HARRISHEALTH

AMBULATORY SURGICAL CENTER (ASC) AT LBJ GOVERNING BODY

Thursday, February 20, 2025
9:00 A.M.

BOARD ROOM
4800 Fournace Place, Bellaire, Texas 77401

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

Notice: Members of the Governing Body may participate by videoconference.

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**	**Ms. Libby Viera-Bland**	**1 min**
II.	**Approval of the Minutes of Previous Meeting**	**Ms. Libby Viera-Bland**	**1 min**
	• ASC at LBJ Governing Body Meeting – November 21, 2024		
III.	**Executive Session**	**Ms. Libby Viera-Bland**	**30 min**
A.	Discussion Regarding Medical Staff Applicants and Privileges for the Ambulatory Surgical Center (ASC) at LBJ, Pursuant to Tex. Occ. Code Ann. §160.007 and Tex. Health & Safety Code Ann. §161.032 to Receive Peer Review and/or Medical Committee Report in Connection with the Evaluation of the Quality of Medical and Health Care Services, Including Consideration of Approval of Medical Staff Applicants and Privileges for the ASC at LBJ Upon Return to Open Session ***– Dr. Scott Perry***		*(10 min)*
B.	Report by the Vice President, Deputy Compliance 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 ***– Mr. Anthony Williams***		*(10 min)*
C.	Report Regarding Quality of Medical and Healthcare, 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 Healthcare 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. Matasha Russell, Dr. Scott Perry and Mr. Matthew Reeder***		*(10 min)*

IV.	**Reconvene**	**Ms. Libby Viera-Bland**	**2 min**
V.	**General Action Item(s)**	**Ms. Libby Viera-Bland**	**10 min**
	A. General Action Item(s) Related to Quality: ASC at LBJ Medical Staff		
	1. Consideration of Approval of Credentialing Changes for Members of the Harris Health ASC at LBJ Medical Staff **– *Dr. Scott Perry***		*(5 min)*
	B. General Action Item(s) Related to Policy and Procedures		
	1. Consideration of Approval of New and/or Amended Policies and Procedures for the ASC at LBJ **– *Mr. Matthew Reeder and Dr. Scott Perry***		
	2. Consideration of Approval of Reviewed Policies and Procedures with No Recommended Changes for the ASC at LBJ **– *Mr. Matthew Reeder and Dr. Scott Perry***		
	C. Miscellaneous General Action Item(s)		
	1. Consideration of Approval of the 2025 Annual Meeting Schedule of the ASC and LBJ Governing Body **– *ASC Governing Body***		*(5 min)*
VI.	**ASC at LBJ Medical Director and Administrator Reports**	**Ms. Libby Viera-Bland**	**15 min**
	A. Report Regarding Medical Staff Operations, Clinical Operations, Statistical Analysis of Services Performed and Operational Opportunities at the Ambulatory Surgical Center, Including Questions and Answers **– *Dr. Scott Perry and Mr. Matthew Reeder***		
	• Safety: Accreditation Status		
VII.	**Adjournment**	**Ms. Libby Viera-Bland**	**1 min**

HARRISHEALTH

MINUTES OF THE HARRIS HEALTH
AMBULATORY SURGICAL CENTER AT LBJ GOVERNING BODY MEETING
November 21, 2024
9:00 AM

AGENDA ITEM	DISCUSSION	ACTION/RECOMMENDATIONS
I. Call to Order & Record of Attendance	The meeting was called to order at 9:01 a.m. by Ms. Carol Paret, Chair. It was noted that a quorum was present and the attendance was recorded. Ms. Paret stated that while some Board members are in the room, others will participate by videoconference as permissible by state law and the Harris Health Videoconferencing Policy. Only participants scheduled to speak have been provided dial in information for the meeting. All others who wish to view the meeting may access the meeting online through the Harris Health website: http://harrishealthtx.swagit.com/live.	**A copy of the attendance is appended to the archived minutes.**
II. Approval of the Minutes of the Previous Meeting	• ASC at LBJ Governing Body Meeting – August 22, 2024	**Motion No. 24.11 – 25** **Moved by Mr. Jim Robinson, seconded by Ms. Libby Viera - Bland, and unanimously passed that the Governing Body approve the minutes of the August 22, 2024 meeting. Motion carried.**
III. Executive Session	At 9:03 a.m., Ms. Paret stated that the ASC Governing Body would enter into Executive Session for Items 'A through C' as permitted by law under Tex. Health & Safety Code Ann. §161.032 and Tex. Occ. Code Ann. §160.007.	
	A. Discussion Regarding Medical Staff Applicants and Privileges for the Ambulatory Surgical Center (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 Consideration of Approval of Medical Staff Applicants and Privileges for the ASC at LBJ Upon Return to Open Session	**No Action Taken.**
	B. Report by the Vice President, Deputy Compliance 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	**No Action Taken.**

	C. Report Regarding Quality of Medical and Healthcare, Pursuant to Tex. Occ. Code Ann. §160.007 and Tex. Health & Safety Code Ann. §161.032 to Receive Peer Review and/or Medical Committee Report in Connection with the Evaluation of the Quality of Medical and Healthcare 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	**No Action Taken.**
IV. Reconvene	At 9:12 a.m., Ms. Paret reconvened the meeting in open session; she noted that a quorum was present and that no action was taken in Executive Session.	
V. General Action Item(s)	**A.** General Action Item(s) Related to Quality: ASC at LBJ Hospital Medical Staff	
	1. Approval of Credentialing Changes for Members of the Harris Health System ASC at LBJ Medical Staff Dr. Scott Perry, Medical Director, ASC, presented the credentialing changes for members of the Harris Health System ASC at LBJ Medical Staff. For November 2024, there were five (5) initial appointments and fifty – six (56) reappointments. A copy of the credentialing report is available in the permanent record.	**Motion No. 24.11 – 26** **Moved by Mr. Jim Robinson, seconded by Ms. Libby Viera - Bland, and unanimously passed that the Governing Body approve V.A.1. Motion carried.**
	B. Miscellaneous General Action Item(s)	
	1. Discussion and Appropriate Action to Elect Officers of the ASC at LBJ Governing Body in Accordance with Article V, Section 2 of Governing Body Bylaws of the Ambulatory Surgical Center (ASC) at LBJ Ms. Paret announced that according to Article V, Section 2 of the Governing Body Bylaws of the Ambulatory Surgical Center at LBJ, an election must be held for the position of Chair for the 2025 Calendar Year. She opened the floor for nominations for the role of Chair. Ms. Libby Viera-Bland accepted the nomination, and no other nominations were made from the floor. Ms. Paret then called for a roll call vote for the position of Chair as follows: • Ms. Carol Paret – Aye • Mr. Jim Robinson – Aye • Ms. Libby Viera – Bland – Aye • Dr. Glorimar Medina – Aye The final results were announced with four (4) votes in favor of Ms. Libby Viera-Bland as the Chair.	**Motion No. 24.11 – 27** **Moved by Ms. Carol Paret, seconded by Mr. Jim Robinson, and unanimously passed that the Governing Body approve V.C.1. Motion carried.**

VI.	**ASC at LBJ Medical Director and Administrator Reports**	**A.** Report Regarding Medical Staff Operations, Clinical Operations, Statistical Analysis of Services Performed and Operational Opportunities at the ASC at LBJ Including Questions and Answers Mr. Matthew Reeder, Administrator of the ASC, stated that the ASC is continuously optimizing its operations, participating in the system-wide satisfaction survey, and expanding its staff to provide the highest quality care to the patients of Harris Health.	**As Presented.**
VII.	**Adjournment**	There being no further business to come before the Governing Body, the meeting adjourned at 9:18 a.m.	

I certify that the foregoing are the Minutes of the Harris Health ASC at LBJ Governing Body Meeting held on November 21, 2024.

Respectfully Submitted,

Carol Paret, BS, Presiding Chair

Recorded by Cherry A. Pierson, MBA

Thursday, November 21, 2024
Harris Health Ambulatory Surgical Center (ASC) at LBJ Governing Body Attendance

GOVERNING BODY MEMBERS PRESENT	GOVERNING BODY MEMBERS ABSENT	OTHER BOARD MEMBERS PRESENT
Carol Paret *(Presiding Chair)*		
Dr. Glorimar Medina		
Jim Robinson		
Libby Viera-Bland		
Matthew Reeder		
Dr. Scott Perry		

HARRIS HEALTH EXECUTIVE LEADERSHIP, STAFF & SPECIAL INVITED GUESTS	
Alexander Barrie	Louis Smith
Anthony Williams	Maria Cowles
Catherine Walther	Dr. Matasha Russell
Cherry Pierson	Micah Rodriguez
Daniel Smith	Nicholas J. Bell
Derek Curtis	Patricia Darnauer
Ebon Swofford *(Harris County Attorney's Office)*	Randy Manarang
Elizabeth Hanshaw Winn *(Harris County Attorney's Office)*	Randy Polanco
Dr. Esmaeil Porsa, *Harris Health System President & Chief Executive Officer*	Samuel De Leon
Dr. Jackie Brock	Sara Thomas *(Harris County Attorney's Office)*
Dr. Jennifer Small	Shawn DeCosta
Jennifer Zarate	Dr. Steven Brass
Jerry Summers	Tekhesia Phillips
Jessey Thomas	Dr. Tien Ko
John Matcek	

Virtual Attendee Notice: *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.*

BOARD OF TRUSTEES

Ambulatory Surgical Center at LBJ Governing Body

HARRISHEALTH

Thursday, February 20, 2025

Executive Session

Discussion Regarding Medical Staff Applicants and Privileges for the Ambulatory Surgical Center (ASC) at LBJ, Pursuant to Tex. Occ. Code Ann. §160.007 and Tex. Health & Safety Code Ann. §161.032 to Receive Peer Review and/or Medical Committee Report in Connection with the Evaluation of the Quality of Medical and Health Care Services, Including Consideration of Approval of Medical Staff Applicants and Privileges for the ASC at LBJ Upon Return to Open Session.

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BOARD OF TRUSTEES

Ambulatory Surgical Center at LBJ Governing Body

HARRISHEALTH

Thursday, February 20, 2025

Executive Session

Report Regarding Quality of Medical and Healthcare, 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 Healthcare 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.

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BOARD OF TRUSTEES

Ambulatory Surgical Center at LBJ Governing Body

HARRISHEALTH

Thursday, February 20, 2025

Consideration of Approval of Credentialing Changes for Members of the Harris Health Ambulatory Surgical Center at LBJ Medical Staff

Ambulatory Surgical Center Governing Body

HARRISHEALTH SYSTEM

February 2025 Medical Staff Credentials Report

Medical Staff Initial Appointments: 4

Medical Staff Reappointments: 15

Medical Staff Files for Discussion: 1

BOARD OF TRUSTEES

Ambulatory Surgical Center at LBJ Governing Body

HARRISHEALTH

Thursday, February 20, 2025

Consideration of Approval of New and/or Amended Policies and Procedures for the ASC 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.

Listed below is a summary of the policy changes, along with the attached back-up material.

- Policy 1003: Change in context and addition of appendix
- Policy 1004: Change in Section I
- Policy 1005: Changes in Section I through Section IV
- Policy 1011: Change in context
- Policy 4002: Change of services
- Policy 4005: Change in context
- Policies 4014-4018: Change in context
- Policy 5002: Change in context
- Policy 5004: Change in context
- Policy 5008: Change in context
- Policy 6003: Change in Section I
- Policy 6014: Change in context
- Policies 6015-6016: Updated Hazard Vulnerability Analysis
- Policy 6019: Extracorporeal Shock Wave Lithotripsy (ESWL) – New policy

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:

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.

K. **WORKSTATION ON WHEELS (WOW):** A mobile station, which provides a computer, keyboard, mouse, barcode scanner, locking drawers, and monitor in order to facilitate medication administration. This unit is not designed or intended for long-term secure storage of medications. (See Appendix A)

GENERAL PROCEDURES:

L. *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.

M. *Disposal of Medication:*

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*.

N. *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).

O. *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 eight "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.

P. *Medication Labeling:*

1. All medications and biologicals not immediately administered and removed from the original container or packaging are labeled in a standard format in accordance with law, regulation, and standards of practice.
2. The Label must include:
    a) Medication/biological name;
    b) Medication/biological strength;
    c) Amount or volume if not apparent from the container or packaging;
    d) Expiration date a time; and
    e) The name or initials of the person transferring the drug.

Q. *Medication transport:*

1. WOWs may be used to securely transport medications removed from ADC to the patient's bedside for an upcoming administration. Medications shall be placed in WOW drawer and then drawer shall be locked. Storage of medications in the WOWs for purposes other than transporting from ADC to the patient's bedside is prohibited.

PROCEDURE FOR MEDICATION ADMINISTRATION:

R. 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.

Commented [PRN1]: 8 Rights of medication administration to follow HH policy

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:*

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

STANDARD ADMINISTRATION TIMES:

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

T. Standard administration times are followed to provide consistency for medication administration schedules with consideration of pharmacological characteristics of certain medications, and patient convenience unless otherwise noted by the physician entering the order in the patient's medical record.

MEDICATION STANDARD CONCENTRATIONS:

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

V. 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.

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

Appendix A: WORKSTATION ON WHEELS (WOW)

Commented [PRN2]: This can be found in system policy 565.40

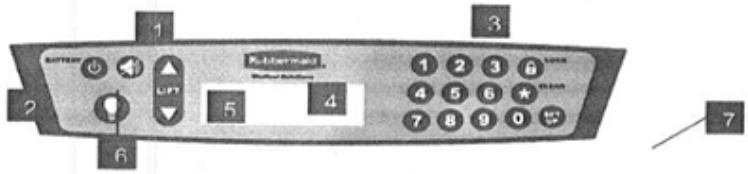
I. General Guidelines

1. One drawer per patient is designated in the WOW
2. Each cart shall have standard access codes. Unit designated codes are provided for WOWs
3. Medications are withdrawn from the Automated Dispensing Cabinet (ADC) per standard Medication Administration times and should not exceed one hour either side of administration time.
4. The person administering the medications shall assure that the time of administration is correct in the date/time field.
5. When not in use, the WOW shall be connected to an electrical outlet.
6. At the end of the shift, the nurse shall monitor to assure that his/her patients' medication drawers in the WOW are empty.
7. Prior to obtaining medications for administration to patients, the nurse checks the eMAR for any new medication orders for each assigned patient and reviews and acknowledges, when appropriate, each new order individually. There shall be no "group acknowledgement" or orders.

II. Procedure

8. Loading the WOW:
    a) Bring the WOW to the ADC area;
    b) Withdraw from ADC patient medications for the next administration period and
    c) Each patient's medications shall be placed into the WOW in an individually labeled drawer.

Rubbermaid Medical Solutions
Quick Reference Guide – AC Medication Carts



1) Height Adjustment: Press either up or down buttons to raise/lower the cart. Range is from 29" (seated) to 44" (tall/standing). Lift mechanism will stop when you release button.

2) Keyboard Light: Press this button to turn on the keyboard light for use in dark rooms. Keyboard light will turn off automatically in 1 minute – your IT staff can adjust this timing if required.

3) PIN Code Access: Enter Code to open the medication drawers. Press "Lock" to relock the drawers. Drawers will automatically lock in 2 minutes if you forget.

4) Battery Indicator: Spiral power cord should be plugged in frequently to charge the cart battery. If this indicator has only 1 or 2 bars, cart should be plugged in IMMEDIATELY. Allowing the cart power level to run all the way down can damage the cart and the cart's battery.

