence of any of the following shall result in an automatic suspension as detailed. An automatic suspension is not considered a final action or an adverse recommendation or action but may be considered in any investigation or proceeding pursuant to Article IX of these Bylaws.

(1) Suspension, limitation or placement of a condition on a member's professional license by the state licensing board shall result in automatic suspension of the member's privileges until the Medical Executive Committee can assess whether the suspension, limitation, or condition will be adopted by the medical staff. As soon as possible, but no later than the tenth (10^{th}) working day after the automatic suspension, the Medical Executive Committee shall convene to review and consider appropriate action.

(2) Indictment of a member for a felony or indictment of any other criminal charges involving substance abuse, minors, assault, battery, fraud, dishonesty, moral turpitude, or the delivery of health care services shall result in automatic suspension of the member's privileges. As soon as possible, but no later than the tenth (10^{th}) working day after the automatic suspension, the Medical Executive Committee shall convene to review and consider appropriate action.

(3) Failure of the member to maintain current required licensure and certifications, as described in Article III, Section 3, shall result in automatic suspension of the member's privileges for up to thirty (30) days. The member's privileges will be reinstated once Medical Staff Services has confirmed that the issue has been resolved to the satisfaction of the Chair of the Medical Executive Committee, or designee. The Chair shall make a report of all such actions at the next regularly scheduled meeting of the Medical Executive Committee and the Medical Executive Committee shall ratify or modify the actions as appropriate. Failure to satisfy this requirement in thirty (30) days will result in a voluntary resignation of the member's privileges and require the submission of an initial credentialing application, which will be processed without preference. In certain circumstances, the Medical Executive Committee may approve an exception to this requirement.

(4) A member's delinquency in completion of medical records shall result in automatic suspension of the member's privileges and medical staff membership until Medical Staff Services has confirmed that the issue has been resolved to the satisfaction of the Chair of the Medical Executive Committee, or designee. The Chair shall make a report of all such resolutions at the next regularly scheduled meeting of the Medical Executive Committee and the Medical Executive Committee shall ratify or modify the resolution as appropriate.

Section 4. Automatic Termination

Occurrence of any of the following shall result in an automatic termination as detailed. An Automatic termination is not considered an adverse recommendation or action but may be considered in any investigation or proceeding pursuant to Article IX of these Bylaws.

(1) Revocation of a physician's professional license by the Texas Medical Board shall cause all the member's clinical privileges and the medical staff membership to automatically terminate.

(2) Conviction of or a guilty or nolo contendere plea to (including deferred adjudication) for a felony or conviction of or a guilty or nolo contendere plea to any other criminal charges involving substance abuse, minors, assault, battery, fraud, dishonesty, moral turpitude, or the delivery of health care services by a member shall result in automatic termination of the member's privileges and medical staff membership.

(3) A member's privileges and staff membership shall automatically terminate if the member becomes an Ineligible Person as that term is defined in these Bylaws.

(4) Loss of employment with Baylor College of Medicine, the University of Texas Health Science Center at Houston, Harris Health, or another entity contracted to provide clinical care at the ASC shall result in automatic termination of the Practitioner's privileges and staff membership. However, if the loss of employment is related to the member's professional competence or conduct, such action is considered an adverse action under Article IX, Section 1.

(5) The privileges and medical staff membership of a member who is suspended four times in a twelve (12) month period for delinquency in completion of medical records shall automatically terminate upon the first day of the fourth suspension within twelve months

(6) The privileges and medical staff membership of a member who remains suspended for six (6) continuous weeks for delinquency in completion of medical records shall automatically terminate upon the last day of the sixth week of continuous suspension.

(7) Failure to notify the Medical Staff Services of the occurrence of any of the events listed in Article VIII, Section 3 shall result in automatic termination of a member's privileges and medical staff membership.

a. Notice

The member must be immediately notified by Special Notice from the Medical Director.

Section 4. Medical Administrative Positions

A Medical Staff member shall not lose staff privileges if his or her medical administrative position is terminated without following the hearing and appellate procedures as outlined in Article IX.

ARTICLE IX — PROCEDURAL RIGHTS OF REVIEW

Section 1. Events Giving Rise to Hearing Rights

a. Actions or Recommended Actions

Subject to the exceptions set forth in Section 1.c of this Article IX, the following actions or recommended actions, if deemed adverse under Section 1.b below, entitle the member (for purposes of Article IX, the term "member" shall include an applicant to the Medical Staff whose application for Medical Staff appointment and clinical privileges has been denied) to a hearing upon timely and proper request as provided in Section 4:

(1) Denial of initial Medical Staff appointment;

(2) Denial of reappointment;

(3) Suspension of appointment, provided that summary suspension entitles the member to request a hearing only as specified in this section;

(4) Revocation of appointment;

(5) Special limitation of the right to admit patients not related to standard administrative or Medical Staff policies within the ASC;

(6) Denial or restriction of requested clinical privileges;

(7) Reduction in clinical privileges;

(8) Suspension of clinical privileges, provided that summary suspension entitles the member to request a hearing only as specified in this section,

(9) Revocation of clinical privileges;

(10) Individual application of, or individual changes in, mandatory consultation or supervision requirement; or

(11) Summary suspension of appointment or clinical privileges, if the recommendation of the Medical Executive Committee or action by the Governing Body is to continue the suspension or to take other action which would entitle the member to request a hearing under Section 4, provided that if the Medical Executive Committee initiates an investigation of the member in accordance with Article VIII, no hearing rights shall accrue until the Medical Executive Committee had acted upon the report of the ad hoc committee.

b. When Deemed Adverse

Except as provided below, any action or recommended action listed in Section 1.a above is deemed adverse to the member only when it has been:

(1) recommended by the Medical Executive Committee; or

(2) taken by the Governing Body under circumstances where no prior right to request a hearing exists.

c. Exceptions to Hearing Rights

(1) Certain Actions or Recommended Actions: Notwithstanding any provision in these ASC Medical Staff Bylaws, or in the Credentialing Procedures Manual to the contrary, the following actions or recommended actions do not entitle the member to a hearing:

(a) the issuance of a verbal warning or formal letter of reprimand;

(b) the imposition of a monitoring or consultation requirement as a condition attached to the exercise of clinical privileges during a provisional period;

(c) the imposition of a probationary period involving review of cases;

(d) the imposition of a requirement for a proctor to be present at procedures performed by the member, provided that there is no requirement for the proctor to grant approval prior to provision of care;

(e) the removal of a Practitioner from a medical administrative office within the hospital unless a contract or employment arrangement provides otherwise; and

(f) any other action or recommended action not listed in Section 1.a above.

(2) Other Situations: An action or recommended action listed in Section 1.a above does not entitle the applicant or member to a hearing when it is:

(a) voluntarily imposed or accepted by the Practitioner;

(b) automatic pursuant to any provision of these ASC Medical Staff Bylaws and related manuals;

(c) taken or recommended with respect to temporary privileges, unless the action must be reported to the National Practitioner Data Bank.

Section 2. Notice of Adverse Action

a. The ASC shall, within fifteen (15) days of receiving written notice of an adverse action or recommended action under Section 1.a, give the Practitioner Special Notice thereof. The notice shall:

(1) advise the Practitioner of the nature of and reasons for the proposed action and of his or her right to mediation or a hearing upon timely and proper request pursuant to Section 3 and/or Section 4 of this Article IX;

(2) specify that the Practitioner has thirty (30) days after receiving the notice within which to submit a request for mediation or a hearing and that the request must satisfy the conditions of Section 3 and/or Section 4;

(3) state that failure to request mediation or a hearing within that time period and in the proper manner constitutes a waiver of rights to mediation or a hearing and to an appellate review on the matter that is the subject of the notice;

(4) state that any higher authority required or permitted under this Article IX to act on the matter following a waiver is not bound by the adverse action or recommended action that the Practitioner has accepted by virtue of the waiver but may take whatever action, whether more or less severe, it deems warranted by the circumstances;

(5) state that upon receipt of his mediation or hearing request, the Practitioner will be notified of the date, time, and place of the hearing, and the grounds upon which the adverse recommendation or action is based; and

(6) provide a brief summary of the rights the Practitioner would have at a hearing, as set forth in Sections 12-14 of this Article.

Section 3. Request for Mediation

a. Within ten (10) days of receipt of the notice of adverse recommendations giving rise to

hearing rights, an affected member may file a written request for mediation. The request must be delivered by Special Notice to the Medical Director and state the reason the member believes mediation is desirable. If a hearing has already been scheduled, mediation must be completed prior to the date of the hearing. If no hearing has been scheduled, the mediation must take place within 45 days of receipt of the request. Under no circumstances will a hearing be delayed beyond the originally scheduled date unless both parties agree to a continuance to a date certain.

b. The mediator shall be selected by the Chairperson of the Medical Executive Committee and must have the qualifications required by state law and experience in medical staff privileging and disputes.

c. The fee of the mediator shall be shared equally among the parties.

d. An individual shall be appointed by the Chairperson of the Medical Executive Committee to participate in the mediation and represent the Medical Executive Committee. The affected member and the representative of the Medical Executive Committee may each be accompanied in the mediation by counsel of their choice.

e. Under no circumstances may the mediation delay the filing of any report required by law, or result in an agreement to take any action not permitted by law. No agreement arising out of the mediation may permit or require the Medical Executive Committee, the Governing Body, or the ASC to violate any legal requirement, accreditation requirement or any requirement of the ASC Medical Staff Bylaws.

f. If no resolution is reached through the mediation, a hearing must be scheduled no later than forty-five (45) days following the mediation, unless otherwise agreed by the parties.