5) Drawer Ajar Indicator: If cart is locked, and one or more drawers are not pushed in all the way, the cart will indicate graphically which drawers are open. Push in open drawers to secure the cart.

6) Mute Button: If the cart battery drains to only 20% remaining, the cart will beep. This beeping will stop when the cart is plugged in, or when the MUTE button is hit. Note that this beeping will occur again at 10% charge, and will repeat every minute, even if the MUTE button is pressed. Cart will shut down at 7-8% power remaining, and will need to be plugged in to regain operation.

7) Keyboard Tray Lock: Red-capped lever under work surface locks the keyboard tray in place for moving between patient rooms. NOTE: Lift keyboard tray at front lip to push/pull easily.

Emergency Stop: The red emergency stop button is used to cut power to the cart's lift mechanism, in case the lift does not stop when you release the up or down button. If the lift is not working, check to be sure the E-stop button is in the "up" position.

Drawer Access Override: In case of PIN code failure, your IT staff has an override key that can be used at the back of the cart to manually operate medication drawers.

REFERENCES/BIBLIOGRAPHY:

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

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	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
		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 / Approved 02/17/2022	The Ambulatory Surgical Center (ASC) at LBJ Governing Body
		Revised / Approved 02/16/2023	The Ambulatory Surgical Center (ASC) at LBJ Governing Body
		Reviewed / Approved 02/22/2024	The Ambulatory Surgical Center (ASC) Governing Body
		Revised / Approved 08/22/2023	The Ambulatory Surgical Center (ASC) Governing Body
		Revised / Approved 08/22/2024	The Ambulatory Surgical Center (ASC) Governing Body

TITLE: **POST-SURGICAL ASSESSMENTS, ANESTHESIA RECOVERY ASSESSMENTS, AND DISCHARGE REQUIREMENTS**

PURPOSE: To establish guidelines that must be followed when evaluating a patient's recovery from surgery and anesthesia, and to set forth the requirements that must be met before the Ambulatory Surgical Center (ASC) at LBJ may discharge a patient.

POLICY STATEMENT:

It is the policy of the Ambulatory Surgical Center (ASC) at LBJ to assess all patients after surgery and prior to patients being discharge from the ASC.

POLICY ELABORATIONS:

I. DEFINITIONS:

RESPONSIBLE ~~ADULT~~ INDIVIDUAL: Someone who accompanies a patient home after a procedure or anesthesia. A legal adult who is willing and able to assist the patient in his or her immediate post-surgical recovery, including but not limited to, assisting the patient with transportation.

Commented [MRM1]: Per American Society of Anesthesiologist (ASA) and American Society of PeriAnesthesia Nurses (ASPAN)

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II. POST-SURGICAL ASSESSMENTS:

A. The overall condition of each patient of the ASC will be assessed by a physician, after each patient's surgery has been completed.

1. The patient will be assessed to determine how the patient's recovery is proceeding;
2. The patient will be assessed to determine if any steps need to be taken to facilitate the patient's recovery; and
3. The patient will be assessed to determine if the patient meets the ASC's established discharge criteria, set forth below.

B. Prior to being discharged from the ASC, patients are required to meet the following criteria:

1. Vital signs are consistent with the patient's age and pre-procedural levels;
2. Shallow cough and gag reflex present;

3. The patient is able to ambulate with minimal assistance;
4. The patient can swallow and retain some fluids;
5. There are no signs of respiratory distress;
6. Oxygen saturation is at pre-surgery level;
7. The patient is alert and oriented, or at the same mental level as the patient was prior to the surgery;
8. The patient's pain score is addressed and reasonable for the type of surgery conducted; and
9. There is minimal surgical bleeding.

C. Each patient's post-surgical assessment must be documented in the patient's medical record. Additionally, all identified post-surgical needs must be addressed in the discharge notes in the patient's medical record.

III. ANESTHESIA RECOVERY ASSESSMENTS:

A. Patients' recovery from anesthesia will be evaluated in a post-anesthesia assessment after surgery to determine whether the patient is recovering appropriately.

B. The post-anesthesia assessment must be completed by an anesthesiologist.

C. The post-anesthesia assessment must include, at minimum, an evaluation of the following criteria:

1. Respiratory function, including respiratory rate, airway patency, and oxygen saturation;
2. Cardiovascular function, including pulse rate and blood pressure;
3. Mental status;
4. Pain;
5. Nausea and vomiting; and
6. Postoperative hydration.

D. The anesthesiologist or CRNA that accompanies the patient to the PACU will provide a verbal report regarding the patient's post-surgery status to a member of the PACU team responsible for the patient. In addition, information regarding the patient's pre-operative condition and the patient's surgery must be provided to the PACU team.

E. A member of the anesthesia recovery team must remain in the post-anesthesia recovery area until the anesthesia care nurse accepts responsibility for the patient.

F. The results of the post-anesthesia assessment based on the above listed criteria must be documented in the patient's medical record. Additionally, the patient's time of arrival in the post-anesthesia recovery unit must be documented in the patient's medical record.

G. A physician must be in the ASC or in the Harris Health Outpatient Clinic until each patient is discharged from the post anesthesia recovery area.

IV. DISCHARGE REQUIREMENTS:

A. No patient may be discharged from the ASC without the following:

1. A post-surgical assessment;
2. A post-anesthesia recovery assessment;
3. A signed discharge order by the surgeon who performed the surgery;
4. Supplies, such as gauze, bandages, etc., sufficient to meet the patient's needs for the first night after the patient's surgery;
5. Written discharge instructions. These instructions must be given to the adult responsible for the patient's care;
6. Prescriptions the patient needs to fill associated with the patient's recovery from surgery;
7. Written instructions specifying the actions the patient should take immediately after surgery to promote the patient's recovery from surgery. The instructions must be given to the adult responsible for the patient's care;
8. Information regarding warning signs of complications; and
9. Information regarding how to contact the physician who will provide follow-up care to the patient.

B. Post-surgical needs must be addressed and included in the discharge notes.

C. The ASC must ensure prior to discharge that the patient is accompanied by a responsible ~~adult~~ individual who will provide suitable transportation for the patient and transport the patient from the ASC. The responsible ~~adult~~ individual must be willing to stay with the patient for at least twelve (12) to twenty-four (24) hours after the patient is discharged depending on the patient's procedure.

REFERENCES/BIBLIOGRAPHY:

42 Code of Federal Regulations (C.F.R.) §416.52(b) Standard: Post-surgical assessment

42 Code of Federal Regulations (C.F.R.) §416.42(a)(2) Standard: Anesthetic risk and evaluation

~~Quad A Version 8.2~~AAAHC Version 43

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) Governing Body
		Reviewed / Approved 03/29/2016	The Ambulatory Surgical Center (ASC) Governing Body
		Reviewed / Approved 02/14/19	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
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		Reviewed / Approved 02/16/2023	The Ambulatory Surgical Center (ASC) Governing Body
		Reviewed / Approved 02/22/2024	The Ambulatory Surgical Center (ASC) Governing Body

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.

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. Patient age;

Commented [PRN1]: Blood pressure and weight measurements have been removed from the presurgical requirements. Staff at the Ambulatory Surgery Center (ASC) will be informed of this policy update, and the presurgical checklist will be revised accordingly.

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3. Pertinent past medical history (personal and family);
4. The number and type of procedure scheduled to be performed on the same date;
5. Reason and indications for procedure (chief complaint);
6. Previous significant surgeries, complications, and medical illnesses (i.e. known comorbidities);
7. Planned anesthesia level
8. Drug and biological sensitivities and allergies;
9. Mental status;
10. Physical examination including a cardio-pulmonary exam and abdominal exam;
11. Pre-procedure diagnosis;
12. Date of visit;

Current medications; Current diagnosis; and

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 patient's medical history and physical examination (if any) must be placed in the patient's medical record prior to the surgical procedure.

E. 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.

Additionally, if the comprehensive physical assessment is performed in the ASC on the same day as the surgical procedure, the assessment of the patient's procedure/anesthesia risk must be conducted separately from the history and physical, including any update assessment incorporated into that history and physical.

III. CURRENT HISTORY AND PHYSICAL:

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Commented [PRN4]: Physicians at the Ambulatory Surgery Center (ASC) are required by CMS regulations to document the planned level of anesthesia in the patient's history and physical examination.

Commented [PRN5]: This is from the interpretation guidelines here:

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/downloads/SCLetter11_06.pdf From Compliance

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 H&P must indicate that the patient is cleared for surgery in an ambulatory setting.

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

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. If no changes were noted during assessment, the qualified licensed practitioner must indicate that the H&P was reviewed, and that "no change" has occurred in the patient's condition since the H&P was completed.

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. Each patient upon admission to the ASC must have a pre-surgical assessment to document at a minimum any changes in the patient's condition since the completion of the H&P.

D. If a patient H&P is conducted prior to the date of the surgical procedure, then the pre-surgical assessment must entail a separate examination in the ASC on the date of surgery. If the patient H&P is conducted after admission to the ASC and on the date of the surgery, some elements of the pre-surgical assessment may be incorporated into the H&P.

E. 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.

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CMS ASC. At the ASC this is called Preop Note.

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.

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

V. ANESTHETIC RISK AND EVALUATION:

A. Immediately prior to surgery, a physician 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:

a. A review of the patient's medical record;
b. The patient's medical history;
c. Prior anesthetic experiences;
d. Drug therapies;
e. Medical examination and assessment of any physical conditions that could affect the decision about the preoperative risk management;
f. A review of medical tests and consultations that might reflect on the administration of anesthesia;
g. A determination relative to the appropriate preoperative medications needed for the conduct of anesthesia; and
h. 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 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.

VI. 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:

   a. Patients with a known risk of a difficult airway;
   b. Patients with an increased risk of developing malignant hyperthermia;
   c. Patients with predictably difficult IV access and who will likely require central venous access;
   d. Patients with a bleeding or clotting disorder;
   e. Patients with moderately severe to severe pulmonary insufficiency (e.g., OSA);
   f. Patients with unstable ischemic heart disease;
   g. Patients with poorly controlled congestive heart failure;
   h. Patients with uncontrolled hypertension and/or diabetes;
   i. Patients who have a significant probability of post-operative voiding problems;
   j. Patients with end stage renal disease;
   k. Patients with known infected wounds that will necessitate terminal cleaning of the OR;
   l. Patients with uncontrolled personality disorders;

m. Patients with uncontrolled seizure disorders;
n. Patients requiring higher levels of nursing care for any medical conditions;
o. Patients who have had a recent stroke;
p. Patients with spinal cord lesions at or above T6;
q. Patients who have taken diet medications within two weeks of the scheduled procedure;
r. Patients who have a history of arrhythmia not evaluated by a cardiologist; and
s. 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

Clarifications to the Ambulatory Surgical Center (ASC) Interpretive Guidelines - Comprehensive Medical History & Physical (H&P) Assessment Ref: S&C-11-06-ASC

AAAHC V43.

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OFFICE OF PRIMARY RESPONSIBILITY:

The Ambulatory Surgical Center (ASC) at LBJ

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		Reviewed / Approved 02/16/2023	The Ambulatory Surgical Center (ASC) Governing Body
		Reviewed / Approved 02/22/2024	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
HARRISHEALTH SYSTEM

Policy No:	ASC-P-1011~~3.32~~
Page Number:	1 of 49
Effective Date:	05/23/2024~~10/31/2003~~
~~Board Motion No:~~	
~~Last Review Date:~~	~~02/14/2024~~
~~Due For Review:~~	~~02/13/2027~~

POLICY AND REGULATIONS MANUAL

TITLE: HIGH ALERT MEDICATIONS

PURPOSE: To improve patient safety at the Ambulatory Surgical Center (ASC) at LBJ by heightening the awareness of safe practices associated with High Alert Medications.

POLICY STATEMENT:

It is the policy of the Ambulatory Surgical Center (ASC) at LBJ, through the implementation of the measures outlined below, ~~I~~identifying high alert medications and developing processes to handle them appropriately~~ is done~~ to help prevent adverse drug events and ensure medication use safety. Medications identified as being "high alert" shall be managed using the recommendations and procedures outlined in this policy to increase awareness of high alert medications.~~-~~

POLICY ELABORATIONS:

I. DEFINITIONS:

A. **DUAL SIGN-OFF**: A process in which two individuals as specifically listed in the special handling sections of Appendix A of this policy do an independent double check and then both sign off in the Medication Administration Record (MAR) (electronic or paper) that all components are correct.

B. **HIGH ALERT MEDICATION**: Medications that bear a heightened risk of causing significant patient harm when they are used in error. Although mistakes may or may not be more common with these drugs, the consequences of an error are clearly more devastating to patients.

C. **INDEPENDENT DOUBLE CHECK**: A procedure in which two licensed healthcare practitioners separately check (alone and apart from each other, then

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compare results) each component of prescribing, dispensing, and verifying the high alert medication before administering it to the patient.

D. **PRESCRIBER**: Individual who is allowed to prescribe medications within the state of Texas and has been granted medical staff privileges by the ASC.~~Harris Health System.~~ For this policy, this definition is limited to individuals with the following credentials:

1. MD- Medical Doctor
2. DO - Doctor of Osteopathy
3. DDS - Doctor of Dental Surgery
4. DMD – Doctor of Dental Medicine
5. ~~Therapeutic Optometrist (OD) – may prescribe any drug as authorized by Section 351.358(a) and (b)(1) of the Texas Optometry Act. Therapeutic Optometrist may not administer or prescribe an oral or parenteral medication to treat glaucoma unless the therapeutic optometrist holds an optometric glaucoma specialist certification from the Texas Optometry Board.~~

~~6.~~ Advance Practice Provider (APP) who issues medication orders or prescriptions under written protocol from a supervising medical doctor or doctor of osteopathy who is a member of ~~Harris Health's Medical~~the ASC Staff such as:

~~b. Physician Assistant (PA)~~
~~c.~~a. Advance Practice Registered Nurse (APRN);
~~d.~~b. Nurse Practitioner (NP); and/or
~~e.~~c. Certified Registered Nurse Anesthetist (CRNA) (applies to medication orders only).

~~Certified Nurse Midwife(CNM)~~
~~Clinical Pharmacist~~

E. **RISK EVALUATION MITIGATION STRATEGY (REMS):** A safety strategy implemented by the U.S. Food and Drug Administration (FDA) to manage a known or potential serious risk associated with a drug or biological product and to enable patients to have continued access to such medicines by managing their safe use. The FDA requires REMS from manufacturers to ensure that the benefits of a drug or biological product outweigh its risks. REMS may be required by the FDA as a part of the approval of a new product, or for an approved product when new safety information arises.

F. **SOUND ALIKE/LOOK ALIKE DRUGS (SALAD)**: Medications with generic or proprietary names that look or sound like other medication names. In addition, these medications may look similar because of packaging or other product labeling.

~~II. SCOPE:~~

~~This policy shall be applicable to the Ambulatory Surgical Center (ASC)all Harris Health locations.~~

II~~I~~. GENERAL:

A. Identifying High Alert Medications:

1. The Harris Health ~~System~~ Department of Pharmacy shall identify, on an annual basis, High Alert Medications ~~from~~ at the ~~Harris Health~~ ASC utilizing specific data, literature sources, patient-safety organizations, and regulatory standards. ~~The list of High Alert Medications shall be referred to the Pharmacy & Therapeutics Committee for final approval.~~

2. High Alert Medications may include, but are not limited to, controlled medications, investigational drugs, medications with a narrow therapeutic range, psychotherapeutic medications, sound alike/look alike drugs

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(SALAD), new medications ~~on~~to the market or newly added to the~~Harris Health's~~ ASC formulary.