Section 4. Request for Hearing

The Practitioner shall have thirty (30) days after receiving the above notice to file a written request for a hearing. The request must be delivered to the Medical Director by Special Notice.

Section 5. Waiver by Failure to Request a Hearing

A member who fails to request a hearing within the time and in the manner specified in Section 4 above waives his or her right to any hearing and appellate review to which he or she might otherwise have been entitled. Such waiver shall apply only to the matters that were the basis for the adverse action or recommended action triggering the Section 2 notice. The Medical Director shall as soon as reasonably practicable send the member Special Notice of each action taken under any of the following Sections and shall notify the Chairperson of the Medical Executive Committee of each such action. The effect of a waiver is as follows:

a. Adverse Action by the Governing Body

A waiver constitutes acceptance of the adverse action, which immediately becomes the final decision of the Governing Body.

b. Adverse Recommendation by the Medical Executive Committee

A waiver constitutes acceptance of the adverse recommendation, which becomes effective immediately and remains so pending the decision of the Governing Body.

The Governing Body shall consider the adverse recommendation as soon as practicable following the waiver but at least at its next regularly scheduled meeting. Its action has the following effect:

(1) If the Governing Body's action accords in all respects with the Medical Executive Committee recommendation, the Governing Body decision becomes effective immediately.

(2) If, on the basis of the same information and material considered by the Medical Executive Committee in formulating its recommendation, the Governing Body proposes a more severe adverse action, the member shall be entitled to a hearing.

Section 6. Additional Information Obtained Following Waiver

When, in considering an adverse Medical Executive Committee recommendation transmitted to it under Section 5.b of this Article IX, the Governing Body acquires or is informed of additional relevant information not available to or considered by the Medical Executive Committee, the Governing Body shall refer the matter back to the Medical Executive Committee for reconsideration within a set time limit. If the source of the additional information referred to in this Section is the member or an individual or group functioning, directly or indirectly, on his or her behalf, the provisions of this Section shall not apply unless the member demonstrates to the satisfaction of the Medical Executive Committee that the information was not reasonably discoverable in time for presentation to and consideration by the party taking the initial adverse action.

a. If the Medical Executive Committee's recommendation following reconsideration is unchanged, the Governing Body shall act on the matter as provided in Section 5.b. of this Article IX.

b. If the Medical Executive Committee's recommendation following reconsideration is still adverse but is more severe than the action originally recommended, it is deemed a new adverse recommendation under Section 1.a of this Article IX and the matter proceeds as such.

c. A favorable Medical Executive Committee recommendation following reconsideration shall be forwarded as soon as reasonably practicable to the Governing Body by the Medical Director. The effect of the Governing Body action is as follows:

(1) Favorable: Favorable Governing Body action on a favorable Medical Executive Committee recommendation becomes effective immediately.

(2) Adverse: If the Governing Body's action is adverse, the member shall be entitled to a hearing.

Section 7. Notice of Time and Place for Hearing

The Medical Director shall deliver a timely and proper request for a hearing to the Chair of the Medical Executive Committee or Chairperson of the Governing Body, depending on whose recommendation or action prompted the hearing request. The Chairperson of the Medical Executive Committee or the Chairperson of the Governing Body, as appropriate, shall then schedule a hearing. Hearings held by the Governing Body or any committee of the Governing

Body under this Article IX of the ASC Medical Staff Bylaws will be closed meetings pursuant to Chapter 151 of the Texas Occupations Code and Section 161.032 of the Texas Health & Safety Code. The hearing date shall be set for as soon as practicable after the Medical Director received the request but in any event no more than forty-five (45) days thereafter. The Medical Director shall send the member Special Notice of the time, place, and date of the hearing, and the identity of the hearing committee members or hearing officer not less than thirty (30) days from the date of the hearing. The notice provided to the member shall contain a list of the witnesses, if any, expected to testify at the hearing on behalf of the Medical Executive Committee or Governing Body, whichever is appropriate. The member must provide a list of the witnesses expected to testify on his behalf within ten (10) days of this notice. If the member is under suspension, he or she may request that the hearing be held not later than twenty (20) days after the Medical Director has received the hearing request. The Medical Director may grant the member's request after consultation with the Chairperson of the Medical Executive Committee or Chairperson of the Governing Body. If the member does not in good faith cooperate in scheduling a hearing date, and as a result, a hearing has not been scheduled within ninety (90) days from the date of the first proposal for a hearing date by the Medical Executive Committee or Chairperson of the Governing Body, the member shall be deemed to have waived the member's right to a hearing in accordance with Article IX, Section 5, unless both parties agree to a delayed hearing date.

The notice of hearing shall contain a concise statement of the member's alleged acts or omissions, a list by number of the specific or representative patient records in question, and/or the other reasons or subject matter forming the basis for the adverse action which is the subject of the hearing.

Section 8. Appointment of Hearing Committee or Hearing Officer

a. By Medical Staff

A hearing occasioned by an adverse Medical Executive Committee recommendation shall be conducted by a hearing committee appointed by the Chairperson of the Medical Executive Committee and composed of at least three (3) members of the Medical Staff. The Chairperson of the Medical Executive Committee shall designate one of the appointees as Chairperson of the committee.

b. By the Governing Body

A hearing occasioned by an adverse action of the Governing Body shall be conducted by a hearing committee appointed by the Chairperson of the Governing Body and composed of at least three (3) persons, including at least two (2) medical staff members when feasible. The Chairperson of the Governing Body shall designate one appointee as Chairperson of the committee.

c. Service on Hearing Committee

An individual shall not be disqualified from serving on a hearing committee merely because he or she has heard the case or has knowledge of the facts involved or what he or she supposes the facts to be. Any member of the Hearing Committee shall not be in direct economic competition with the member involved. Direct economic competition may not be shown based solely on the member's medical school affiliation. Within ten (10) days of receipt of the Notice of Hearing, the member under review may submit a written challenge to a member of the hearing panel,

specifying the manner in which the hearing committee member is deemed to be disqualified along with supporting facts and circumstances. The Medical Executive Committee or Governing Body, as appropriate, shall consider and rule on the challenge.

d. Hearing Officer in Lieu of Hearing Committee

Subject to the approval of the Governing Body, the Medical Executive Committee may determine that the hearing will be conducted in front of a hearing officer to be appointed by the Medical Executive Committee. This officer shall not be in direct economic competition with the member involved. The term "hearing officer" as used in this Section 8.d shall be used to refer to a hearing officer who is appointed in lieu of a Hearing Committee and shall not refer to an appointed presiding officer of a Hearing Committee, provided, however, that a presiding officer still may be appointed. The decision of a Hearing Officer appointed in lieu of a Hearing Committee shall have the same force and effect as a decision by the Hearing Committee.

Section 9. Final List of Witnesses

The witness lists required in Section 7 of this Article IX shall be amended as soon as possible by the appropriate party when additional witnesses are identified. The final list of witnesses must be submitted to the Presiding Officer and exchanged by the member and the Medical Executive Committee or the Governing Body, as appropriate, no later than seven (7) days prior to the hearing. Failure of a party to comply with this requirement shall constitute good cause for the Presiding Officer to grant a continuance or otherwise limit the testimony of witnesses not disclosed within the required timeframe.

Section 10. Documents

All documents the parties plan to introduce into evidence at the hearing must be submitted to the Presiding Officer and exchanged by the member and the Medical Executive Committee or the Governing Body, as appropriate, no later than seven (7) days prior to the hearing. Failure of a party to comply with this requirement shall constitute good cause for the Presiding Officer to grant a continuance or otherwise limit the introduction into evidence of documents not produced within the required timeframe.

Section 11. Personal Presence

The personal presence of the member is required throughout the hearing, unless the member's presence is excused for any specified time by the hearing committee. The presence of the member's representative does not substitute for the personal presence of the member. A member who fails, without good cause, to be present throughout the hearing unless excused or who fails to proceed at the hearing in accordance with Article IX of these ASC Medical Staff Bylaws shall be deemed to have waived his or her rights in the same manner and with the same consequence as provided in Sections 4 and 5 of this Article IX, if applicable.

Section 12. Presiding Officer

The hearing officer, if appointed pursuant to Article IX Section 37 of these ASC Medical Staff Bylaws, or if not appointed, the hearing committee Chairperson, shall be the presiding officer. The presiding officer shall maintain decorum and assure that all participants have a reasonable

opportunity to present relevant evidence. He or she shall determine the order of procedure during the hearing and make all rulings on matters of procedure and the admissibility of evidence. The presiding officer shall not act as a prosecuting officer or as an advocate to any party to the hearing. If a hearing officer is appointed, he or she shall not be entitled to vote. If the Chairperson of the hearing committee serves as the presiding officer, he or she shall be entitled to vote.

Section 13. Representation

The member may be represented at the hearing by a member of the Medical Staff in good standing, a member of his or her local professional society, or an attorney of his or her choice. The Medical Executive Committee or Governing Body, depending on whose recommendation or action prompted the hearing, shall designate a medical staff member to support its recommendation or action and, in addition, may appoint an attorney to represent it.

Section 14. Rights of Parties

During the hearing, each party shall have the following rights, which shall be exercised in a manner so as to permit the hearing to proceed efficiently and expeditiously:

(1) provide an opening statement no longer than 5 minutes each;
(2) call and examine witnesses;
(3) introduce exhibits;
(4) cross-examine any witness on any matter relevant to the issues;
(5) impeach any witness; and
(6) rebut any evidence.

If the member does not testify in his or her own behalf, he or she may be called and examined as if under cross-examination.

Section 15. Procedure and Evidence

The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence. In the discretion of the presiding officer, any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs may be considered, regardless of the admissibility of such evidence in a court of law. Each party shall be entitled, prior to, during, or at the close of the hearing, to submit memoranda concerning any issue of law or fact, and those memoranda shall become part of the hearing record. Written memoranda, if any, must be presented to the presiding officer, and a copy must be provided to the other party. The hearing committee may ask questions of the witnesses, call additional witnesses, or request documentary evidence if it deems it is appropriate.

Section 16. Official Notice

In reaching a decision, the hearing committee may take official notice, either before or after submission of the matter for decision, of any generally accepted technical or scientific matter relating to the issues under consideration and of any facts that may be judicially noticed by the courts of the State of Texas. Participants in the hearing shall be informed of the matters to be noticed and those matters shall be noted in the hearing record. Either party shall have the opportunity to request that a matter be officially noticed and to refute the officially noticed matters by written or oral presentation of authority, in a manner to be determined by the hearing committee. Reasonable additional time shall be granted, if requested, to present written rebuttal of any evidence admitted on official notice.

Section 17. Burden of Proof

The body whose adverse action or recommended action occasioned the hearing shall have the burden of coming forward with evidence in support thereof. Thereafter, the member shall have the burden of coming forward with evidence and proving by clear and convincing evidence that the adverse action or recommended action lacks any substantial factual basis or is otherwise arbitrary, unreasonable, or capricious.

Section 18. Hearing Record

A court reporter shall be used to record the hearing, although those giving testimony need not be sworn by said reporter. The court reporter shall transcribe the hearing and submit a written copy to the presiding officer within 10 business days after adjournment of the hearing for his/her review. The presiding officer shall return any noted corrections to the court reporter within 7 days. The member may within ten days after the hearing's adjournment also request a copy of the hearing report upon payment of any reasonable costs associated with the preparation of said report and in such event may review the hearing report and return any noted corrections to the court reporter within 7 days. If the member fails to request a copy of the hearing report or if the hearing report is not returned in 7 days, the right to make any changes is waived.

Section 19. Postponement

Requests for postponement or continuance of a hearing may be granted by the presiding officer or hearing committee only upon a timely showing of good cause.

Section 20. Presence of Hearing Committee Members and Vote

A majority of the hearing committee must be present throughout the hearing and deliberations. If a committee member is absent from any part of the hearing or deliberations, the presiding officer, in his or her discretion, may rule that such member may not participate further in the hearing or deliberations or in the decision of the hearing committee.

Section 21. Recesses and Adjournment

The hearing committee may recess and reconvene the hearing without Special Notice for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence, the hearing shall be adjourned. The hearing committee shall, at a time convenient to itself, conduct its deliberations outside the presence of the parties.

Section 22. Hearing Committee Report

Within twenty (20) days after adjournment of the hearing, the hearing committee shall make a written report of its findings and recommendations with such reference to the hearing record and other considered documentation as it deems appropriate. The hearing committee shall forward the report to the body whose adverse action or recommended action occasioned the hearing. The member shall also be given a copy of the report by Special Notice. The hearing record and other documentation shall be transmitted to the Medical Staff Office for safekeeping as official records and minutes of the Medical Staff and shall be made available for review by any party between the hours of 8:00 a.m. and 4:30 p.m. Monday through Friday, excluding holidays.

Section 23. Action on Hearing Committee Report

Within thirty (30) days after receiving the hearing committee report, the body whose adverse action or recommended action occasioned the hearing shall consider said report and affirm, modify, or reverse its action or recommended action. It shall transmit the result to the Medical Director.

Section 24. Notice and Effect of Result

a. Notice

As soon as is reasonably practicable, the Medical Director shall send a copy of the result to the member by Special Notice and to the Chairperson of the Medical Executive Committee.

b. Effect of Favorable Result

(1) Adopted by the Governing Body: If the Governing Body's determination is favorable to the member, it shall become effective immediately.

(2) Adopted by the Medical Executive Committee: If the Medical Executive Committee result is favorable to the member, the Medical Director shall, as soon as is reasonably practicable, forward it to the Governing Body which may adopt or reject the result in whole or in part, or refer the matter back to the Medical Executive Committee for further reconsideration. Any referral back shall state the reasons, set a time limit within which a subsequent recommendation must be made, and may include a directive for an additional hearing. After receiving a subsequent recommendation and any new evidence, the Governing Body shall take action. Favorable action by the Governing Body shall become effective immediately.

c. Effect of Adverse Result

If the hearing results in an adverse recommendation, the member shall receive Special Notice of his or her right to request appellate review.

Section 25. Request for Appellate Review

A member shall have thirty (30) days after receiving Special Notice of an adverse result to file a written request for an appellate review. The request must be delivered to the Medical Director by Special Notice.

Section 26. Waiver by Failure to Request Appellate Review

A member who fails to request an appellate review within the time and in the manner specified in Section 24 of this Article IX shall have waived any right to a review. The waiver has the same force and effect as provided in Sections 5 and 6 of this Article IX, if applicable.

Section 27. Notice of Time and Place for Appellate Review

The Medical Director shall deliver a timely and proper request for appellate review to the Chairperson of the Governing Body. As soon as practicable, said Chairperson shall schedule an appellate review to commence not less than thirty (30) days nor more than sixty (60) days after the

Medical Director received the request. If the member is under suspension, he or she may request that the appellate review be held not later than twenty (20) days after the Medical Director has received the appellate review request. The Medical Director may grant the member's request after consultation with the Chairperson of the Medical Executive Committee or Governing Body. At least thirty (30) days prior to the appellate review, the Medical Director shall send the member Special Notice of the time, place, and date of the review. The time for appellate review may be extended by the Chairperson of the Governing Body for good cause.

Section 28. Appellate Review Body

The appellate review may be conducted by the Governing Body. The Chairperson of the Governing Body will appoint a committee consisting of three (3) to nine (9) members of the Governing Body to hear the appeal, including at least one (1) physician. The Chairperson shall designate one of the members as Chairperson.

Section 29. Nature of Proceedings

The proceedings by the review body are a review based upon the hearing record, the hearing committee's report, all subsequent results and actions, the written statements, if any, provided below, and any other material that may be presented and accepted. The presiding officer shall direct the Medical Staff Office to make the hearing record and hearing committee report available at the appellate review for use by any party. The review body shall determine whether the foregoing evidence demonstrates that the member has met the applicable burden of proof as required under Section 16 of this Article IX.

Section 30. Written Statements

The member may submit a written statement detailing the findings of fact, conclusions, and procedural matters with which he or she disagrees and his or her reasons. This written statement may cover any matters raised at any step in the hearing process. The statement shall be submitted to the appellate review body and to the group whose adverse action or recommended action occasioned the review through the Medical Director at least five (5) days prior to the scheduled date of the review, except if the time limit is waived by the review body or its presiding officer. A similar statement may be submitted by the body whose adverse action or recommended action occasioned the review, and if submitted, the Medical Director shall provide a copy to the member and to the appellate review body at least ten (10) days prior to the scheduled date of the appellate review.

Section 31. Presiding Officer

The Chairperson of the appellate review body is the presiding officer. He or she shall determine the order of procedure during the review, make all required rulings, and maintain decorum.

Section 32. Oral Statement

The appellate review body, in its sole discretion, may allow the parties or their representatives to personally appear and make oral statements in favor of their positions. Any party or representative appearing shall be required to answer questions put by any member of the review body.

Section 33. Consideration of New or Additional Matters

New or additional matters or evidence not raised or presented during the original hearing or in the hearing report and not otherwise reflected in the record may be introduced at the appellate review only at the discretion of the review body and only if the party requesting consideration of the matter or evidence demonstrates to the satisfaction of the review body that it could not have been discovered in time for the initial hearing. The requesting party shall provide, through the Medical Director, a written, substantive description of the matter or evidence to the appellate review body and the other party prior to its being introduced at the review. Any such new or additional matters or evidence shall be subject to the same rights of cross-examination, impeachment, and rebuttal provided at the hearing pursuant to Section 13 of this Article IX.

Section 34. Powers

The appellate review body has all the powers granted to the hearing committee, and any additional powers that are reasonably appropriate to or necessary for the discharge of its responsibilities.