B. ~~B.~~ **High Alert Medication List:**

A list of High Alert Medications (see Appendix A) which require special procedures shall be maintained to reduce the risk of errors and minimize harm related to:

1. Storage, preparation, labeling, and delivery;
2. Prescribing (order entry);
3. Prescription/Order Processing;
4. Administration; and
5. Patient Monitoring.

C. Pharmacy shall maintain clearly labeled, segregated storage bins for high alert medications in the pharmacy.

D. The Automatic Dispensing Cabinet (ADC) shall alert the individual removing the medication that the medication is a High Alert medication.

E. High Alert medications dispensed from pharmacy (i.e., not in the ADC) shall be clearly identified as ~~labeled with~~ a "High-Alert" medication~~label~~.

F. ~~C.~~ A list of SALAD shall also be maintained (see Appendix B).

The following process shall be followed for SALAD medication(s):

1. Shall be stored apart from each other and in a separate location within pharmacy-/~~-automated dispensing cabinets (~~ADC~~s~~);
2. Look-alike name pairs will be distinguished using TALL MAN letters;

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3. No verbal or new telephone orders shall be accepted for chemotherapy or SALAD~~ except during emergency situations or for order clarification as outlined in Harris Health System Policies 7.31 Patient Care Orders and 581.00 Prescribing and Processing of Chemotherapy Orders and Prescriptions~~; and
4. Physicians are encouraged to write an indication for all medications.

~~D.~~G. Pharmacy purchasing shall make an effort to avoid purchasing products that look alike and switch to more distinct packaging, if possible. Independent double check requirements can be found in the special handling section of each drug or drug class in the attached appendices.

~~E.~~ Aseptic technique shall be used to prepare and administer medications per ASC-P-1003~~Harris Health System Policy 565.00~~ *Medication Administration.*

~~F. REMS medications will be handled in accordance with Harris Health System Policy 592.00 Risk Evaluation and Mitigation Strategy Policy~~

~~See appendix C of this policy for *Guidelines For The Administration Of Intravenous Potassium.*~~

H.

~~Appendix~~	~~Title~~
~~A~~	~~High Alert Medications Special Handling~~
~~B~~	~~List of Sound Alike/Look Alike Drug Name Pairs with Tall Man Lettering~~
~~C~~	~~Guidelines for the Administration of Intravenous Potassium~~

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REFERENCES/BIBLIOGRAPHY:

Institute of Safe Medication Practices List of High Alert Medications in Acute Care Settings, 2018 https://www.ismp.org/sites/default/files/attachments/2018-08/highAlert2018-Acute-Final.pdf

Institute of Safe Medication Practices Canada Safety Bulletin. Neuromuscular Blocking Agents: Sustaining Packaging Improvements Over Time (Fall 2014). Alberta RN. 70(3):18-21.

~~Harris Health System~~ASC-~~P~~~~olicy~~ 5030~~.00~~00 Adverse Drug Event Reporting and Monitoring ~~Harris~~

~~Health System Policy 565.40 Medication Storage, Labeling and Disposal~~

~~Harris Health System Policy 565.50 Administration of Cytotoxic Chemotherapy and Biotherapy Agents~~

~~Harris Health System Policy 581.00 Prescribing and Processing of Chemotherapy Orders and Prescriptions~~

~~Harris Health System Policy~~ASC-~~P~~~~olicy~~ 6008~~582.00~~ Management and Accountability of Controlled Substances

~~Harris Health System Policy 582.10 Patient Controlled Analgesia~~

~~Harris Health System Policy 585.00 Investigational Drug Orders and Prescriptions Harris~~

~~Health System Policy 592.00 Risk Evaluation and Mitigation Strategy Policy Harris Health System Policy 7.31 Patient Care Orders~~

ASC-~~P~~~~olicy~~ 1000 Acute Pain Management ~~Harris Health System Policy 412 Pain Assessment and Reassessment Harris Health System~~

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~~Harris Health System Form 284445 Anticoagulation Transition Chart~~

42 CFR §482.25 – Condition of Participation: Pharmaceutical Services §482.25 (a)(1)

Cornish, P., Hyland, S., Kocsmara, C. (2007). Enhancing safety with potassium phosphates injection, Institute for Safe Medication Practices Canada, 18(4), 34-36.

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Tubman, M., Majumdar, S., Lee, D., Klassen, T.P. (2005). Best practices for safe handling of products containing concentrated potassium, British Medical Journal, 331, 274-277.

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Lexicomp (2019) Wolters Kluwer Health Clinical Drug Information, Inc. Available at http://online.lexi.com/action/home Accessed 11/27/2019.

OFFICE OF PRIMARY RESPONSIBILITY:

The Ambulatory Surgical Center (ASC) at LBJ
~~Harris Health System Department of Pharmacy~~

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HARRISHEALTH
AMBULATORY SURGICAL CENTER AT LBJ
HARRISHEALTH SYSTEM

Policy No: ASC-P-1011~~3.32~~
Page Number: 8 of 49

Effective Date: 05/23/2024~~10/31/2003~~

~~Board Motion No:~~

~~Last Review Date: 02/14/2024~~

~~Due For Review: 02/13/2027~~

POLICY AND REGULATIONS MANUAL

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APPENDIX A
HIGH ALERT MEDICATION SPECIAL HANDLING

Effective Date	Version # (If Applicable)	Review/ Revision Date (Indicate Reviewed or Revised)	Approved by:
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Appendix A
High Alert Medication Special Handling

DRUG CLASS		SPECIAL HANDLING
Neuromuscular Blocking Agents	Examples: Cisatracurium Pancuronium Rocuronium Succinylcholine Vecuronium	a. Selection/Procurement: • Look-alike packaging will be assessed on entry to the

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organization by inventory staff.

b. Storage/Labeling:

- Inside the pharmacy, neuromuscular blocking agents (NMBs) shall be segregated from all other medications by placing them in separate lidded containers in refrigerator or inventory storage area
- Outside of the pharmacy, neuromuscular blockers shall only be stored in kits/trays (e.g. RSI kits, anesthesia trays), intensive care units, operating room areas, radiology diagnostic procedure area and the emergency rooms (in these areas, store NMBs in kits or secure in ADC (e.g. lidded ADC pockets/drawers/containers).
- Affix an auxiliary warning label (in addition to manufacturer's warnings) directly on

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all vials and/or other containers stocked in storage locations

- Place appropriate auxiliary labels on all final medication containers of NMBs including syringes and IV bags (exception: anesthesia-prepared syringes of NMBs)

c. Ordering/Transcription:

- Verbal orders for neuromuscular blockers are discouraged.

d. Preparing/Dispensing:

- Pharmacy will label all vials with warning stickers that alert that the medication is a paralyzing agent (e.g. "Caution Neuromuscular Blocker", "Paralyzing agent", "Warning: Paralyzing Agent – Causes Respiratory Arrest", etc.)

e. Administration:

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		• Initiation doses of neuromuscular blockers must be done in the presence of a prescriber.
~~Opiate/Narcotic / Controlled Substance epidurals, infusions, and PCAs~~	~~Examples: Hydromorphone, Fentanyl, Midazolam~~	~~. Selection/Procurement:~~ ~~• Look-alike packaging will be assessed on entry to the organization by inventory staff.~~ ~~• Standardization of PCA and epidural preparations to be maintained by formulary management staff~~ ~~. Storage:~~ ~~• Controlled substances are to be stored in a secured area.~~ ~~• Naloxone or an equivalent reversal agent shall be available in all areas where narcotics are used.~~

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Preparing/Dispensing:

- Only standardized concentrations (premixed when available) will be prepared/dispensed
- Non-standard concentrations will be labeled with a concentration warning.

. Administration:

- Portless tubing shall be used for administration of controlled substances
- Dual Sign-Off Required: Two nurses shall independently check the drug, drug line, dose, rate, concentration, route, and pump setting of a PCA, Epidural, and Narcotic Drip prior to administration.
- Dual sign-off documentation in the Medication

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		Administration Record is required. • Waste disposal shall be handled according to the Management and Accountability of Controlled Substances Policy 582.00 • Assessment of the patient's pain shall follow the steps outlined in the Pain Assessment and Reassessment Policy 412.
Anticoagulants and Thrombolytics	Warfarin	a. Selection/Procurement: • Every effort will be made to ensure product consistency b. Preparing/Dispensing: • Pharmacy shall dispense warfarin tablets in exact patient doses. • Baseline laboratory values (e.g. PT/INR)

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		will be assessed prior to dispense. c. Administration: • Nursing shall not split warfarin tablets. • When feasible, all inpatient warfarin doses shall be administered at seventeen hundred (1700) as per Harris Health Standard Medication Administration Time Policy. • Verification of baseline labs including PT/INR.
	Direct Oral Anticoagulants (DOACs) and Factor Xa Inhibitors: Examples: rivaroxaban, apixaban, dabigatran, fondaparinux	a. Selection/Procurement: • Every effort will be made to ensure product consistency b. Preparing/Dispensing: • Pharmacy staff shall dispense tablets in exact patient doses. • Baseline laboratory values (e.g. renal

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		function) shall be assessed prior to dispensing. c. Ordering/Transcription: • If available, order sets shall be the preferred order mode for these medications • The Anticoagulation Transition Chart (Form #284445) is available as a reference for transitioning between anticoagulants d. Administration • Administer with meals if appropriate
	Heparin vials and infusions Alteplase and tenecteplase Infusions	a. Selection/Procurement: • Look-alike packaging will be assessed on entry to the organization by inventory staff. • Every effort will be made ensure product consistency

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b. Storage:

- Heparin bags will be stored apart from Hespan.
- Heparin vials will be stored apart from insulin.
- Vials will additionally not be available in automated dispensing cabinets in neonatal and pediatric areas.

c. Preparing/Dispensing:

- Only standardized concentrations (premixed when available) will be prepared/dispensed
- Non-standard concentrations will be labeled with a concentration warning.
- Baseline laboratory values (e.g. PTT) will be assessed prior to dispensing.

d. Ordering/Transcription:

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- If available, order sets shall be the preferred order mode for these medications
- The Anticoagulation Transition Chart (Form# 284445) is available as a reference for transitioning between anticoagulants

e. Administration:

- Bolus heparin doses are to be given from a heparin vial rather than modifying the rate of infusion.
- Dual Sign-Off Required: Two clinicians (prescriber or nurse) shall independently check the drug, dose, rate, concentration, pump settings, and route prior to administration.
- Dual sign-off documentation in the Medication Administration Record is required.

Insulin	Examples: Regular, NPH, Glargine, Lispro, U-500 (concentrated insulin)	a. Selection/Procurement: • Look-alike packaging will be assessed on entry to the organization by inventory staff. • Standardization of insulin preparations to be maintained by formulary management staff. b. Storage: • Insulin vials will be stored apart from heparin vials. • Insulin vials/pens will be stored as outlined in the Harris Health System Medication Storage, Labeling and Disposal Policy. c. Preparing/Dispensing: • Only standardized concentrations will be prepared/dispensed • Non-standard concentrations will be labeled with a

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		concentration warning. • Only U-500 insulin syringes shall be dispensed with U-500 insulin vials d. Ordering/Transcription: • If available, order sets shall be the preferred route to order these medications • The U-500 insulin and syringe orders or order panel shall be used to order U-500 insulin or syringes e. Administration: • Subcutaneous or intravenous push doses of insulin are to be administered using an insulin syringe. • A U-500 insulin syringe shall be used for administering U-500 insulin orders. • Dual Sign-Off Required: Two nurses shall independently

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		check the drug, dose, rate, concentration, pump settings, and route prior to administration of subcutaneous, intravenous push and infusions of insulin. • Dual sign-off in the Medication Administration Record is required. • Appropriate rules for mixing of insulins should be followed. f. Hospital at Home (HaH): • Dual Sign-Off Required: Two nurses shall independently check the drug, dose, concentration, and route prior to administration of subcutaneous insulin. One of the two nurses may perform the independent check virtually. • U-500 insulin, insulin infusions, or intravenous push insulin will not be

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		utilized in the HaH setting.
Intrathecal Medication	Examples: Cytarabine Methotrexate Thiotepa Gentamycin Vancomycin Hydrocortisone	. Preparing/Dispensing: • Pharmacy will label medications ordered to be given intrathecally with special labeling on the syringe and bag. • Medication used must be preservative free . Ordering/Transcription: • Verbal orders for Intrathecal medications shall not be accepted . Administration: • Verify baseline labs prior to administration • Intrathecal medications are only to be given by a physician • Dual Sign-Off Required: physician administering

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		medications with another licensed clinician such as another physician or nurse shall independently check the drug, dose, rate, concentration, pump settings, and route prior to administration. • Dual sign-off with the administering physician in the Medication Administration Record is required.
Chemotherapy		a. Selection/Procurement: • Look-alike packaging will be assessed on entry to the organization by inventory staff. b. Storage: • Chemotherapy agents will be stored apart from other non-chemotherapeutic drugs.

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c. Ordering/Transcription:

- Verbal or telephone orders for chemotherapy shall not be accepted. Orders must include a height, a weight, the dosing calculation, and the therapeutic indication. Follow ordering transcription process as outlined in Policy and Procedures 581.00 Prescribing and Processing of Chemotherapy Orders.

d. Preparing/Dispensing:

- All orders for chemotherapy shall be independently verified by two licensed pharmacists
- All doses shall be labeled with a special chemotherapy warning sticker
- Lab values must be verified prior to dispensing

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		e. Administration: • Dual Sign-Off Required: Two chemo-trained nurses shall independently check the drug, dose, rate, concentration, pump settings and route prior to administration. • Dual sign-off documentation of such shall be done on the Chemotherapy Administration note in the outpatient setting and/or in accordance with the Administration of Cytotoxic Chemotherapy and Biotherapy Agents Policy 565.5. • No chemotherapy agents shall be administered as intravenous push (IVP)
Electrolytes	IV Calcium Calcium Chloride,	a. Selection/Procurement:

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	Calcium Gluconate	• Look-alike packaging will be assessed on entry to the organization by inventory staff. b. Storage: • Calcium vials containing more than 1 gram are stored in the pharmacy only. c. Ordering/Transcription: • The provider shall specify which salt form is desired (gluconate or chloride) • Calcium shall be ordered in grams. d. Preparing/Dispensing: • Only standardized concentrations (premixed when available) will be prepared/dispensed • Non-standard concentrations will be labeled with a concentration warning.

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		e. Administration: • Using a central line is recommended for ongoing administration of calcium chloride to prevent risk of extravasation. If a central line is not immediately available, it may be infused through a peripheral line.
	Intravenous Magnesium	a. Selection/Procurement: • Look-alike packaging will be assessed on entry to the organization by inventory staff. b. Storage: • Magnesium vials and syringes greater than 1 g/2 mL should only be stored in the Pharmacy (Exceptions: With appropriate safeguards, it may be stored in certain areas that are

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		deemed appropriate for specific indication including intramuscular injection in management of severe eclampsia) c. Ordering/Transcription: • Magnesium shall be ordered in grams. d. Preparing/Dispensing: • Only standardized concentrations (premixed when available) will be prepared/dispensed. • Non-standard concentrations will be labeled with a sticker. e. Administration: • Verify lab values and route prior to administration
	Intravenous Phosphate salts Potassium Phosphate	a. Selection/Procurement: • Look-alike packaging will be assessed on entry to the

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	Sodium Phosphate	organization by inventory staff. b. Storage: • Concentrated potassium or sodium phosphate vials shall not be dispensed from the Harris Health System Pharmacy (Pharmacy) or stocked in patient care areas outside Pharmacy. c. Ordering/Transcription: • Phosphate shall be ordered in millimoles only. d. Preparing/Dispensing: • Only diluted intravenous products shall be dispensed • The approved standardized concentration (premixed when available) will be prepared/dispensed e. Administration:

		• Infusions of potassium solutions with a concentration greater than ten (10) mEq/one hundred (100) mL will require two (2) nurses to independently check the drug, dose, rate, concentration, pump settings, and route prior to administration and document in the Medication Administration Record. • Intravenous potassium phosphate shall not be administered intravenous push (IVP). • Verify lab values prior to administration • See Appendix C: Guidelines for the Administration of Intravenous Potassium.

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	Intravenous Potassium Chloride	a. Selection/Procurement: • Look-alike packaging will be assessed on entry to the organization by inventory staff. b. Storage: • Concentrated potassium chloride vials shall not be dispensed from the Pharmacy or stocked in patient care areas outside Pharmacy. c. Ordering/Transcription: • Orders for intermittent infusions in neonatal patients must be co-signed by two (2) physicians • Ordering shall adhere to maximum allowable concentrations as outlined in Appendix C: Guidelines for the Administration of Intravenous Potassium. d. Preparing/Dispensing:

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- Potassium solutions shall only be admixed in the Pharmacy
- Only standardized concentrations (premixed when available) will be prepared/dispensed
- Non-standard concentrations will be labeled with a concentration warning

e. Administration:

- Verify lab values prior to administration
- Intravenous potassium chloride shall not be administered intravenous push (IVP).
- Intermittent potassium infusions must be administered via an infusion pump.
- Infusions of potassium solutions with a concentration greater than ten (10) mEq/one hundred

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		(100) mL will require two (2) nurses to independently check the drug, dose, rate, concentration, pump settings and route prior to administration and document in the Medication Administration Record. • See Appendix C: Guidelines for the Administration of Intravenous Potassium.
	IV Hypertonic Sodium Chloride Examples: Sodium Chloride (2%, 3%, 5%, 23.4%)	a. Selection/Procurement: • Look-alike packaging will be assessed on entry to the organization by inventory staff. b. Storage: • Hypertonic sodium chloride shall only be stored in the pharmacy. c. Preparing/Dispensing:

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- Each bag or syringe shall be labeled to alert staff of increased concentration.

d. Ordering/Transcription:

- Avoid the use of verbal orders; concentration must be included with the order.
- Sodium chloride 23.4% CONCENTRATED injection shall ONLY be ordered by trained physicians in the critical care units and emergency department and must follow up with appropriate monitoring
- If available, order sets shall be the preferred route to order these medications.

e. Administration:

- Verify lab values prior to administration
- Using a central line is recommended for

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		ongoing administration to prevent risk of extravasation. • When a central line is not immediately available, one single dose of 3% or 5% hypertonic sodium chloride solution may be infused through a peripheral line. • sodium chloride 23.4% CONCENTRATED injection shall ONLY be given via central line. • sodium chloride 23.4% CONCENTRATED injection shall ONLY be administered by trained physicians in the critical care units and emergency department and must follow up with appropriate monitoring • Dual Sign-Off Required 2%, 3% 5%: Two nurses shall

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		independently check the drug, dose, rate, concentration, pump settings if applicable, and route prior to administration • Dual Sign-Off Required 23.4%: Two clinicians (a Physician and a Nurse) shall independently check the drug, dose, rate, concentration, pump settings if applicable, and route prior to administration • Dual sign-off documentation in the Medication Administration Record is required. For sodium chloride 23.4% CONCENTRATED injection, a Nurse shall do the independent check sign off in the medication administration record and document physician's administration

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		sodium chloride 23.4% CONCENTRATED injection
	Sodium Bicarbonate: Adult: 8.4% (1 mEq/mL) Pediatric 4.2% (0.5 mEq/mL)	a. Selection/Procurement: • Look-alike packaging will be assessed on entry to the organization by inventory staff. b. Storage: The adult (8.4%) and pediatric (4.2%) syringes shall be stored separately in the pharmacy c. Preparing/Dispensing: Infusions of sodium bicarbonate shall be diluted prior to dispensing d. Ordering/Transcription: • If available, order sets shall be the preferred route to order these medications e. Administration: • Verify lab values prior to administration • Vesicant - Avoid extravasation

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Diuretics	Mannitol	a. Selection/Procurement: • Look-alike packaging will be assessed on entry to the organization by inventory staff. b. Storage: • Mannitol vials and bags shall be stored per manufacturer recommendations • Storage in a warmer shall be handled as outlined in Policy 565.40 Medication Storage, Labeling and Disposal c. Preparing/Dispensing: • Each bag or syringe shall be labeled to alert staff of increased concentration. d. Ordering/Transcription: • If available, order sets shall be the preferred route to order mannitol

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		e. Administration: • Administration into a large central vein is recommended • Vesicant – Avoid extravasation • Inspect for crystals prior to administration. If crystals present, re-dissolve by warming solution • Use a 5 micron or smaller filter for administering infusion solutions containing mannitol 20% or greater

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AMBULATORY SURGICAL CENTER AT LBJ
HARRISHEALTH SYSTEM

Policy No:	ASC-P-1011~~3.32~~
Page Number:	40 of 49
Effective Date:	05/23/2024~~10/31/2003~~
~~Board Motion No:~~	
~~Last Review Date:~~	~~02/14/2024~~
~~Due For Review:~~	~~02/13/2027~~

POLICY AND REGULATIONS MANUAL

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APPENDIX B

LIST~~EXAMPLES~~ OF SOUND ALIKE/LOOK ALIKE DRUG NAME PAIRS WITH TALL MAN LETTERING

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~~1. cloNIDine and KlonoPIN~~

~~2. vinBLAStine, vinCRIStine and vinORELbine~~

~~3. DOXOrubicin, DAUNOrubicin, and IDArubicin~~

~~4. concentrated liquid morphine and conventional morphine~~

~~5.~~1. morphine and **HYDRO**morphone

~~6. laniVUDine and lamoTRIgine~~

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~~6. folic acid and folINIC acid (leucovorin)~~

8.2. CeleXA and CeleBREX

9.3. DOPamine and DOBUTamine

10.4. hydrOXYzine and hydrALAZINE

~~11. glucoPHAGE and glucoVANCE~~

12.5. amLODIPine and aMILoride

~~13. quiNIDine and quiNINE~~

~~14. glipiZIDE and glyBURIDE~~

~~15. Tdap and DTap (ADAccel and DAPTAccl)~~

~~16. RETROvir and RITONavir~~

~~17. sulfaSALAzine and sulfADIAZINE~~

18.6. mitoMYcin and mitoXANTRONE

19.7. levoFLOXacin and levETIRAcetam

20.8. dexAMETHasone and dexmedeTOMIDine

~~rifAMPin and rifAXIMin~~

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21. ~~predniSONE and prednisoLONE~~

22. ~~infLIXimab and riTUXimab~~

23. ~~PACLitaxel and DOCEtaxel (also brand names Taxol and Taxotere)~~

24. ~~CISplatin and CARBOplatin~~

~~APPENDIX C~~

~~GUIDELINES FOR THE ADMINISTRATION OF INTRAVENOUS POTASSIUM~~

~~I. ROUTES OF ADMINISTRATION:~~

~~A. The enteral route is the preferred route of administration for all patients (adult, neonatal, and pediatric) requiring potassium supplementation unless the patient's medical condition warrants intravenous therapy.~~

~~B. Intravenous route of potassium should be used when any of the following medical conditions exists:~~

~~1. The patient is unable to tolerate or receive oral medications;~~

~~2. The patient is experiencing hypokalemia-associated dysrhythmias; or~~

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3. The patient is extremely hypokalemic [K+] less than 2.5 mmol per liter) and is at high risk for developing complications of worsening hypokalemia.

C. Intravenous (IV) potassium acetate, potassium chloride or potassium phosphate shall not be administered IV push.

D. Intermittent potassium infusions must be administered via an infusion pump.

II. CONCENTRATIONS AND DOSING:

A. Adult Intermittent and Maintenance Potassium Infusion:

The following guidelines are for ordering potassium as an intermittent potassium infusion in adult patients:

1. Only approved standardized concentrations (premixed when available) will be prepared/dispensed:

2. KCl intermittent infusions shall be standardized to 10 mEq/100 mL and 20 mEq/100 mL solutions. Premixed bags will be used when availabl*NOTE: Infusions of potassium solutions with a concentration greater than 10 mEq/100 mL will require two nurses to independently check the drug dose and pump settings prior to administration and document in the Medication Administration Record.

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3. Maintenance, large volume, potassium infusions shall be standardized to 20 mEq/L, 40 mEq/L and 60 mEq/L.

4. The following table outlines the standard and maximum allowable concentrations and rates of infusion for intravenous potassium in adult patients:

Infusion Type	Standard and Maximum Concentration of Potassium*	Maximum Rate of Infusion
Maintenance, large volume IV fluids (peripheral line)	Standard: 20, 40 or 60 mEq/L Maximum: 80 mEq/L	10 mEq/hour
Central TPN	Standard: Per patient Maximum: 80 mEq/L	40 mEq/hour

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~~Intermittent Potassium Infusion – Adult with Central line~~	~~Standard: 10 or 20 mEq/100 mL~~ ~~Maximum: 40 mEq/100 mL (central line)~~	~~Routine: 10 mEq/hour~~ ~~Continuous cardiac monitoring: 20 mEq/hour~~ ~~Serum K+< 2.5 mmol/L and continuous cardiac monitoring: 40 mEq/hour~~
~~Intermittent Potassium Infusion – Adult with peripheral line~~	~~Standard: 10 or 20 mEq/100 mL~~ ~~Maximum: 10 mEq/100 mL (peripheral line)~~	~~10 mEq/hour~~

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~~B. Neonatal and Pediatric KCl Intermittent Infusions:~~

~~C. The following guidelines are for ordering potassium as a KCl infusion in the neonatal and pediatric patients:~~

~~1. All orders for a KCl intermittent infusion in neonatal and pediatric patients must be co-signed by two (2) prescribers;~~

~~2. Two (2) Neonatal Intensive Care Unit (NICU) nurses must review and cosign the Medication Administration Record prior to the administration of intermittent KCl infusions; and~~

~~3. The following table outlines the allowable concentrations and rates of infusion for neonatal and pediatric patients~~

~~NEONATES and PEDIATRICS~~	
~~Patients must be on a cardiac monitor when receiving IV potassium~~	
~~Dose~~	~~For Serum Potassium (K+) < 2.5 mmol/L:~~ ~~Dose = 0.5 – 1 mEq/kg/dose (Maximum dose: 10 mEq per hour)~~ ~~Infuse dose over 4 hours~~

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Intermittent IV Infusion	Peripheral Line Concentration: 0.06 mEq/mL Central Line Concentration: 0.2 mEq/mL
Intravenous Maintenance Therapy	Peripheral and Central Lines Concentration: 0.06 mEq/mL Maximum
	-
Oral Therapy **Preferred Route**	Available as Potassium Chloride injection (2 mEq/mL) Dose: 1 – 5 mEq/kg/day in divided doses Do not exceed 1 – 2 mEq/kg as a single dose

*Note: 1 mmol of potassium phosphate provides 1.5 mEq of potassium

4. The patient's current weight should be used for dosing.

5. The mEq/kg dose of potassium should be calculated for any amounts above the standard (2 mEq/100 mL) in the TPN.

6. IV intermittent doses should be given based on potassium levels

7. Follow-up labs should be obtained one (1) to two (2) hours after a KCl intermittent infusion or four (4) to six (6) hours after an oral bolus dose.

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~~Total potassium infusion rate (to include IV solutions and KCl intermittent infusion) should not exceed 1 mEq/kg/hour.~~

~~The maximum allowable IV potassium admixtures concentrations may be further diluted.~~

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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 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~~ includes procedures that may be performed in the ASC. However, the approved list of procedures may include procedures that are not ~~contained~~ on Harris Health's ~~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.

APPENDIXES:

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		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 08/08/19	The Ambulatory Surgical Center (ASC) at LBJ Governing Body
		Revised / Approved 05/09/2019	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
		Reviewed / Approved 02/17/2022	The Ambulatory Surgical Center (ASC) at LBJ Governing Body
		Reviewed / Approved 02/16/2023	The Ambulatory Surgical Center (ASC) at LBJ Governing Body
		Reviewed / Approved 02/22/2024	The Ambulatory Surgical Center (ASC) at LBJ Governing Body

ATTACHMENT A

Approved Procedures for the Ambulatory Surgical Center (ASC) at LBJ
Approved 01/28/2025~~02/16/2023~~

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 abscess
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 stabilization/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 meniscectomy (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 meniscectomy
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
CO_2 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: INCAPACITATED AND/OR IMPAIRED PROVIDERS

PURPOSE: To establish the guidelines to follow when a member of the Ambulatory Surgical Center (ASC) at LBJ's medical staff is or becomes incapacitated and impaired and the incapacity and/or impairment compromises the quality of patient care or patient safety.

POLICY STATEMENT:

To protect the safety of patients, the Ambulatory Surgical Center (ASC) at LBJ has established a procedure to follow when an ASC medical staff member becomes or is incapacitated and/or impaired and compromises the quality of care provided to patients.

POLICY ELABORATIONS:

I. DEFINITIONS:

INCAPACITATED PROVIDER: An ASC medical staff member who is unable to practice medicine because of a physical or mental illness that requires immediate medical attention.

IMPAIRED PROVIDER: An ASC medical staff member with a physical, behavioral or mental impairment that could affect their ability to perform their clinical privileges.

INCAPACITATED WORKFORCE MEMBER: An ASC healthcare staff member who is unable to engage in patient care because of a physical or mental illness that requires immediate medical attention.

IMPAIRED WORKFORCE MEMBER: An ASC healthcare staff member with a physical, behavioral or mental impairment that could affect their ability to perform their clinical duties.

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:

Workforce members may employ CUS. They are Concerned, t~~T~~hey are Uncomfortable, and they recognize a Safety issue that they feel Stop the L~~l~~ine is appropriate.

A. *Incapacitated Surgeon:*

If the surgeon performing a patient's surgery becomes incapacitated due to a physical or mental illness that requires immediate medical attention during a patient's surgery/procedure, the following protocol must be followed:

a. The Incapacitated Provider must be assessed and given proper aid.

The operating room nurse will contact the charge nurse. The charge nurse will notify the anesthesiologist. If the charge nurse is not immediately available, the operating room nurse is responsible for contacting the anesthesiologist. The anesthesiologist will assess the provider and treat appropriately.

b. If directed by the physician assessing the Incapacitated Provider, the nurse or his or her designee will call 911.

c. After the Incapacitated Provider has been stabilized, the Medical Director must assess the patient. If the patient is stable, the Medical Director will attempt to locate another surgeon with the appropriate privileges and who is readily available and competent to complete the patient's interrupted surgery. If a surgeon with appropriate privileges is not readily available, a surgeon with general surgery privileges will be located to safely close the patient and make arrangements to obtain the appropriate follow-up care for the patient which may include transferring the patient to a hospital.