Section 35. Presence of Members and Vote

A majority of the members of the review body must be present throughout the appellate review and deliberations. If a member is absent from any part of the proceedings, the presiding officer of the appellate review may, in his discretion, rule that said member shall not be permitted to participate further in the review or deliberations or in the decision of the review body.

Section 36. Recesses and Adjournments

The review body may recess and reconvene the proceedings without Special Notice for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. At the conclusion of the oral statements, if allowed, the appellate review shall be adjourned. The review body shall then, at a time convenient to itself, conduct its deliberations outside the presence of the parties.

Section 37. Action Taken

Within thirty (30) days after adjournment pursuant to Section 21 of this Article IX, the review body shall prepare its report and conclusion with the result as provided below. The Medical Director shall send notice of each action taken under Section 22 of this Article IX below to the Chairperson of the Medical Executive Committee for transmittal to the appropriate Staff authorities and to the member by Special Notice.

a. Governing Body Decision

(1) Within fifteen (15) days after adjournment, appellate review body shall make its decision, including a statement of the basis of the decision. The appellate review body may decide:

(a) that the adverse recommendation be affirmed;

(b) that the adverse recommendation be denied;

(c) that the matter be the subject of further hearing or other

appropriate procedures within a specified time period; or

(d) that modification of the adverse recommendation be made so that it is no longer unreasonable, arbitrary, capricious, or discriminatory.

If the appellate review body finds that the procedures were substantially complied with and that the adverse recommendation which is the subject of the appeal was not unreasonable, arbitrary, capricious, discriminatory, or lacking in basis, it shall affirm the adverse recommendation in its decision.

(2) A majority vote of the members of the appellate review body authorized to vote is required for an adverse decision.

(3) The decision of the appellate review body on behalf of the Governing Body shall be effective upon the date of such decision, unless reversed or modified by the Governing Body within thirty (30) days.

(4) A copy of the appellate review body's decision shall be sent to the member by Special Notice within five (5) days following its decision.

Section 38. Hearing Officer Appointment and Duties

The use of a hearing officer to preside at the evidentiary hearing is optional and is to be determined by, and the actual officer if any to be used is to be selected by the Chairperson of the Medical Executive Committee in conjunction with the Medical Director. A hearing officer may or may not be an attorney at law, but must be experienced in and recognized for conducting Medical Staff hearings in an orderly, efficient, and non-partisan manner.

Section 39. Number of Hearings and Reviews

Notwithstanding any other provision of these ASC Medical Staff Bylaws, no member shall be entitled as a right to more than one evidentiary hearing and appellate review with respect to the subject matter that is the basis of the adverse action or recommended action giving use to the right.

Section 40. Release

By requesting a hearing or appellate review under this Article IX, a member agrees to be bound by the provisions of Article VIII of these ASC Medical Staff Bylaws.

ARTICLE X – MEDICAL DIRECTOR

Section 1. Appointment

The Medical Director shall be appointed and approved by the ASC Governing Body. The Medical Director appointment may be cancelled by either the Governing Body or the Medical Director by providing thirty (30) days written notice to either party. The Medical Director shall perform the duties assigned by the ASC's Governing Body and by the Governing Body Bylaws and the ASC Medical Staff Bylaws.

Section 2. Responsibilities

The Medical Director is invested with the following duties and prerogatives:

1. Call and preside over Quality Improvement (QI) meetings.
2. Facilitate adherence of the Medical Staff of the ASC to the ASC Bylaws.
3. Be chief spokesperson and enunciator of policy for the Medical Staff.
4. Monitor adherence to policies with respect to patient rights.
5. Assist the Administrator in arranging for an appropriately trained, professional staff capable of providing safe, efficient, quality patient care.
6. Assist the Administrator in developing a structure that clearly delineates the authority and responsibility of the Medical Staff within the organization.
7. Take the initiative in developing, on behalf of the Medical Staff, appropriate policies and procedures for the safe, effective conduct of business and provision of patient care; and review all clinical policies and procedures of the ASC. The Medical Director shall be specifically authorized to approve (after consultation with the appropriate QI specialty representatives) and implement policies and procedures (subject to such subsequent QI review and ASC Governing Body ratification).
8. Take the initiative in developing, on behalf of the Medical Staff, Quality Improvement, Risk Management, and Peer Review programs in accordance with applicable standards.
9. Advise the Administrator in arranging for ancillary services including laboratory, radiology, and pathology services.
10. Carry out all other duties specifically entrusted to him/her by the QI, ASC Governing Body or any other provision of these Bylaws.

ARTICLE XI — COMMITTEES

The Governing Body, or Medical Director with the approval of the Governing Body, may establish such committees as are necessary to fulfill the functions of the ASC. Membership of the Medical Executive Committee and other committees established under this Article of the Bylaws will be by appointment of the Governing Body, with the advice of the Medical Director, unless otherwise specified.

Unless otherwise specified in these Bylaws or at the time of selection or appointment of a Committee, non-Medical staff members of a committee shall serve in an ex-officio capacity without a vote.

Committees of the Medical Staff described in the ASC Medical Staff Bylaws all function as "medical committees" and/or "medical peer review committees" pursuant to state law. Each committee's records and proceedings are, therefore, confidential, legally privileged, and protected from discovery under certain circumstances.

The function that the committee performs determines the protected status of its activities. Information is protected by the privilege if it is sought out or brought to the attention of the medical committee and/or medical peer review committee for purposes of an investigation, review, or other deliberative proceeding. Medical peer review activities include the evaluation of medical and health care services, including the evaluation of the qualifications of professional health care practitioners and of patient care provided by those practitioners. These review activities include evaluating the merits of complaints involving health-care practitioners, and determinations or recommendations regarding those complaints. The medical peer review privilege applies to records and proceedings of the committee, and oral and written communications made to a medical peer review committee when engaged in medical peer review activities. Medical committee

activities also include the evaluation of medical and health care services. The medical committee privilege protection extends to the minutes of meetings, correspondence between committee members relating to the deliberative process, and any final committee product, such as any recommendation or determination.

In order to protect the confidential nature of the quality and peer review activities conducted by the committee, the committee's records and proceedings must be used only in the exercise of proper medical committee and/or medical peer review functions to be protected as described herein. Therefore, committee meetings must be limited to only the committee members and invited guests who need to attend the meetings. The committee must meet in executive session when discussing and evaluating the qualifications and professional conduct of professional health care practitioners and patient care provided by those practitioners. At the beginning of each meeting, the committee members and invited guests must be advised that the records and proceedings must be held in strict confidence and not used or disclosed other than in committee meetings, without prior approval from the Chair of the committee. Documents prepared by or considered by committee in the committee meetings must clearly indicate that they are not to be copied, are solely for use by the committee, and are privileged and confidential.

The records and proceedings of the ASC departments ***that support*** the quality and peer review functions of a committee, such as the Patient Safety/Risk Management and Quality Program departments are also confidential, legally privileged, and protected from discovery, if the records are prepared by or at the direction of the committee, and are not kept in the ordinary course of business. Routine administrative records prepared by the ASC in the ordinary course of business are not legally privileged or protected from discovery. Documents that are gratuitously submitted to the committee, or which have been created without committee impetus and purpose, are also not protected.

Section 1. The Medical Executive Committee

a. Membership
All Active Medical Staff members are eligible for membership on the Medical Executive Committee. The Medical Director shall act as the Chair of the Medical Executive Committee.

b. Voting Members

The Medical Executive Committee shall consist of five (5) members of the Active Medical Staff, including the Medical Director. There shall be no more than one (1) committee member per specialty and there must be a committee member from anesthesiology.

c. Election of Voting Members

Voting members of the Medical Executive Committee will be elected every two (2) years. Nominations and voting will occur at the beginning of the first Medical Executive Committee meeting of the new term. In the event a voting member is unable to complete his or her term, a special election will occur at the next Medical Executive Committee to fill the position.

d. Ex-officio Non-Voting Members:

(1) The Administrator of the ASC at LBJ.

e. Invited Guests

At the request of a committee member, non-voting guests may attend meetings of the Medical Executive Committee.

f. Duties

(1) Report to the Governing Body on all evaluation, monitoring and recommendations regarding the appropriateness and quality of health care services rendered to the patients at the ASC;

(2) Review, investigate, and make recommendations on matters relating to the professional competence and conduct of Practitioners and APPs, including the merits of complaints and appropriate corrective action;

(3) Represent and act on behalf of the Medical Staff and APPs between meetings, subject to such limitations imposed by these Bylaws;

(4) Coordinate the activities of and initiate and implement general policies applicable to the Medical Staff;

(5) Receive and act upon committee reports;

(6) Act as the liaison between the Medical Staff and the Governing Body;

(7) Periodically review all information available concerning the performance and clinical competence of Practitioners and APPs with clinical priviliges and make recommendations for reappointment or changes in clinical privileges;

(8) Take all reasonable steps to ensure professional, ethical conduct and competent clinical performance on the part of the Practitioners and APPs with clinical privileges in the ASC;

(9) Review credentials of all applicants to the Medical Staff, as well as APPs, make recommendations on initial appointment and reappointment to the medical staff, and delineate clinical privileges;

(10) Perform appropriate functions related to quality assessment and improvement, medical records, surgery, infection control and antibiotic usage, tissue review, medical staff utilization, pharmacy and therapeutics, anesthesiology, and other such functions; and

(11) Perform other duties as requested by the Governing Body.