B. *Incapacitated Anesthesiologist/CRNA:*

If the anesthesiologist/Certified Registered Nurse Anesthetist (CRNA) responsible for providing anesthesia to the patient becomes incapacitated due to a physical or mental illness that requires immediate medical attention during a patient's surgery, the following protocol must be followed:

a. The Incapacitated Provider must be assessed and given proper aid, including calling the RRT if necessary.

The operating room nurse will contact the charge nurse. The charge nurse will notify the Medical Director or his or her designee. The Medical Director or his or her designee will assess the provider and treat appropriately

b. If directed by the surgeon, the nurse or his or her designee will call 911.

c. After the Incapacitated Provider has been stabilized, the surgeon must assess the patient. The surgeon must contact the Medical Director or his or her designee to locate a readily available and competent anesthesiologist/CRNA to allow the surgeon to complete the patient's surgery/procedure.

C. *Incapacitated Workforce Member:*

If the Workforce Member responsible for providing care to the patient becomes incapacitated due to a physical or mental illness that requires immediate medical attention during a patient's care, the following protocol must be followed:

a. The Incapacitated Workforce Member must be assessed and given proper aid, including calling the RRT if necessary.

The charge nurse will be contacted. The charge nurse will notify the Medical Director or his or her designee. The Medical Director or his or her designee will assess the Workforce Member and treat appropriately

b. If directed by the Director, Medical Director, or their designees, the nurse or his or her designee will call 911.

D. c. After the Incapacitated Workforce Member has been stabilized, the ASC care team must assess the patient. The Director, Medical Director, or their designees must contact the Medical Director or his or her designee to locate a readily available and competent Workforce Member to allow the care of the patient to be completed.

E.

~~C.~~F. Impaired Provider

1. Impaired Surgeon
    i. If the surgeon performing a patient's surgery becomes impaired a Workforce member will contact the charge nurse. The charge nurse will notify the Nurse Manager. If the charge nurse is not immediately available, the operating room nurse is responsible for contacting the Nurse Manager. The Nurse Manager will contact the anesthesiologist supervising the case to help assess the provider and treat appropriately.
    ii. If directed by the physician assessing the surgeon, the nurse or his or her designee will call 911.
    iii. After the surgeon has been stabilized, the Medical Director must assess the patient. If the patient is stable, the Medical Director will attempt to locate another surgeon with the appropriate privileges and who is readily available and competent to complete the patient's interrupted surgery. If a surgeon with appropriate privileges is not readily available, a surgeon with general surgery privileges will be located to safely close the patient and make arrangements to obtain the appropriate follow-up care for the patient which may include transferring the patient to a hospital.
2. Impaired Anesthesiologist/CRNA:
    i. If the anesthesiologist/Certified Registered Nurse Anesthetist (CRNA) responsible for providing anesthesia to the patient becomes impaired due to a physical or mental illness that requires immediate medical attention during a patient's surgery, the following protocol must be followed:
        a. The anesthesia professional must be assessed and given proper aid, including calling the RRT if necessary.
        b. The operating room nurse will contact the charge nurse. The charge nurse will notify the Medical Director or his or her designee. The

Medical Director or his or her designee will assess the anesthesia professional and treat appropriately

c. If directed by the Medical Director or his or her designee, the nurse or his or her designee will call 911.

ii. After the anesthesia professional has been stabilized, the surgeon must assess the patient. The surgeon must contact the Medical Director or his or her designee to locate a readily available and competent anesthesiologist/CRNA to allow the surgeon to complete the patient's surgery/procedure.

3. Impaired Workforce Member

i. If the Workforce Member responsible for providing care to the patient becomes impaired due to a physical or mental illness that requires immediate medical attention during a patient's care, the following protocol must be followed:

ii. The Workforce Member must be assessed and given proper aid, including calling the RRT if necessary.

iii. The charge nurse will be contacted. The charge nurse will notify the Medical Director or his or her designee. The Medical Director or his or her designee will assess the Workforce Member and treat appropriately

iv. If directed by the Medical Director or his or her designee, the nurse or his or her designee will call 911.

v. After the Incapacitated Workforce Member has been stabilized, the ASC care team must assess the patient. The Director, Medical Director, or their designees must contact the Director, Medical Director, or his or her designee to locate a readily available and competent Workforce Member to allow the care of the patient to be completed.

4.

The individual who suspects the provider of being impaired must give an oral or, preferably, written report to the Medical Director and the Administrator or their designees. The report must be factual and shall include a description of the incident(s) that led to the belief that the provider might be impaired. The individual making the report does not need to have proof of the impairment, but must state the facts that led to the suspicions.

4.5. The individual who suspects the provider of being impaired shall enter an eIRS report.

5.6. The Medical Director and the Administrator shall seek the advice of Harris Health Risk Management team to determine whether any conduct must be reported to law enforcement authorities or other government agencies, and what further steps must be taken.

REFERENCES/BIBLIOGRAPHY:

AAAHC v42 Handbook

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
		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
		Reviewed / Approved 02/25/2021	The Ambulatory Surgical Center (ASC) at LBJ Governing Body
		Reviewed / Approved 02/17/2022	The Ambulatory Surgical Center (ASC) at LBJ Governing Body
		Reviewed / Approved 02/16/2023	The Ambulatory Surgical Center (ASC) at LBJ Governing Body
		Reviewed / Approved 02/22/2024	The Ambulatory Surgical Center (ASC) at LBJ Governing Body
		Revised / Approved 05/23/2024	The Ambulatory Surgical Center (ASC) at LBJ Governing Body

HARRISHEALTH
AMBULATORY SURGICAL CENTER AT LBJ

Policy No: ASC-P-4014
Page Number: 1 of 40

Effective Date:
Board Motion No: n/a

TITLE: PROFESSIONAL PRACTICE EVALUATION

PURPOSE: To establish a positive educational approach to performance issues and a culture of continuous improvement for Physicians/Practitioners and Advanced Practice Professionals (APP) which includes fairly, effectively, and efficiently evaluating the care being provided, comparing it to established patient care protocols and benchmarks when possible.

POLICY STATEMENT:

The Ambulatory Surgical Center (ASC) at LBJ Professional Practice Evaluation (PPE) includes several ~~related but distinct~~ components. The PPE process described in this policy is used when questions or concerns are raised about a practitioner's or APP's clinical performance. This process has traditionally been referred to as "peer review." This Pp~~p~~olicy will provide constructive feedback, education, and performance improvement assistance to Practitioner's and APP's regarding the quality, appropriateness, and safety of the care they provide. This Pp~~p~~olicy will ~~effectively~~ guide the ASC to disseminate lessons learned and promote education sessions ~~so that all~~to allow Practitioner's and APP's ~~in a relevant specialty area~~ ~~will~~to benefit from the PPE process and ~~also~~ participate in the culture of continuous improvement. The Policy will also ~~, and~~ promote the identification and resolution of ~~system~~ ASC process issues that may adversely affect the quality and safely of care being provided to patients.~~.~~

POLICY ELABORATIONS:

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I. DEFINITIONS:

A. **Assigned Reviewer:** ~~means a~~A Practitioner or APP who is requested by the ASC Medical Director to:

1. S~~s~~erve as a consultant and assist performing the review; or

2. C~~c~~onduct a review, document his/her clinical findings on a case review form, submit the form to the ASC Medical Director that assigned the review, and be available to discuss findings and answer questions.

~~A.~~ **APP or Advanced Practice Professional:** Shall have the same meaning as that term is defined in the Medical Staff Bylaws

B.

C. **Clinical Specialty Review Committee (CSRC):** A~~a~~ committee of at least one Practitioner or APP from the ASC~~a clinical service or specialty~~, working in conjunction with the ASC Medical Director. The individual(s) and committee that will function as CSRCs will be designated by the ASC MEC Medical Director. CSRCs receive cases for review, obtain input from assigned reviewers as needed, complete the case review form in this Policy, and make a determination as described in Section 2.D of this Policy.

D. **Executive Session:** ~~a~~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.

E. **~~ASC~~ Medical Executive Committee ~~(ASC MEC)~~:** A~~a~~ multi-specialty medical peer review committee ~~under Texas law~~ that oversees the professional practice evaluation process, conducts case reviews, works with Practitioners and APPs in a constructive and educational manner to help address ~~any~~ clinical performance issues, and develop~~s~~ Voluntary Enhancement Plans as described in this Policy. The ASC MEC has the authority to conduct non-routine, formal investigations and to recommend restrictions of clinical privileges to the Governing Body. The

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composition and duties of the ASC MEC are described in the Medical Staff Bylaws.

F. **Peer Review:** A process used when questions or concerns are raised about a Practitioner's or APP's clinical performance.

G. **Practitioner:** shall have the same meaning as that term is defined in the Medical Staff Bylaws.

H. **Professional Practice Evaluation ~~(PPE)~~:** refers to the ASC's routine peer review process. It is used to evaluate a Practitioner's or APP's professional performance when any questions or concerns arise. The PPE process outlined in this Policy is applicable to all Practitioners and APPs and is not intended to be a precursor to any disciplinary action, but rather is designed to promote improved patient safety and quality through continuous improvement.

I. **Professional Practice Evaluation Specialist:**

J. **Voluntary Enhancement Plan:**

Workforce: The members of the governing body of the Ambulatory Surgical Center (ASC) at LBJ, employees, medical staff, trainees, contractors, volunteers, and vendors.

K.

~~B.~~ **PEER REVIEW~~:~~**

II.

~~1.~~ The ASC at LBJ will ~~***A process used when questions or concerns are raised about a Practitioner's or APP's clinical performance***~~.

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~~a.~~ ~~The process used to c~~confirm an individual's competence to exercise newly granted privileges described in th~~e~~ ~~Policy on~~ Initial and Annual Performance ~~Data~~ Review (policy ASC-P-4018) for ~~r~~Recently ~~g~~Granted ~~p~~Privileges.

A.

~~a.~~ E~~The process used to e~~valuate a Practitioner's or APP's competence on an ongoing basis is described in the Ongoing Performance Data Review Policy (Policy ASC-P-4016).~~;~~

1.

Concerns regarding a Practitioner's or APP's professional conduct or health status shall be reviewed in accordance with the Medical Staff Professionalism Policy (ASC-P-4015) or Practitioner ~~(ASC-P-4015)~~ and Professional Health Policy (ASC-P-4017), respectively.~~;~~

2.

~~c.~~ If a matter involves both clinical and behavioral concerns, the ASC Medical Director shall coordinate the reviews. The behavioral concerns shall be addressed pursuant to the Professionalism Policy.

3.

III. ~~STEP BY STEP REVIEW PROCESS:~~ PROCESS

~~2.~~ ~~The s~~The process by which the Peer Review process occurs is ~~teps are~~ illustrated in Appendix A, ~~the~~ Flowchart of Professional Practice Evaluation Process and the ASC Medical Executive Committee (MEC) Case Review Algorithm~~, , both of which are included in Appendix A to this policy.~~

~~a.~~ ~~Specific Triggers:~~ The ASC shall utilize ~~identify~~ adverse outcomes, clinical occurrences, or complications as described by the accrediting body that oversees the ASC as events to activate the ~~that will trigger the~~ PPE process. The ASC MEC will review and approve the~~se~~ activating ~~triggers and review them periodically to~~events to ~~e~~valuate their effectiveness. Members of the ASC Workforce may

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report to the ASC Medical Director concerns related to the safety or quality of care provided to a patient by an individual Practitioner or APP. The ASC PPE review form may be used for this purpose. Cases or issues may be identified for review through other means, including but not limited to those described in the PPE Manual (PPE Triggers that Prompt the PPE Review Process). Individuals who report concerns will receive a follow-up communication, either verbally or in writing. A template for response, Response to Reported Concerns, is included in this Policy.

A.

. **Reported Concerns:** Physicians, APPs, and/or Harris Health employees may report to the ASC Medical Director concerns related to the safety or quality of care provided to a patient by an individual Practitioner or APP. The ASC PPE review form may be used for this purpose.

. **Other Cases or Issues: Cases or issues may be identified for review through any other means, including but not limited to those described in the PPE Manual (PPE Triggers that Prompt the PPE Review Process).**

0. *FOLLOW UP WITH INDIVIDUALS WHO REPORTED CONCERNS: Individuals who report concerns will receive a follow-up communication, either verbally or in writing. A template Response to Reported Concerns is included in the PPE Manual.*

I.IV. PPE SPECIALIST:

1. Log in: All cases or issues identified for review shall be referred to the PPE Specialist. They will , who will log the matter in some manner trecord the issue that facilitates the subsequent tracking and analysis of the case or issue such as (e.g., a confidential database or spreadsheet).

A.

2. Fact Finding: The PPE Specialists will review, as necessary, the medical record, other relevant documentation, and the Practitioner's or APP's professional

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practice evaluation history. The PPE Specialists may also interview and gather information from Harris Health employees, Practitioner's, APP's, patients, family, visitors, and others who may have relevant information.

B.

a. For any ~~Practitioner-specific or APP-sp~~specific concerns that may be referred for review from a~~the serious~~significant safety event or sentinel event ~~review provided~~, interviews and other fact-finding events should be coordinated between the two processes, to the extent possible, to avoid redundancy and duplication of effort.

C.

b. ~~Review and Determination:~~ The PPE Specialists shall consult with the Chair of the ASC MEC if there is any uncertainty about the proper determination or review process for a case. The PPE Specialists will then:

D.

1. Determine ~~that~~if no further review is required and close the case pursuant to criteria approved by the ASC MEC. The PPE Specialists may not close cases that were commenced by a reported concerns from a Practitioner or APP. The PPE Specialists will provide periodic reports to the ASC MEC of cases closed pursuant to this subsection. Such reports should include the

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specific trigger that causes the case to be identified so the ASC MEC can evaluate the utility of such triggers;

2. Send an Awareness Letter based on criteria approved by the ASC MEC or; See Section G of this policy; and

~~3.~~ Determine that further review is required.~~;~~

3.

~~c.~~ Preparation of Case for Further Review: The PPE Specialists shall prepare cases that require further review. Preparation of the case may include the following:

E.

1. Completion of the appropriate portions of the ASC PPE case review form;
2. As needed, modifying the case review form to reflect specialty-specific issues, as may be directed by the ASC Medical Director;
3. Preparation of a timeline or summary of the care provided;
4. Identification of relevant patient care protocols or guidelines; and
5. Identification of relevant literature.

~~I.~~ **TRIAGE AND REGERRAL OF CASE FOR FURTHER REVIEW:**

V.

~~2.~~A. ~~General:~~ In their discretion, the ASC Medical Director may develop standard operating procedures to guide the triage and referral of cases for further review as described in this section.

~~3.~~B. ~~Referral to Clinical Specialty Review Committee:~~ The PPE Specialists will refer most cases requiring further review to the appropriate CSRC. The PPE Specialists will consult with the ASC MEC Medical Director if there is any uncertainty about which CSRC should review a case.

1. ~~3. Referrals to ASC MEC:~~ A case shall be referred to the ASC MEC designated by the ASC MEC Medical Director if the ASC MEC Medical

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Director determines the case involves a concern for which expedited review is needed.

~~4.~~ Referrals to the ASC MEC in Executive Session:

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~~a.~~ If a Voluntary Enhancement Plan is currently in effect, the PPE Specialists will consult with the ASC Medical Director to determine if the case should be referred directly to the ASC MEC rather than to a CSRC.