ARTICLE XII— IMMUNITY FROM LIABILITY

The following shall be express conditions to any Medical Staff member's application for clinical privileges within the ASC at LBJ:

Condition 1.

Any act, communication, report, recommendation, or disclosure, with respect to any such Medical Staff member performed, or made in good faith and without malice, for the purpose of achieving and maintaining quality patient care in this or any other health care facility, shall be privileged and immune from liability to the fullest extent permitted by law.

Condition 2.

All such privileges and immunities shall extend to members of The ASC at LBJ's Medical Staff and of its Governing Body, its other Practitioners, its Medical Director and his or her representatives, the Administrator of the ASC at LBJ, and to third parties who supply information to any of the foregoing authorized to receive, release, or act upon the same. For the purpose of this Article XVII, the term

"third parties" means both individuals and organizations who provide information to an authorized representative of the Governing Body or of the Medical Staff.

Condition 3.

There shall be, to the fullest extent permitted by law, absolute immunity from civil liability arising from any such act, communication, report, recommendation, or disclosure, even where the information involved would otherwise be deemed privileged.

Condition 4.

All such immunity shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with this or any other health care institution's activities, including, but not limited to:

a. Applications for appointment or clinical privileges;

b. Periodic reappraisals for reappointment or clinical privileges;

c. Corrective action, including summary suspension;

d. Hearings and appellate reviews;

e. Medical care evaluations;

f. Utilization reviews; and

g. Other ASC, department, service or committee activities related to quality patient care and inter-professional conduct.

Condition 5.

The acts, communications, reports, recommendations and disclosures referred to in this Article XII may relate to a Medical Staff member's professional qualifications, ethics, or any other matter that might directly or indirectly have an effect on patient care.

Condition 6.

Each Medical Staff member shall, upon request of the ASC at LBJ, execute a release in favor of the entities identified in the Second paragraph of this Section and consistent with the provisions of this Article XII.

ARTICLE X111 — CONFLICTS OF INTEREST

Section 1. Definitions

Conflicts of Interest – A conflict of interest potentially exists when a Medical Staff member, or a relative, has direct or indirect interests, including financial and personal interests, or business transactions or professional activities, that may compromise or appear to compromise: (1) the Medical Staff member's clinical judgment; (2) the delivery of patient care; or (3) the Medical Staff member's ability to fulfill his or her Medical Staff obligations.

Section 2. Compliance

Medical Staff members must comply with the Conflict of Interest policies of their affiliated organization (e.g. Baylor College of Medicine, The University of Texas Health Science Center at Houston, or Harris Health for Contract Practitioners and Medical Staff members employed by Harris Health).

Section 3. Disclosure of Potential Conflict of Interest

a. A Medical Staff member shall have a duty to disclose any conflict of interest when such interest is relevant to a matter of action (including a recommendation to Harris Health Administration or the Governing Body) being considered by a committee, department or other body of the Medical Staff. In a Medical Staff member's dealings with and on behalf of the ASC, the Medical Staff member shall be held to a strict rule of honest and fair dealing with the ASC. The Medical Staff member shall not use his or her position, or knowledge gained there from, so that a conflict might arise between the interests of the ASC and those of the Medical Staff member.

b. As a matter of procedure, the Chairperson of the Medical Staff committee or other body designated to consider a matter that may lead to the provision of items, services or facilities to the ASC by a third party or the establishment of a business relationship between a third party and the ASC shall inquire, prior to any discussion of the matter, whether any Medical Staff member has a conflict of interest. The existence of a potential conflict of interest on the part of any committee member may be called to the attention of the committee Chairperson by any Medical Staff member with knowledge of the matter.

c. Any Medical Staff member with a conflict of interest on any matter should not vote or use his or her personal influence regarding the matter, and he or she should not be counted in determining the quorum for the body taking action or making a recommendation to the Governing Body. The minutes of that meeting should reflect that a disclosure was made, the abstention from voting, and the quorum situation.

d. The foregoing requirements should not be construed as preventing the Medical Staff member from briefly stating his or her position in the matter, nor from answering pertinent questions by the Governing Body or other Medical Staff members since his or her knowledge may be of great assistance.

ARTICLE XIV — RULES AND REGULATIONS

The Medical Staff shall adopt such Rules and Regulations as may be necessary to implement more specifically the general principles found within these Bylaws, subject to the approval of the Governing Body. These shall relate to the proper conduct of Medical Staff organizational activities, as well as embody the level of practice that is to be required of each Practitioner in the ASC. Such Rules and Regulations shall be a part of these Bylaws, except that they may be amended or repealed without previous notice at any general Medical Staff meeting, or by the Medical Executive Committee or at any special Medical Staff meeting on notice, provided a quorum is present. A two-thirds affirmative vote of those present shall be required for amendment or repeal. Such changes shall become effective when approved by the Governing Body.

If the voting members of the Medical Staff propose to adopt a rule, regulation, or policy, or an amendment thereto, they shall communicate the proposal to the Medical Executive Committee prior to submission of the proposal to the Governing Body. If the Medical Executive Committee proposes to adopt a rule or regulation, or an amendment thereto, it first communicates the proposal to the Medical Staff. When the Medical Executive Committee proposes a policy or an amendment thereto, it shall thereafter report the change to the Medical Staff.

If the Medical Executive Committee or Medical Director identifies an urgent need for amendment to Rules and Regulations to comply with laws or regulations, the Medical Executive Committee may provisionally adopt, and the Governing Body may provisionally approve, an urgent amendment without prior notification of the Medical Staff. In such cases, the Medical Staff shall be immediately notified by the Medical Executive Committee. The Medical Staff shall have the opportunity for retrospective review of and comment on the provisional amendment. If there is no conflict between the Medical Staff and the Medical Executive Committee, the provisional amendment shall remain in place. If there is conflict over the provisional amendment, the process for resolving conflict between the Medical Staff and the Medical Executive Committee shall be implemented. If necessary, a revised amendment may be submitted to the Governing Body for action.

If there is a conflict between these Bylaws and the Rules and Regulations, the Bylaws shall prevail.

ARTICLE XV— PHYSICIAN/PRACTITIONER HEALTH ISSUES POLICY

The Medical Staff shall adopt such Physician/Practitioner Health Issues. Policy as may be necessary to implement more specifically the general principles found within these Bylaws, subject to the approval of the Governing Body. These shall relate to the proper conduct of Medical Staff organizational activities, as well as embody the level of practice that is to be required of each Practitioner in the ASC. Such Physician/Practitioner Health Issues Policy shall be a part of these Bylaws, except that the Policy may be amended or repealed without previous notice at any general meeting of Medical Staff, or by the Medical Executive Committee or at any special Medical Staff meeting on notice, provided a quorum is present. A two-thirds affirmative vote of those present shall be required for amendment or repeal. Such changes shall become effective when approved by the Governing Body.

ARTICLE XVI — CREDENTIALING POLICIES AND PROCEDURES

The Medical Staff shall adopt a Medical Staff Credentialing Procedures Manual as may be necessary to implement more specifically the general principles found within these Bylaws, subject to the approval of the Governing Body. These shall relate to the proper conduct of Medical Staff organizational activities, as well as embody the level of practice that is to be required of each Practitioner in the ASC. Such Medical Staff Credentialing Procedures Manual shall be a part of these Bylaws, except that the Manual may be amended or repealed without previous notice at any general meeting of Medical Staff, or by the Medical Executive Committee or at any special Medical Staff meeting on notice, provided a quorum is present. A majority vote of those present shall be required for amendment or repeal. Such changes shall become effective when approved by the Governing Body.

ARTICLE XVII — AMENDMENTS

Section 1. Amendment Process

a. Amendment(s) to the Bylaws may be proposed at any meeting of the Medical Executive Committee.

b. All proposed amendments to the Bylaws approved by the Medical Executive Committee shall be submitted to the members of the Active Medical Staff for approval.

The proposed amendment(s) to be adopted shall require a majority vote of the Active Medical Staff voting on the proposed amendment. Proposed Bylaws may be voted on at any regular or special meeting of the Medical Staff or submitted to the members of the Active Medical Staff for vote by written or electronic ballot, as approved by the Medical Executive Committee. Notice of such regular or special meeting shall be made at least fifteen (15) days in advance and shall include the Bylaws amendment(s) to be voted upon.

c. Bylaws Amendment(s) approved by the Medical Executive Committee and the Medical Staff shall be forwarded to the Governing Body, which shall approve, disapprove or approve with modifications. If the Governing Body modifies any Bylaw amendments approved by the Medical Executive Committee and the Medical Staff, such amendments, as modified, shall be returned to the Medical Executive Committee, which may accept or reject the modifications. If the Medical Executive Committee accepts the modifications, the amendment shall be submitted to the members of the Active Medical Staff for approval or disapproval as described in Section (b) above. If the Medical Executive Committee rejects the modification, the amendment shall be submitted again to the Governing Body, which may either approve or disapprove the amendment. Any disputes regarding proposed bylaws amendments shall be referred to the Joint Conference Committee for discussion and further recommendation to the Medical Executive Committee and the Governing Body.

d. Bylaws Amendments may also be proposed to the Governing Body by the Medical Staff by majority vote of the members of the Active Medical Staff voting on the proposed amendment. Proposed Bylaws shall be brought before the Active Medical Staff by petition signed by 20% of the members of the Active Staff. Any such proposed Bylaw amendment shall be submitted to the Medical Executive Committee for review and comment before it is submitted to the voting members of the Active Medical Staff. Any Bylaw amendment approved by a majority of the Active Medical Staff shall be presented to the Governing Body for final action along with any comments from the Medical Executive Committee.

e. These Bylaws, and all amendments thereto, shall be effective when approved by the Governing Body, unless otherwise stated in the Bylaw provision or amendment approved by the Governing Body, and shall apply to all pending matters to the extent practical, unless the Governing Body directs otherwise.

f. These Bylaws shall not be unilaterally amended by the Governing Body or the Medical Staff.