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~~b.~~ The Chief of Service, working with the ASC Medical Director, may direct the PPE Specialists to refer a case directly to the ASC MEC if they determine that the case raises unusual or significant concerns for which direct referral to the ASC MEC is the most appropriate review process.

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~~c.~~ Referrals Involving Certain Complex Cases: **Formatted:** Heading 3, Left, No bullets or numbering

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a) ~~1.~~ Practitioner's or APP's from two or more specialties or Clinical Services; **Formatted:** Heading 4, Left, Indent: Left: 0", First line: 0"

b) ~~2.~~ A member of the CSRC who would otherwise be expected to review the case; or

c) ~~3.~~ A matter for which necessary clinical expertise is not available on the Medical Staff the PPE Specialists will consult with the ASC Medical Director regarding referral of the case. The ASC Medical Director will determine the appropriate review process, and may decide that two or more CSRCs will review the case and complete assessments simultaneously, that an assigned reviewer will complete the review, or that the case will be referred to the ASC MEC so that

an external review may be obtained, see Section I.A. of this Ppolicy.

~~J.~~ **CLINICAL SPECIALTY REVIEW COMMITTEE (CRSE) (ASC MEDICAL EXECUTIVE COMMITTEE)~~:~~**

VI.

~~1.~~A. ~~Review:~~ When a case is assigned to a CSRC, a member of the CSRC will conduct the initial review of the case on behalf of the CSRC and then discuss the case with the other member(s) of the CSRC in reaching a determination. The CSRC member and CSRC shall complete the case review form.

~~2.~~B. ~~Assistance from Assigned Reviewer:~~ The CSRC member conducting the initial review or the CSRC may seek assistance from an Assigned Reviewer. The Assigned Reviewer will generally serve as a consultant to the CSRC member or CSRC. As may be requested, the Assigned Reviewer may also complete a case review form and report his or her findings back to the CSRC member or CSRC. In all cases, the CSRC remains responsible for completing the case review form.

~~3.~~C. ~~Input from Practitioner or APP:~~ If a CSRC member or an Assigned Reviewer has any questions or concerns about the care provided by the Practitioner or APP, the CSRC member or Assigned Reviewer shall obtain input from the Practitioner or APP prior to completing the review. Section 4 of this Policy and the PPE Manual

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(Request for Input from Practitioner or APP sent by CSRC, AR, or ASC MEC) contain additional information on obtaining input from the Practitioner or APP.

~~3. Determinations:~~ CSRCs may,

~~b.~~D. with the agreement of the ASC MEC Medical Director:

~~1.~~a) Determine that no further review is required and the case is closed;

~~2.~~b) Send an Educational Letter to the Practitioner or APP;

~~3.~~c) Conduct or facilitate Collegial Counseling with the Practitioner or APP; or

~~c.~~d) Report their findings to the ASC MEC for determination.

~~1.~~E. Input from the Practitioner or APP must be obtained before an Educational Letter is sent or Collegial Counseling is conducted See Section G of this policy.

~~K.~~ **AMBULATORY SURGICAL CENTER MEDICAL EXECUTIVE COMMITTEE (MEC) EXECUTIVE SESSION~~:~~**

VII.

~~1.~~A. ~~Review of Prior Decisions:~~ The ASC MEC will periodically review reports of cases closed and other determinations by individuals under this Policy. If the ASC MEC disagrees with a determination made by other parties, the ASC MEC may consult with the party who made the prior determination and may conduct an additional review of the case.

~~2.~~B. ~~Review:~~ The ASC MEC shall consider the Case Review Forms, supporting documentation, input obtained from the Practitioners or APPs involved, findings, and recommendations for all cases referred to it.

~~3.~~C. ~~Case Presentation:~~ A member of the CSRC responsible for the initial assessment, an Assigned Reviewer, ASC Medical Director, or designee, should present the case to the ASC MEC.

~~4.~~D. ~~Determination if Additional Expertise or Information is Required:~~ The ASC MEC shall determine whether any additional clinical expertise is needed to adequately

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identify and address concerns raised in the case. If additional clinical expertise is needed, the ASC Medical Director may:

~~a.~~1. I~~i~~nvite a specialist on the ASC Medical Staff with the appropriate clinical expertise to attend an ASC MEC meeting ~~(either in person or electronically)~~ as a guest to assist the ASC MEC in its review of issues, determinations, and follow-up actions;

~~b.~~2. Assign the review to a Practitioner or APP on the Medical Staff with the appropriate clinical expertise, with a report of the assessment back to the ASC MEC; or

~~c.~~3. ~~-~~Arrange for an external review from an individual not on the Medical Staff in accordance with this policy

~~5.~~E. ~~Input from a physician or APP:~~ If the ASC MEC has questions or concerns about the care provided by the physician or APP, the ASC MEC may obtain additional input from the physician or APP beyond what has already been obtained, prior to making any final determinations or findings.

~~6.~~F. ~~Determinations:~~ Based on its review of all information obtained, including input from the physician or APP, the ASC MEC may:

~~a.~~1. Determine that no further review or action is required. If information was sought from the Practitioner or APP involved, the Practitioner or APP shall be notified of the determination~~:~~.

~~b.~~2. Send an Educational Letter See Section G of this policy;

~~c.~~3. Conduct or facilitate Collegial Counseling See Section I of this policy; or

~~d.~~4. Develop a Voluntary Enhancement Plan, after consultation with the Medical Director See Section G of this policy.

As noted in Section G of this policy, input from the physician or APP must be obtained before an Educational Letter is sent, Collegial Counseling is conducted, or a Voluntary Enhancement Plan is proposed. In making this determination, the

ASC MEC should consult the guidance in the Case Review Algorithm set forth in Appendix A.

G.

VIII. ASC MEC OFFICERS:

A. Matters that require expedited review given the seriousness of the issue may be referred by the ASC MEC Medical Director to an ASC MEC Officer(s). In such case, the ASC MEC Officer(s) will conduct a preliminary review, take action necessary to protect patients, commence the process to obtain additional expertise if needed, and refer the case to a CSRC of the full ASC MEC for review.

B. Timeframes for review:

1. General: The time frames specified in this section are provided only as guidelines. All participants in the process shall use their best efforts to adhere to these guidelines, with the goal of completing reviews, from initial identification to final determination, within 90 days.

2. Assigned Reviewers: Assigned Reviewers are expected to either consult with the CSRC member, CSRC, or ASC MEC, depending on who

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requested assistance, or submit a completed case review form, if applicable, within 14 calendar days of;

~~i.~~a) The review being assigned; or

~~ii.~~b) Their receipt of any requested input from the Practitioner or APP, whichever is later.

~~c.~~3. ~~Clinical Specialty Review Committees:~~ The CSRC member who conducts the initial review is expected to submit the completed portion of the case review form within 14 calendar days of the following, whichever is latest:

~~i.~~a) The review being assigned;

~~ii.~~b) Receipt of any requested input from the Practitioner or APP;

~~iii.~~c) Receipt of information from an Assigned Reviewer or a case review form, if applicable. The CSRC is then expected to complete its review within 30 calendar days of the following, whichever is later;

~~iv.~~d) Its receipt of the CSRC members assessment; or

~~v.~~e) Its receipt of any additional input requested from the Practitioner or APP.

~~d.~~4. ~~External Reviewers:~~ If an external review is sought as set forth, those involved will use their best efforts to take the steps needed to have the report returned within 30 days of the decision to seek the external review ~~(e.g., by ensuring that relevant information is provided promptly to the external reviewer, and that the contract with the external reviewer includes an appropriate deadline for review).~~.

~~2.~~5. ~~No Further Review Required:~~ Cases may be closed according to the process set forth in this Policy if a determination is made that there are no clinical issues or concerns presented in the case that require further review. Documentation of cases that are closed shall be provided to the PPE Specialists, who shall maintain records of closed cases and provide periodic reports to the ASC MEC. If information was sought from the Practitioner or APP involved, the Practitioner or APP shall also be notified of the determination. A letter that may be used for that purpose is included in the

PPE Manual ~~(Notice to Practitioner or APP That No Further Review or Action is Required When Input Had Been Requested).~~.

~~3.~~C. ~~Exemplary Care:~~ If the ASC MEC determines that a Practitioner or APP provided exemplary care in a case under review, the Practitioner or APP should be sent a letter recognizing such efforts.

~~Pursuant to the Medical Staff Bylaws:~~ This Policy outlines collegial and progressive steps that can be taken to address clinical concerns about a Practitioner or APP. However, a single incident or pattern of care may be of such concern that more significant action is required. Therefore, nothing in this Policy precludes an immediate referral of a matter to the ASC MEC pursuant to the Medical Staff Bylaws or the elimination of any particular step in the Policy when deemed necessary under the circumstances. Such referral shall not preclude other action under applicable policies including policies of the ASC~~Harris Health~~, Baylor College of Medicine, The University of Texas Health Science Center at Houston's McGovern Medical School, or other third-parties with Practitioners or APPs on the ASC's~~Harris Health's~~ Medical Staff.

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~~M.~~IX. OPTIONS TO ADDRESS CLINICAL CONCERNS:

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~~2.~~A. ~~General:~~ This Policy and the case review form in the PPE Manual discourage the use of any scoring, leveling, or grading of cases because those practices, while traditional, can foster a punitive, isolating, and destructive culture surrounding PPE activities. Instead, this Policy focuses on specific efforts to address any issues that may be identified in a constructive and educational manner and thus foster a culture of continuous improvement. As such, this Policy encourages the use of initial mentoring efforts and progressive steps by the ASC medical staff in order to successfully address questions relating to an individual's clinical practice.

~~3.~~B. ~~Initial Mentoring Efforts:~~ Initial Mentoring Efforts may include, but are not limited to, discussions, mentoring, coaching, and sharing of comparative data. There is no requirement that input be obtained prior to Initial Mentoring Efforts or that they be documented. However, brief documentation is encouraged to help

determine if any pattern may be developing that would recommend a more formal response. Any documentation will be maintained in the Practitioner's or APP's confidential file. A description of Initial Mentoring Efforts and progressive steps is included in this policy.

~~4.~~C. ~~Progressive Steps:~~ For matters that are reported to, or identified by, the PPE Specialists and reviewed under this Policy, the ASC Medical Staff will generally use Progressive Steps to address performance issues that may be identified. Additional information on each of the following Progressive Steps may be found in this Policy. A description of Initial Mentoring Efforts and Progressive Steps is included in this Policy.

~~a.~~1. ~~Awareness Letters:~~ Intended to make Practitioners and APPs aware of an expectation or requirement. They are non-punitive, informational tools to help Practitioners and APPs self-correct and improve their performance through timely feedback.

~~i.~~a) The ASC MEC will prepare a list of objective occurrences for which an Awareness Letter will be sent to a Practitioner or APP. The list may be modified by the ASC MEC at any time.

~~ii.~~b) PPE Specialists will generate an Awareness Letter to be sent to a Practitioner or APP upon the occurrence of an event which has been

identified ahead of time by the ASC MEC. The Awareness Letter will be signed by the ASC MEC.

~~b.~~c) ~~Educational Letters:~~ Describe the opportunities for improvement that were identified in the care reviewed and offer specific recommendations for future practice.

~~i.~~d) Educational Letters may be sent by a CSRC, with the agreement of the ASC MEC Medical Director.

~~ii.~~e) The Medical Director will be informed of the substance of any Educational Letter and may contact the PPE Specialists to review a copy of the letter.

~~iii.~~f) A Sample Educational Letter is included in this policy.

~~c.~~g) ~~Collegial Counseling:~~ A formal, planned, face-to-face discussion between the Practitioner or APP and the ASC Medical Director.

~~i.~~h) A CSRC, with the agreement of the ASC Medical Director may use Collegial Counseling to address concerns with a Practitioner or APP.

~~ii.~~i) Collegial Counseling shall be followed by a letter that summarizes the discussion and the recommendations and expectations regarding the Practitioner's or APP's future practice at the ASC.

~~iii.~~j) The ASC Medical Director shall be informed of the substance of any Collegial Counseling and the follow-up letter, regardless of who conducts or facilitates it, and may contact the PPE Specialists to review a copy of the follow-up letter.

~~iv.~~k) A Collegial Counseling Checklist to help prepare for such a meeting and a Sample Follow-Up Letter to Collegial Counseling are included in this Policy.

~~5.~~D. ~~Voluntary Enhancement Plan:~~ The ASC MEC may develop a Voluntary Enhancement Plan to bring about sustained improvement in an individual's practice. This Policy provides examples of the elements that may be included in a Voluntary Enhancement Plan. However, a Voluntary Enhancement Plan may include any activity that the ASC MEC determines will help the Practitioner or

APP to improve and is not disciplinary in nature. Additional guidance on Voluntary Enhancement Plans is included in the PPE Manual, including Voluntary Enhancement Plan Options – Implementation Issues Checklist and a Voluntary Enhancement Plan Template Letter.

~~a.~~1. If a Practitioner or APP disagrees with the need for a Voluntary Enhancement Plan developed by the ASC MEC, the Practitioner or APP is under no obligation to participate in the Voluntary Enhancement Plan. In such case, the ASC MEC cannot compel the Practitioner or APP to agree with the Voluntary Enhancement Plan. Instead, the ASC MEC may take other appropriate action pursuant to the Medical Staff Bylaws to resolve the matter.

~~b.~~2. ~~Documentation:~~ Awareness Letters, Educational Letters, follow-up letters to Collegial Counseling, and Voluntary Enhancement Plan documentation will be placed in the Practitioner's or APP's confidential file and considered in the reappointment process.

~~Confidentiality:~~ All Initial Mentoring Efforts and Progressive Steps are part of the ASC's confidential performance improvement and PPE/Peer Review activities. Information related to them will be maintained in a confidential manner consistent with their privileged status under state and federal law.

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~~N.~~X. OBTAINING INPUT FROM THE PRACTITIONER

~~1.~~A. ~~Input Required:~~ Obtaining input from the Practitioner or APP under review is an essential element of a transparent and constructive review process. Accordingly, no Educational Letter, Collegial Counseling, or Voluntary Enhancement Plan shall be implemented until the Practitioner or APP is first notified of the specific concerns and provides input as described in this Section. Prior notice and a request for input are not required before an Awareness Letter is sent to a Practitioner or APP.

~~2.~~B. ~~Manner of Providing Input:~~ The Practitioner or APP shall provide input through a written description and explanation of the care provided, responding to any

specific questions posed in the correspondence to the Practitioner or APP (e.g., email or letter). Upon the request of either the Practitioner or APP, or the person or committee conducting the review, the Practitioner or APP may also provide input by meeting with appropriate individuals ~~(as determined by the individual or committee conducting the review)~~ to discuss the issues.

~~3.~~C. ~~Office Records:~~ As part of a request for input pursuant to this Policy, the person or committee requesting input may ask the Practitioner or APP to provide a copy of, or access to, medical records from the Practitioner's or APP's office that are relevant to a review being conducted under this Policy. Failure to provide such copies or access will be viewed as a failure to provide requested input.

~~4.~~D. ~~Sharing Identity of Any Individual Reporting a Concern:~~ Since this policy does not involve disciplinary action or restrictions of privileges, the specific identity of any individual reporting a concern or otherwise providing information about a matter (the "reporter") will not be disclosed to the Practitioner or APP unless the individual consents or the information is later used to support an adverse professional review action that results in a Medical Staff hearing.

~~5.~~E. Retaliation Prohibited: Retaliation by the Practitioner or APP against anyone who is believed to have reported a concern or otherwise provided information about a matter is inappropriate conduct and will be addressed through this Policy.