Section 2. Editorial Amendments

Notwithstanding Section 1 of this Article XVIII, the Medical Staff Services shall have the authority to make non-substantive editorial changes to the Bylaws and to correct any typographical, formatting, and inadvertent errors.

Section 3. Review Process

These Bylaws shall be reviewed at least annually and amendments made according to the described amendment procedure.

ARTICLE XVIII — PARLIAMENTARY PROCEDURES

Where these Bylaws do not conflict, *Robert's Rules of Order* shall be used in the conduct of Medical Staff meetings.

ARTICLE XIX — CONFLICT MANAGEMENT

A conflict management process shall be developed and implemented when a conflict arises between the Medical Executive Committee and Medical Staff on issues including, but not limited to, proposals to adopt provisions of, or amendments to, the Rules and Regulations or these Bylaws. The conflict management process shall include a meeting between the involved parties as early as possible to identify the conflict, gathering information about the conflict, working with all parties to manage and, to the extent possible, resolve the conflict, and ultimately protect patient safety and quality of care. As necessary, the Medical Director shall appoint an individual to act as mediator between the groups in an effort to resolve the conflict. The Governing Body shall have the ultimate discretion to determine an effective resolution to any conflict between the Medical Staff and the Medical Executive Committee, should the parties not be able to come to a resolution. The Governing Body shall regularly review whether the process is effective at managing conflict and shall revise the process as necessary.

ARTICLE XX - ADOPTION

These Bylaws shall be adopted at any regular or special meeting of the Active Staff, shall replace any previous Bylaws, and shall become immediately effective when approved by the Governing Body of The Ambulatory Surgical Center (ASC) at LBJ.

Accepted and adopted by the Medical Director and Chair of the Medical Executive Committee of the Ambulatory Surgical Center (ASC) at LBJ and the ASC Governing Body on March 29, 2018.

Scott Perry, MD
Medical Director, Chair of Medicial Executive Committee
ASC at LBJ

Ewan D. Johnson, MD
Chair, ASC Governing Body

BOARD OF TRUSTEES

HARRISHEALTH SYSTEM

Ambulatory Surgical Center at LBJ Governing Body

Thursday, February 17, 2022

Ambulatory Surgical Center at LBJ Medical Director and Administrator Reports

Report Regarding Medical Staff Operations, Clinical Operations, Statistical Analysis of Services Performed and Operational Opportunities at the ASC at LBJ, Including Questions and Answers.

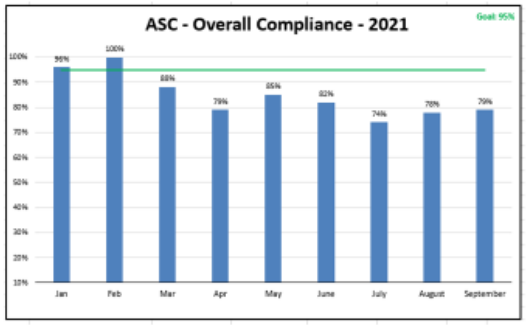
MINUTES OF THE AMBULATORY SURGERY CENTER MEDICAL EXECUTIVE COMMITTEE
Harris Health System
October 26, 2021 7:00 am

AGENDA ITEM	DISCUSSION	ACTION/RECOMMENDATIONS
CALL TO ORDER	The meeting was called to order at 7:00 a.m. by Scott Perry, MD, Chairperson.	**As reported.**
MINUTES OF THE PREVIOUS MEETING	The September 28, 2021 minutes of the Ambulatory Surgery Center (ASC) Medical Executive Committee were approved as presented.	**The minutes will be presented to the ASC Governing Board for acceptance.**
ANNOUNCEMENTS/INFORMATION	**Staffing at the ASC & OR Block Schedule** Dr. Perry stated that we have been operating under very limited resources (between 2-3 rooms for most of October). He stated that we will be at 4 rooms starting today and for the remainder of the week. We will operate between 3-4 rooms next week with one day possibly at 5 rooms. This will remain going into November. We will be releasing block schedules every two weeks so we can be fluid and flexible with our staffing. Stephanie Ramirez sent a new schedule out yesterday that covers through early November.	
UNFINISHED BUSINESS	**ASC Pre-Operative Screening Clinic Report** Dr. Perry stated that there have been several interviews for a medical director for the pre-op clinic. Dr. Doyle has headed up the search and interview committee to find the new medical director. **Resident Outreach Education** Dr. Perry stated that most of our hand hygiene fallouts have been around the residents and medical students. We have made efforts to try to target residents and medical students. We have developed a corrective action plan around our hand hygiene numbers, which have consistently fallen just below benchmark. Ms. Kimes presented the most recent hand hygiene data. She presented the overall ASC compliance for 2021 and the “clean-in”/“clean-out” compliance for September broken down by category of staff.	

AGENDA ITEM	DISCUSSION	ACTION/RECOMMENDATIONS

HARRISHEALTH SYSTEM

September Hand Hygiene 2021



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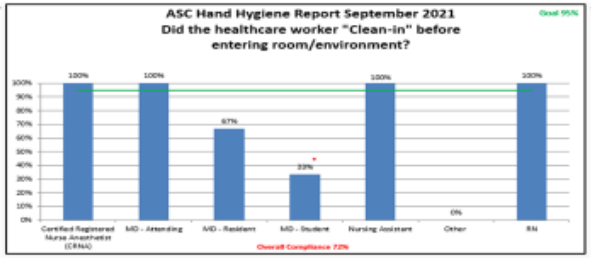
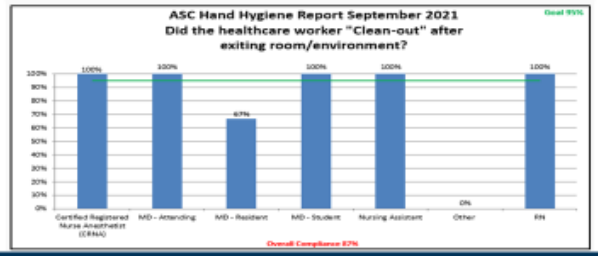
HARRISHEALTH SYSTEM





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AGENDA ITEM	DISCUSSION	ACTION/RECOMMENDATIONS
	The 5 Moments for Hand Hygiene was developed by Quality and IP using the World Health Organization guidelines and is what the ASC is using to base their program on.  She reviewed pictures of the preop area and PACU bays showing the location of dispensers and the patient zones for each. She also reviewed pictures of the ASC OR. Focus is on identifying opportunities with the medical students, residents and faculty. Dr. Perry addressed the zones for the OR, asking if one is considered compliant if they foam in at the outside and walk in or is it required again when passing through to the OR since it may not have been witnessed from inside the OR. Ms. Kimes stated that this should count as compliant. The dispenser outside the door can be heard inside the room and those inside also witness when one walks through the doors rubbing their hands. The opportunities identified in the operating room are during the times of transporting patients to and from the room. She stated that they will be going into more detail in QRC. Dr. Chung asked what the methodology was for informing someone of a fall-out and if it was done in real time. Ms. Kimes stated that we have Just in Time coaches and observers that are supposed to intervene and address issues as they are happening or right after. We are down to 2 coaches and one observer. Part of our corrective action plan is to increase these numbers to have more interaction with the students and residents. Dr. Perry stated that the Just in Time coaches are very proactive and	