~~6.~~F. ~~Discussions Outside Committee Meetings:~~ Individual members of the ASC MEC should not engage in separate discussions with a Practitioner or APP regarding the review of a case unless the committee in question has asked the individual committee member to speak with the Practitioner or APP on its behalf. Similarly, unless formally requested to do so, Practitioners or APPs may not provide verbal input to the PPE Specialists or to any other individual and ask that individual to relay that verbal input to an individual or MEC involved in the review. The goal of these requirements is to ensure that all individuals and committees involved in the review process receive the same, accurate information. Practitioners and APP's must also refrain from any discussions or lobbying with other Medical Staff

members or Governing Body members outside the authorized review process outlined in this Policy.

~~Failure to Provide Requested Input or Attend Meeting:~~ A Practitioner or APP is required to provide written input or attend a meeting as requested by a CSRC and/or the ASC MEC within the time frame specified by the committee. Failure to respond within the specified timeframe may mean the review will proceed without input from the Practitioner or APP.

G.

~~O.~~XI. **ADDITIONAL PROVISIONS GOVERNING THE CLINICAL REVIEW PROCESS**

~~1.~~A. ~~External Reviews:~~ Obtaining an external review is within the discretion of the ASC MEC acting in consultation with Harris Health's Chief Medical Executive. No Practitioner or APP has the right to demand the ASC obtain an external review in any particular circumstance.

~~a.~~1. If a decision is made to obtain an external review, the Practitioner or APP involved shall be notified of that decision and the nature of the external review. Upon completion of the external review, the Practitioner or APP shall be provided a copy of the reviewer's report (except that any comments related to care provided by other individuals shall be redacted).

~~b.~~2. The report of the external reviewer is a record of the committee that requested it and will be maintained in a confidential manner as described in this Policy.

~~2.~~B. ~~System Process Issues:~~ Quality of care and patient safety depend on many factors in addition to Practitioner or APP performance. If system processes or procedures that may have adversely affected, or could adversely affect, outcomes or patient safety are identified through the process outlined in this Policy, the issue shall be referred to the ASC MEC. The referral will stay on the ASC MEC's agenda until it determines the issue has been resolved.

~~3.~~C. ~~Peer Learning Sessions/Dissemination of Lessons Learned: Peer~~Peer l~~L~~earning s~~S~~essions and the dissemination of educational information through other

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mechanisms are integral parts of the PPE/peer review process and assist Practitioners and APPs in continuously improving the quality and safety of the care they provide. These activities will be conducted in a confidential manner, consistent with their confidential and privileged status under the state peer review protection law and any other applicable federal or state law. Additional guidance on pPeer lHearning sSessions is included in the PPE Manual.

~~4.~~D. ~~Confidentiality:~~ Maintaining confidentiality is a fundamental and essential element of an effective professional practice evaluation process.

~~a.~~1. ~~Documentation: All~~All documentation that is prepared in accordance with this Policy shall be managed in a manner reasonably calculated to assure privacy and shall be maintained in appropriate Medical Staff files. All documents (whether paper or electronic) should be conspicuously marked with the notation "Confidential PPE/Peer Review" or words to that effect, consistent with their privileged and protected status under state or federal law. However, failure to mark documents in this manner shall not be viewed as an indication that the document is not privileged.

~~b.~~2. ~~Verbal Communications:~~ Telephone and in-person conversations should take place in private, at appropriate times, and locations to minimize the risk of a breach of confidentiality.

~~c.~~3. ~~Email: Harris Health or other s~~Secure institutional e-mail may be used to communicate between individuals participating in the professional practice evaluation process, including with those reviewing a case and with the Practitioner or APP whose care is being reviewed. ~~All e-mails~~Communication should include a standard convention, such as "Confidential PPE/Peer Review Communication" in the subject line.

Communication via ~~E~~e-mail should not be sent to personal e-mail accounts unless;

~~i.~~a) T~~t~~he e-mail merely directs recipients to check their ~~Harris Health or other~~ secure institutional e-mail; or

~~ii.~~b) ~~t~~The email is encrypted in a manner ~~approved by Harris Health policy~~.

~~d.~~4. ~~Risk Management:~~ Information that is generated pursuant to this PPE Policy may not be documented in risk management files or disclosed as part of any risk management activities.

~~e.~~5. ~~Participants in the PPE Process:~~ All individuals involved in the PPE process, ~~(~~Medical Staff and ASC ~~Harris Health employees)~~members, will maintain the confidentiality of the process. All such individuals should sign an appropriate Confidentiality Agreement. Any breaches of confidentiality by Practitioners or APPs will be reviewed under the Medical Staff Professionalism Policy. Breaches of confidentiality by ASC~~Harris Health~~ employees will be referred to human resources.

~~f.~~6. ~~Practitioner or APP Under Review:~~ The Practitioner or APP under review must also maintain ~~all~~ information related to the review in a strictly confidential manner, as required by Texas law. The Practitioner or APP may not disclose information to, or discuss it with, anyone outside of the review process set forth in this Policy without first obtaining the permission of the ASC MEC Medical Director, except for any legal counsel who may be advising the Practitioner or APP. Violations of this provision will be reviewed under the Medical Staff Professionalism Policy.

~~g.~~7. ~~Communication with Practitioner or APP that Include a Deadline: Before~~Before ~~any paper or electronic~~ any correspondence, that includes a deadline for a response, ~~(for example, a request for input or to attend a meeting)~~ is ~~mailed or e-mailed t~~conveyed to a Practitioner or APP, a reasonable attempt at verbal communication, e.g. a ~~text message should be sent or a~~ phone call, should be made ~~(or voice mail left)~~ to alert the Practitioner or APP that the correspondence is being sent. The intent of

any such ~~text message or phone call~~communication is to make the Practitioner or APP aware of the correspondence so that the deadline is not missed. However, failure to send ~~a text message or make a phone call~~ communication shall not be cause for the Practitioner or APP to miss a deadline.

~~h.~~8. ~~Supervising Physicians and Advances Practice Professionals:~~ Except as noted below, a physician who has a supervisory or collaborative relationship with an APP for state licensure purposes shall be kept apprised of any concerns that are reviewed pursuant to this Policy involving the APP. Without limiting the foregoing, the supervising or collaborating physician will be copied on all correspondence that an APP is sent under this Policy and may be invited to participate in any meetings or interventions. The supervising or collaborating physician shall maintain in a confidential manner all information related to reviews under this Policy and may be required to sign a Confidentiality Agreement. Notification to the supervising or collaborating physician as described in this Section is not required, or may be delayed, if the individual or committee conducting the review determines that notification would be inconsistent with a fair and effective review.

~~5.~~E. ~~Delegation of Functions:~~ The ASC MEC is responsible for the PPE/quality assurance process described in this Policy, subject to the oversight of the Governing Body. To promote a prompt and effective review process, the ASC MEC may delegate to the PPE Specialist(s), Assigned Reviewers, and/or CSRC members, the authority to perform the functions described in this Policy on behalf of the ASC MEC. Actions taken by these individuals will be reported to and reviewed by the ASC MEC as set forth in this Policy.

~~a.~~1. When a function under this Policy is to be carried out by one of the individuals identified in the prior subsection, by a member of ASC ~~management~~, or by an ASC Medical Staff member, the individual, or the committee through its chair, may delegate performance of the function to a qualified designee who is a Practitioner, APP, or ASC employee (or a committee of such individuals). Any such designee must treat and maintain

all information in a strictly confidential manner and is bound by all other terms, conditions, and requirements of this Policy. In addition, the delegating individual or committee is responsible for ensuring that the designee appropriately performs the function in question. Any documentation created by the designee are records of the committee that is ultimately responsible for the review in a particular matter.

~~b.~~2. When an individual assigned a function under this Policy is unavailable or unable to perform that function, one or more ASC Medical Staff members may perform the function personally or delegate it to another appropriate individual as set forth above.

6.F. ~~No Legal Counsel or Recordings During Collegial Meetings:~~ To promote the collegial and educational objectives of this Policy, all discussions and meetings with a Practitioner or APP shall generally involve only the Practitioner or APP and the appropriate Medical Staff members and ASC personnel. No counsel representing the Practitioner, APP, Medical Staff, or the ASC shall attend any of these meetings. ~~I~~At~~n~~ their discretion, ASC Medical Staff l~~L~~eaders may permit a Practitioner or APP to invite another Practitioner or APP to the meeting. In such case, the invited Practitioner or APP may not participate in the discussion or in any way serve as an advocate for the Practitioner or APP under review, must sign a Confidentiality Agreement, and may be required to leave the meeting at any time.

~~a.~~ Practitioners or APPs may not create an audio or video recording of a meeting nor may they broadcast it in any manner ~~(e.g., via live streaming)~~. If a recording is made in violation of this rule, the recording shall be destroyed. In their discretion, Medical Staff may require that smart phones, tablets, and/or ~~iPads, and~~ similar devices be left outside the meeting room. In exceptional circumstances, ASC Medical Staff or ~~ASC~~ personnel may record a meeting if necessary to prepare accurate minutes or an interview summary. Once the document is prepared, however, any such recording shall also be destroyed.

~~P.~~**XII. PROFESSIONAL PRACTICE EVALUATION REPORTS~~:~~**

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~~1.~~A. ~~Practitioner / APP PPE History Reports:~~ A Practitioner or APP history report showing all cases that have been reviewed for a Practitioner or APP within the

past two years and their dispositions should be generated for each Practitioner or APP for consideration and evaluation by the appropriate ASC Medical Director and the ASC MEC in the reappointment process.

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~~2.~~B. ~~Reports to the ASC Medical Executive Committee, Medical Staff, and Governing Body:~~ The PPE Specialist(s) shall prepare reports at least annually that provide aggregate information regarding the PPE process ~~(e.g., numbers of cases reviewed by department or specialty; types and numbers of dispositions for the cases, including numbers of cases closed at each level of the process; listing of education initiatives based on reviews; listing of system issues identified)~~. These reports shall be disseminated to the ASC MEC~~edical Executive Committee~~, ~~all~~ Practitioners and APP's at the ASC, and the Governing Body for the purposes of reinforcing the primary objectives outlined in Section 1. A of this policy and permitting appropriate oversight.

~~3.~~C. ~~Reports on Request:~~ The PPE Specialists shall prepare reports as requested by the ASC Medical Director, ASC MEC, or the Governing Body.

XIII. PPE MANUAL~~:~~

~~Q.~~ The ASC MEC shall recommend Governing Body approval of forms, template letters, and other documents that assist with the implementation of this Policy. Collectively, these documents are known as the Professional Practice Evaluation Manual. Such documents shall be developed and maintained by the PPE Specialists. Individuals performing pursuant to this Policy should use the

document currently approved for that function and revise per the current ASC processes~~as necessary~~.

XIV. SUBSTANTIAL COMPLIANCE:

~~R.~~ -While every effort will be made to comply with all provisions of this Policy, substantial compliance is required. Technical or minor deviations from the procedures set forth within this Policy do not invalidate any review or action taken.

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XV. AGREEMENT TO VOLUNTARILY REFRAIN FROM EXERCISING CLINICAL PRIVILEGES OR OTHER PRACTICE CONDITIONS:

~~S.~~A. At any point in the review process described in this Policy, the ASC MEC or a representative designated by the ASC MEC Medical Director may ask a Practitioner or APP to voluntarily refrain from exercising clinical privileges while the review proceeds. As an alternative, ASC Medical Staff ~~L~~leaders and the Practitioner or APP may also agree upon practice conditions that will protect the Practitioner, APP, patients, and staff during the review process. Prior to any such action, the Practitioner or APP shall be given the opportunity to discuss these issues with the ASC MEC Medical Director or their representatives and provide written input regarding them.

~~T.~~B. These actions are not considered to be disciplinary actions and do not imply any admission by the Practitioner or APP or final finding of responsibility for the

concerns that have been raised. They are temporary precautions and reflect professionalism and cooperation with the review process.

2. In light of the voluntary and non-disciplinary nature of these actions, they do not generally represent matters that require any report to any State Board or to the National Practitioner Data Bank.

T. ***Definitions and Acronyms:***

1.A. ***Assigned Reviewer: means a Practitioner or APP who is requested by the ASC Medical Director to:***

i.A. serve as a consultant and assist performing the review; or

ii.A. conduct a review, document his/her clinical findings on a case review form, submit the form to the ASC Medical Director that assigned the review, and be available to discuss findings and answer questions.

2.A. APP or Advanced Practice Professional: Shall have the same meaning as that term is defined in the Medical Staff Bylaws

A. Clinical Specialty Review Committee (CSRC): a committee of at least one Practitioner or APP from a clinical service or specialty, working in conjunction with the ASC Medical Director. The individual(s) and committee that will function as CSRCs will be designated by the ASC MEC Medical Director. CSRCs receive cases for review, obtain input from assigned reviewers as needed, complete the case review form in this Policy, and make a determination as described in Section 2.D of this Policy.

3.A. Executive Session: 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.

4.A. ASC Medical Executive Committee (ASC MEC): a multi specialty medical peer review committee under Texas law that oversees the professional practice evaluation process, conducts case reviews, works with Practitioners and APPs in a constructive and educational manner to help address any clinical performance issues, and develops Voluntary Enhancement Plans as described in this Policy.