AGENDA ITEM	DISCUSSION	ACTION/RECOMMENDATIONS
	interactive when they identify fall-outs. It is hoped that we can increase our efforts as we get staffed back up over the next several weeks.	
NEW BUSINESS	**Provisional Status** Dr. Perry stated that he has been working with Adriana Barron on issues related to provisional status. According to our Bylaws, a provider is put on provisional status when credentialed at ASC. The provider is required to do 10 cases during that 120 day period. If they don't do those 10 cases, they lose their credentialing or have to come back to the MEC to extend that provisional status. We have discussed the possibility of eliminating provisional status from the Bylaws. The Bylaws would be changed to require 10 cases within one year. A provider would lose their privileges if they did not get those 10 cases within that one year period. Providers that do low their privileges at ASC would not be able to automatically reapply for credentials. Adriana presented a draft of the Bylaws change. She stated that it has been a challenge meeting the requirements that are currently in the Bylaws but changes also need to take into consideration that we want active staff credentialed in the ASC. One recommendation is to remove the provisional category and add a clause for reappointments. The provider's case number would need to be reviewed at the time of reappointment. Discussion ensued. Dr. Millas stated that there are many providers that come infrequently and small services that do not do many cases in the ASC. He asked how we account for those categories of individuals. Dr. Ko asked why we have provisional status and if it was an industry standard. We are not a typical community ASC and we take care of Harris Health patients at the surgical center. When we have a need for physicians due to illness or staff vacancies, we end up rushing to find coverage. Carolynn Jones stated that there is no regulatory requirement to have this provisional status. However, it was brought forward as a best practice by the consultant we worked with to set up the ASC. It is used as a way for the ASC to keep their medical staff smaller, more focused and more efficient. It is used primarily on the private side but there was also a desire to not have another 2000+ medical staff. We do need to discuss workflow efficiencies if we're going to have a larger medical staff and what that would mean for MSS. Dr. Perry stated that there is also an administrative burden as far as AAAASF requirements. Dr. Ko stated that there is a difference between being on staff and never operating here versus staff who have only done 5-10 cases in two years. The discussion might need to focus on what that minimum number of cases should be. Discussion ensued. Ms. Jones stated that one idea would be to develop minimum case numbers by service based on the amount of block time devoted to that service. Dr. Perry agreed with that idea, stating that it makes sense for the minimum number to be proportional to the size of the service. The committee was in agreement with discussing this further and starting the process of amending the Bylaws.	
STANDING BUSINESS	**Medical Staff Services Report** *Credentialing* Ms. Barron presented two initial appointments for approval. Both are clean files.	

AGENDA ITEM	DISCUSSION	ACTION/RECOMMENDATIONS

Initial Appointments

Last Name	First Name	Degree	Service
Chen	Grant	MD	Anesthesiology
Rysavy	Mary	MD	OB/GYN

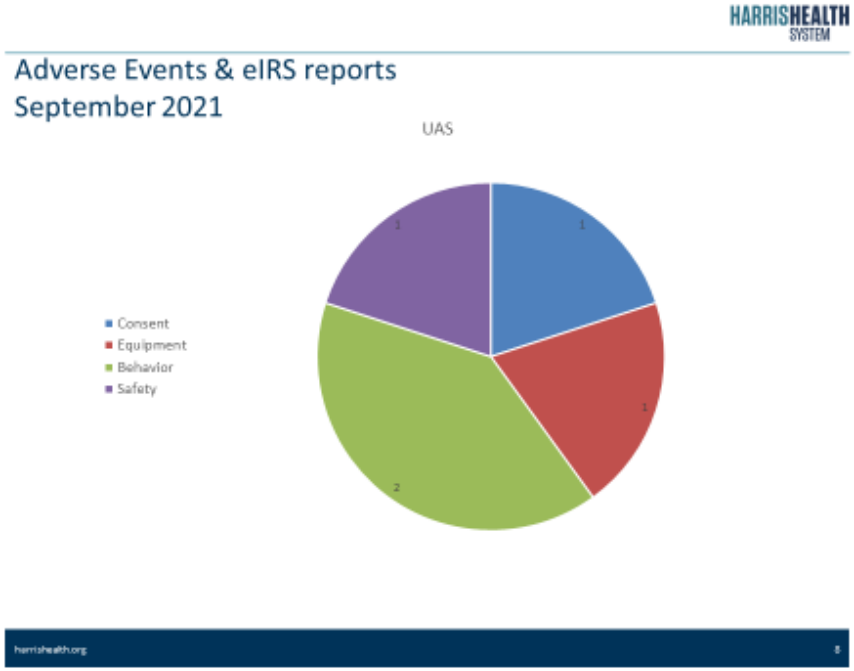
It was moved and seconded to approve all credentialing files as presented. Motion carried.

It was moved and seconded to approve all files for temporary privileges. Motion carried.

Quality Presentation

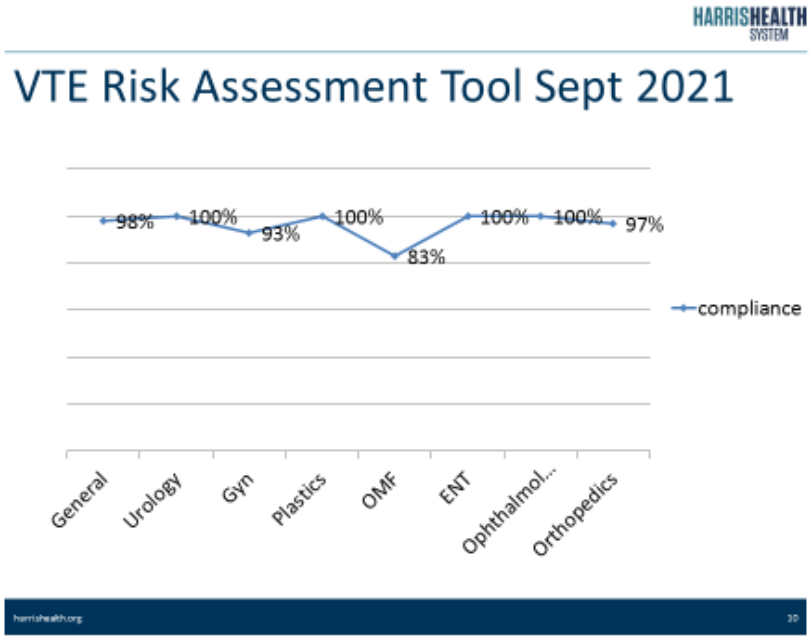
AAAASF Patient Safety Data Reporting

Amy Kimes presented the ASC Quality (September) Report. She presented adverse events for September.



It was moved and seconded to approve all credentialing files as presented. Motion carried.

It was moved and seconded to approve all files for temporary privileges. Motion carried.

AGENDA ITEM	DISCUSSION	ACTION/RECOMMENDATIONS
	There were 7 EC visits after ASC encounter, which is a decrease from previous months. The breakdown was presented to the committee. She presented compliance for VTE Risk Assessment for September. There were only 5 fall-outs out of 238 surgical cases for the month.  She addressed Patient Safety Data Reporting, stating that we are in Reporting Period IV (October-December) and cases are due January 15. She reviewed the preop documentation requirements as a reminder.	
ADMINISTRATIVE REPORT	**ASC Scorecard** Mr. Reeder presented the ASC Scorecard for information and review. He stated that we continue to have challenges around EC visits and unplanned hospital admissions. Our patient satisfaction numbers have started to go back up again with our biggest challenges being pain control and communication. He reviewed case volumes, elective block utilization, first case on-time starts, turnover times, and cancellation rates. Dr. Ko stated that during this last surge, we were waiving co-pays or at least delaying the collection of co-pays for patients coming through the EC that could have their case done at ASC. He asked what the status of this was. Without this waiver, surgeons are forced to admit these patients for surgery in the main	

AGENDA ITEM	DISCUSSION	ACTION/RECOMMENDATIONS
	hospital. This is obviously less efficient and also contributes to boarding hours and lack of hospital beds. Pollie Martinez stated that the waiver has not expired and we are looking at bringing back the required deposit in November. However, we can work to waive the deposit and set up a payment plan on a case by case basis for those patients that need it. Discussion ensued. Dr. Ko stated that fractures are not emergencies but are time sensitive. Those patients will need to be done in the main hospital if not approved for ASC. Ms. Martinez stated that her team works closely with Dr. McAlister's team and the self-pay patients. An override is an option and the patient will receive the bill for services after the visit. She stated that they are also sometimes able to get patients screened and their eligibility done within one day. Dr. McAlister stated that one of the proposals he made in the past was to actually change the process and have a separate category of patient – the cash requirement would be waived for those patients. Dr. Ko suggested we look into this. We need to hardwire the process to make it more streamlined. Dr. Perry agreed. He stated that he would follow-up with Ms. Martinez and Dr. McAlister. Dr. Chung asked if there had been any change in no-show rates for those cases with waived co-pays. Dr. McAlister stated that they have not seen that from the orthopedic side.	**Dr. Perry will follow-up with Pollie Martinez and Dr. McAlister.**
ADJOURNMENT	There being no further business to come before the committee, the meeting was adjourned at 7:55 a.m.	

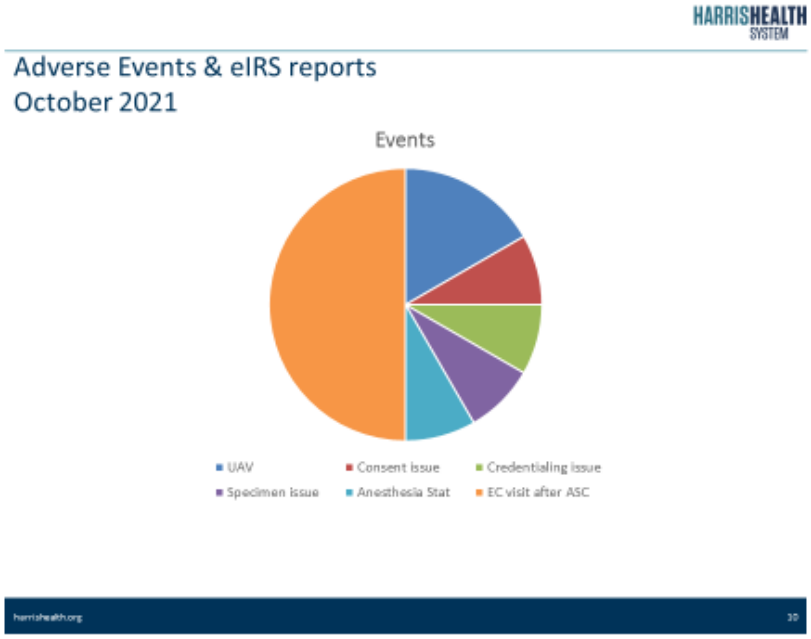
Scott Perry, M.D., Chairperson

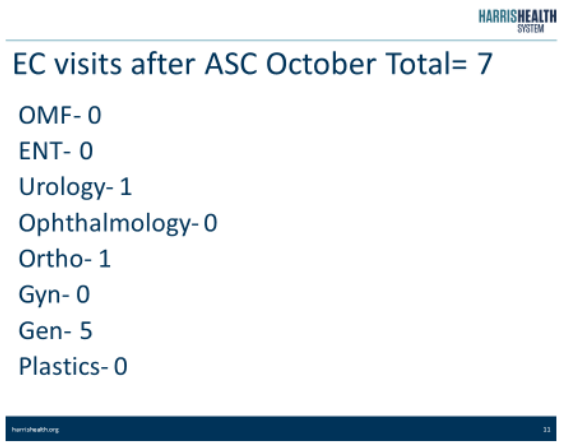
Minutes recorded by Medical Staff Services (CR)

MINUTES OF THE AMBULATORY SURGERY CENTER MEDICAL EXECUTIVE COMMITTEE
Harris Health System
November 30, 2021 7:00 am

AGENDA ITEM	DISCUSSION	ACTION/RECOMMENDATIONS
CALL TO ORDER	The meeting was called to order at 7:00 a.m. by Scott Perry, MD, Chairperson.	
MINUTES OF THE PREVIOUS MEETING	The October 26, 2021 minutes of the Ambulatory Surgery Center (ASC) Medical Executive Committee were approved as presented.	**Approved**
ADMINISTRATIVE REPORT	**ASC Scorecard** Matt Reeder presented the ASC Scorecard, stating that numbers were consistent with prior month. We had some issues with unplanned anterior vitrectomies in October. We had a challenge around residents performing assessments and failing to include the portion addressing how one lens may be more fragile than another. We have reeducated some of the residents and should see an improvement for the November report. We continue to work through our emergency department visits. We did not have any unplanned hospital admissions for the month. Our patient experience numbers continue to fluctuate month to month. Matt Reeder presented the OR dashboard for October. He reviewed elective block utilization for the month, noting that ENT was at 85% and General Surgery at 87%. We still have some challenges around first case on time starts. We do not have any grace period and it is not industry standard to have a grace period. Turnover time was reviewed and was at 21 minutes for the month. Dr. Brass stated that we will be having a separate meeting with the team about unplanned admissions and visits to the EC. There is some work underway to drill down on the causes of those occurrences. He asked if information related to causes, hours of occurrences and related discharges, and education/information given for after hours could be sent to him prior to that meeting. It would be helpful to have this to understand what the main issues are and how the current processes are working. Mr. Reeder stated that he would email that information to Dr. Brass and Louis Smith. Dr. McAlister stated that the Chiefs of Service were receiving daily/weekly updates related to first case on time starts. He asked if this would pick back up when staffing levels improved. Mr. Reeder stated that he would begin working on getting those updates out again.	
ANNOUNCEMENTS/INFORMATION	**Introduction – Rebecca Lee** Dr. Perry introduced and welcomed Rebecca Lee, the new ASC OR manager. She is a NP and has experience working in the operating room. We are looking forward to having her leadership experience and abilities as we rebuild our OR team. **Flu Vaccine Deadline** Adriana Barron reminded the committee that today is the flu vaccination deadline. We are at 84% compliance for faculty as of yesterday - another report will be run this morning. Providers that do not provide proof of vaccination or an approved exemption request will have their Epic access inactivated and will not be able to provide patient care.	

AGENDA ITEM	DISCUSSION	ACTION/RECOMMENDATIONS
	OR Staffing Dr. Perry stated that the biggest challenge in the ASC right now is related to OR staffing. We have 3 rooms running today and that number will fluctuate over the next several weeks. We are continuing to focus on recruitment and have put in an inquiry around equalizing the pay scale between the ambulatory side and the inpatient side. He will continue to make the block schedule 2 weeks in advance for the current time.	
UNFINISHED BUSINESS	**Resident Outreach Education** Dr. Perry stated that we started a new initiative around hand hygiene targeting our trainees to help improve compliance. Amy Kimes presented the most recent hand hygiene data. She stated that the fallouts over the past several months were primarily around our residents and medical students. She presented compliance for the current calendar year. We saw a small increase in compliance for October but our numbers from the current campaign will not show up until the next report. The compliance by location (OR and Pre-Op/PACU) and by provider type was presented. We still have a lot of work to do and continue to identify opportunities for improvement. Discussion ensued regarding just in time training. Dr. Brass will contact Dr. Perry to discuss this topic offline. The 5 Moments for Hand Hygiene was developed by Quality and IP using the World Health Organization guidelines and is what the ASC is using to base their program on.  	

AGENDA ITEM	DISCUSSION	ACTION/RECOMMENDATIONS
	She reviewed pictures of the preop area and PACU bays showing the location of dispensers and the patient zones for each. She also reviewed pictures of the ASC OR. **Provisional Status Update – Proposed Changes to Bylaws** Dr. Perry stated that a proposed change to the Bylaws was sent to the committee members. The changes were to the sections addressing active, affiliate, and active status. The proposal removes the language on provisional staff, which is the initial status when joining the ASC. Credentialed providers would then only be liable for those 10 cases per year and no longer the 10 cases within the first 90 days. The committee discussed the pros and cons of the proposed changes. A meeting will be set up offline to discuss the proposed changes.	
STANDING BUSINESS – Contd.	**Quality Presentation** **AAAASF Patient Safety Data Reporting** Amy Kimes referred back to the ASC Quality (October) Report. She presented the adverse events and eIRS reports for the month. AAAASF is going to require all EC visits after an ASC encounter to be reported as an adverse event effective 10-18-21.  	

AGENDA ITEM	DISCUSSION	ACTION/RECOMMENDATIONS
	She presented the breakdown of EC visits after ASC for October.  Discussion ensued regarding the new reporting standards for EC visits. For committee purposes, the EC visits will be broken out by time from ASC discharge. VTE Risk Assessment compliance for October was reviewed. ENT was at 80% but they are a lower volume service so any fall outs will greatly impact their numbers. There were 4 fallouts for the month resulting in 98% compliance overall. She reviewed reminders for patient safety data reporting and preop documentation requirements.	
ADJOURNMENT	There being no further business to come before the committee, the meeting was adjourned at 7:45 a.m.	

Scott Perry, M.D., Chairperson

Minutes recorded by Medical Staff Services (CR)

BOARD OF TRUSTEES

HARRISHEALTH SYSTEM

Ambulatory Surgical Center at LBJ Governing Body

Thursday, February 17, 2022

Executive Session

Consideration of Approval of Medical Staff Applicants and Privileges for the ASC at LBJ, Pursuant to Tex. Health & Safety Code Ann. §161.032 and Tex. Occ. Code Ann. §160.007 to Receive Peer Review and/or Medical Committee Report in Connection with the Evaluation of the Quality of Medical and Health Care Services, Including Possible Action Upon Return to Open Session.

- Pages 428-435 Were Intentionally Left Blank-

BOARD OF TRUSTEES

HARRISHEALTH SYSTEM

Ambulatory Surgical Center at LBJ Governing Body

Thursday, February 17, 2022

Executive Session

Report by the Executive Vice President, Chief Compliance and Risk Officer, Regarding Compliance with Medicare, Medicaid, HIPAA and Other Federal and State Health Care Program Requirements Including a Status of Fraud and Abuse Investigations, Pursuant to Texas Health & Safety Code §161.032, and Possible Action Regarding This Matter Upon Return to Open Session.

This information is being presented for informational purposes only.

BOARD OF TRUSTEES

HARRISHEALTH SYSTEM

Ambulatory Surgical Center at LBJ Governing Body

Thursday, February 17, 2022

Executive Session

Report by the Chief Medical Executive Regarding Quality of Medical and Health Care, Pursuant to Tex. Health & Safety Code Ann. §161.032 and Tex. Occ. Code Ann. §160.007 to Receive Peer Review and/or Medical Committee Report in Connection with the Evaluation of the Quality of Medical and Health Care Services including ASC at LBJ Quality Scorecard Report, Quality Review Committee Report and Medical Executive Committee Report, Including Possible Action Upon Return to Open Session.

- Pages 438-446 Were Intentionally Left Blank-