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~~The ASC MEC has the authority to conduct non-routine, formal investigations and to recommend restrictions of clinical privileges to the Governing Body. The composition and duties of the ASC MEC are described in the Medical Staff Bylaws.~~

~~5.~~A. ~~Practitioner: shall have the same meaning as that term is defined in the Medical Staff Bylaws.~~

~~6.~~ ~~Professional Practice Evaluation (PPE): refers to the ASC's routine peer review process. It is used to evaluate a Practitioner's or APP's professional performance when any questions or concerns arise. The PPE process outlined in this Policy is applicable to all Practitioners and APPs and is not intended to be a precursor to any disciplinary action, but rather is designed to promote improved patient safety and quality through continuous improvement.~~

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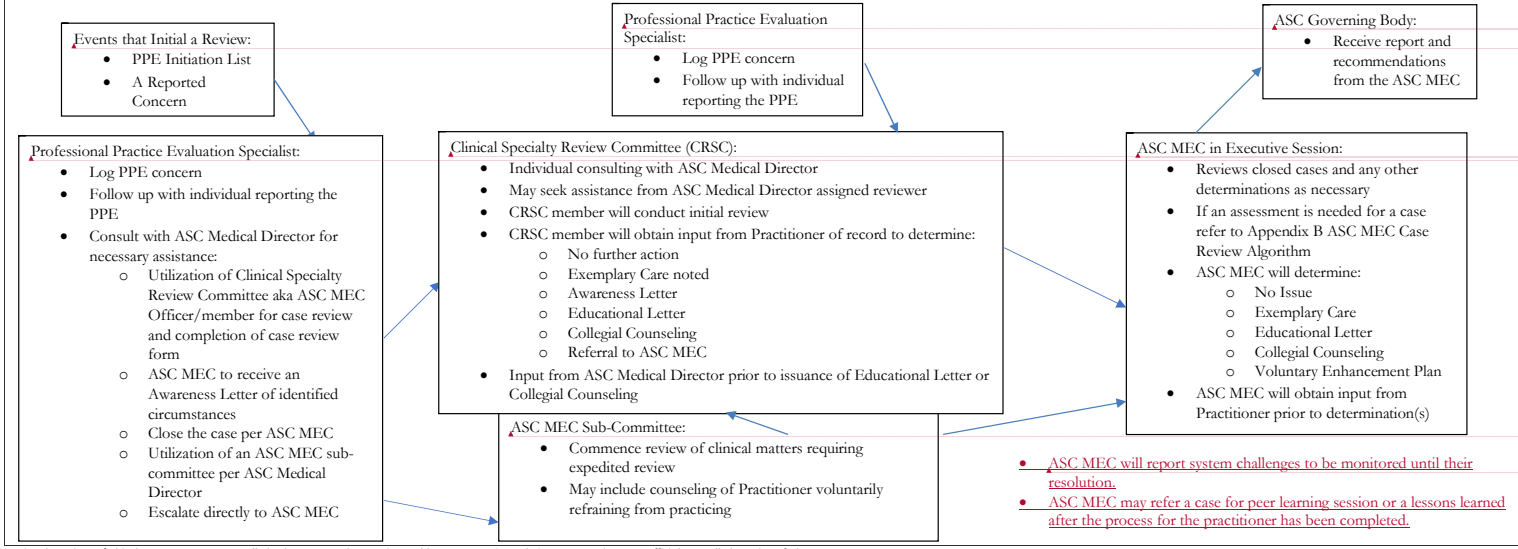
Appendix A
Ambulatory Surgical Center at LBJ
Professional Practice Evaluation Process



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Ap

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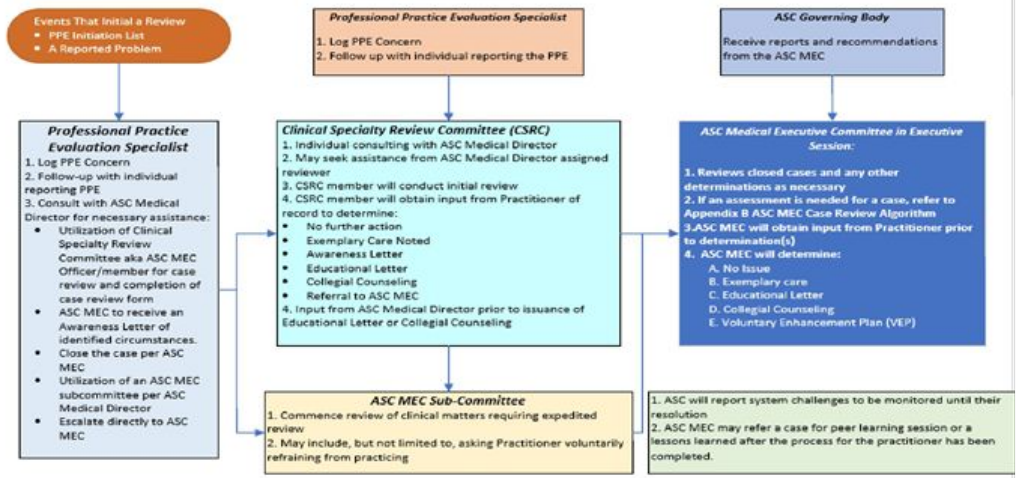
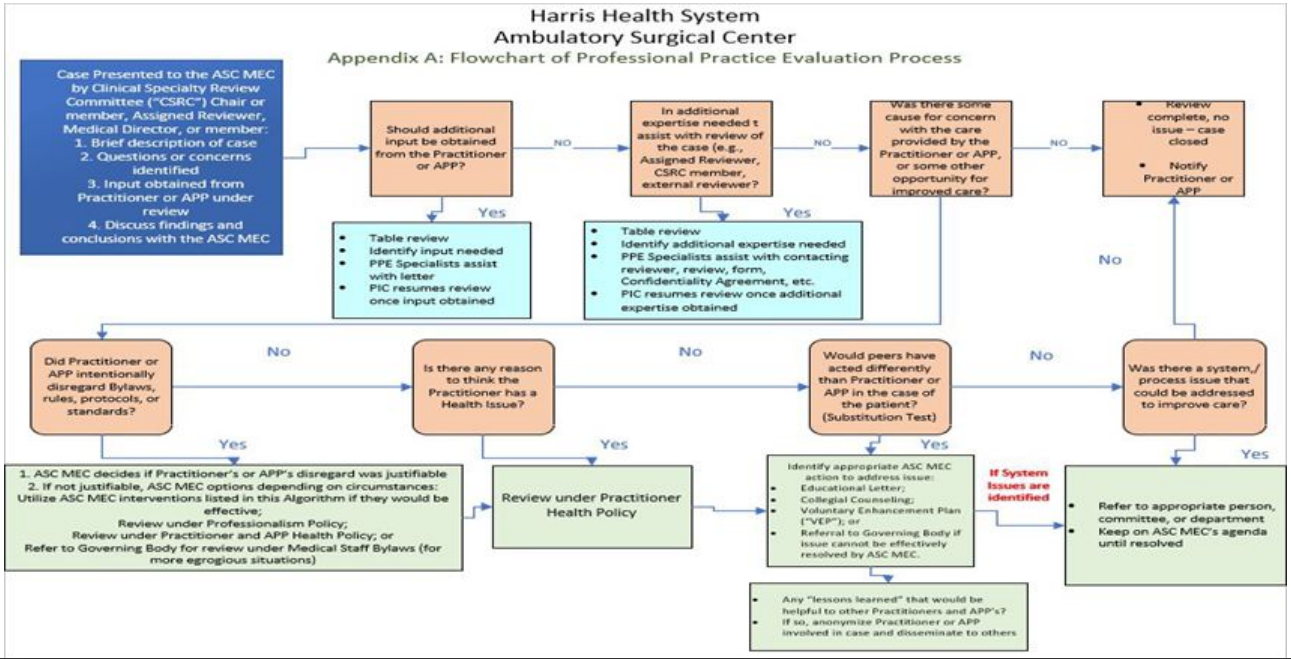
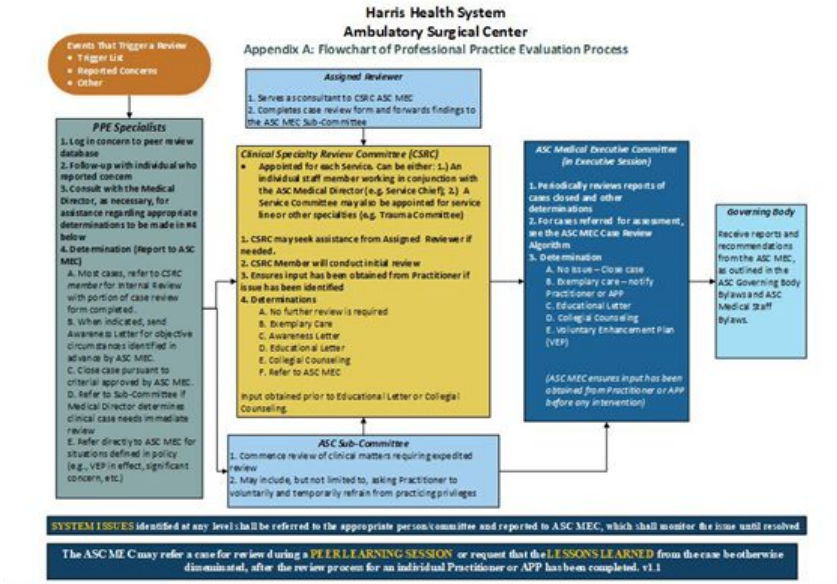
Harris Health System
Ambulatory Surgical Center
Appendix A: Flowchart of Professional Practice Evaluation Process




Harris Health System
Ambulatory Surgical Center
Appendix A: Flowchart of Professional Practice Evaluation Process
Case Presented to the ASC MEC by Clinical Specialty Review Committee ("CSRC") Chair or member, Assigned Reviewer, Medical Director, or member:
1. Brief description of case
2. Questions or concerns identified
3. Input obtained from Practitioner or APP under review
4. Discuss findings and conclusions with the ASC MEC
Should additional input be obtained from the Practitioner or APP?
NO
In additional expertise needed t assist with review of the case (e.g., Assigned Reviewer, CSRC member, external reviewer?
NO
Was there some cause for concern with the care provided by the Practitioner or APP, or some other opportunity for improved care?
NO
Review complete, no issue – case closed
Notify Practitioner or APP
Yes
Table review
Identify input needed
PPE Specialists assist with letter
PIC resumes review once input obtained
Yes
Table review
Identify additional expertise needed
PPE Specialists assist with contacting reviewer, review, form, Confidentiality Agreement, etc.
PIC resumes review once additional expertise obtained
No
Did Practitioner or APP intentionally disregard Bylaws, rules, protocols, or standards?
No
Is there any reason to think the Practitioner has a Health Issue?
No
Would peers have acted differently than Practitioner or APP in the case of the patient? (Substitution Test)
No
Was there a system,/ process issue that could be addressed to improve care?
Yes
1. ASC MEC decides if Practitioner's or APP's disregard was justifiable
2. If not justifiable, ASC MEC options depending on circumstances: Utilize ASC MEC interventions listed in this Algorithm if they would be effective;
Review under Professionalism Policy;
Review under Practitioner and APP Health Policy; or
Refer to Governing Body for review under Medical Staff Bylaws (for more egregious situations)
Yes
Review under Practitioner Health Policy
Yes
Identify appropriate ASC MEC action to address issue:
Educational Letter;
Collegial Counseling;
Voluntary Enhancement Plan ("VEP"); or
Referral to Governing Body if issue cannot be effectively resolved by ASC MEC.
Yes
If System Issues are identified
Refer to appropriate person, committee, or department
Keep on ASC MEC's agenda until resolved
Yes
Any "lessons learned" that would be helpful to other Practitioners and APP's?
If so, anonymize Practitioner or APP involved in case and disseminate to others



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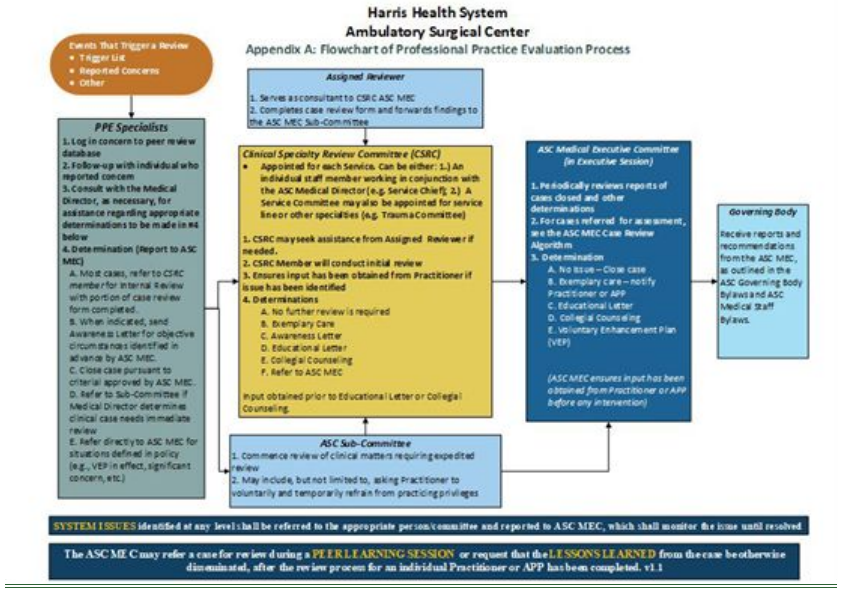
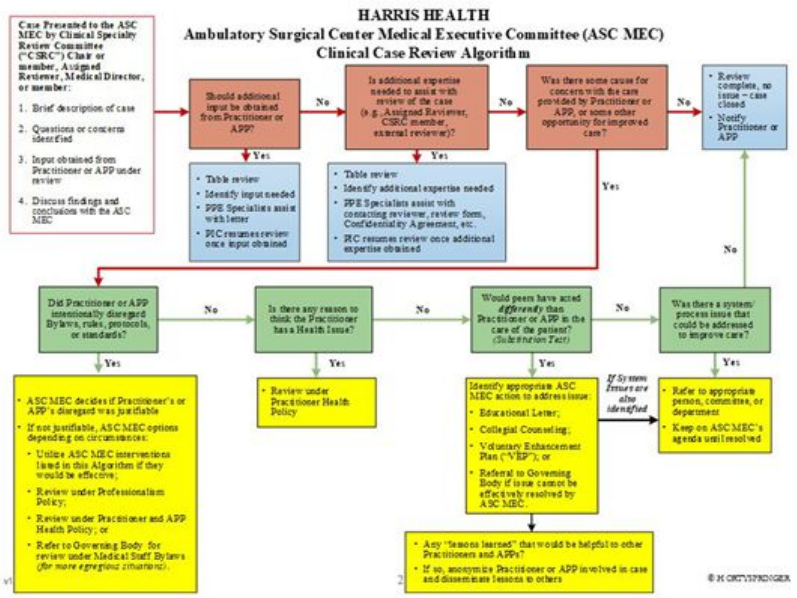

Harris Health System
Ambulatory Surgical Center
Appendix A: Flowchart of Professional Practice Evaluation Process
Events That Trigger a Review
• Trigger List
• Reported Concerns
• Other
Assigned Reviewer
1. Serves as consultant to CSRC ASC MEC
2. Completes case review form and forwards findings to the ASC MEC Sub-Committee
PPE Specialists
1. Log in concern to peer review database
2. Follow-up with individual who reported concern
3. Consult with the Medical Director, as necessary, for assistance regarding appropriate determinations to be made in #4 below
4. Determination (Report to ASC MEC)
A. Most cases, refer to CSRC member for Internal Review with portion of case review form completed.
B. When indicated, send Awareness Letter for objective circumstances identified in advance by ASC MEC.
C. Close case pursuant to criteria approved by ASC MEC
D. Refer to Sub-Committee if Medical Director determines clinical case needs immediate review
E. Refer directly to ASC MEC for situations defined in policy (e.g., VEP in effect, significant concern, etc.)
Clinical Specialty Review Committee (CSRC)
• Appointed for each Service. Can be either: 1.) An individual staff member working in conjunction with the ASC Medical Director (e.g. Service Chief); 2.) A Service Committee may also be appointed for service line or other specialties (e.g. Trauma Committee)
1. CSRC may seek assistance from Assigned Reviewer if needed.
2. CSRC Member will conduct initial review
3. Ensures input has been obtained from Practitioner if issue has been identified
4. Determinations
A. No further review is required
B. Exemplary Care
C. Awareness Letter
D. Educational Letter
E. Collegial Counseling
F. Refer to ASC MEC
Input obtained prior to Educational Letter or Collegial Counseling.
ASC Sub-Committee
1. Commence review of clinical matters requiring expedited review
2. May include, but not limited to, asking Practitioner to voluntarily and temporarily refrain from practicing privileges
ASC Medical Executive Committee (in Executive Session)
1. Periodically reviews reports of cases closed and other determinations
2. For cases referred for assessment, see the ASC MEC Case Review Algorithm
3. Determination
A. No issue – Close case
B. Exemplary care – notify Practitioner or APP
C. Educational Letter
D. Collegial Counseling
E. Voluntary Enhancement Plan (VEP)
(ASC MEC ensures input has been obtained from Practitioner or APP before any intervention)
Governing Body
Receive reports and recommendations from the ASC MEC, as outlined in the ASC Governing Body Bylaws and ASC Medical Staff Bylaws.
SYSTEM ISSUES identified at any level shall be referred to the appropriate person/committee and reported to ASC MEC, which shall monitor the issue until resolved
The ASC MEC may refer a case for review during a PEER LEARNING SESSION or request that the LESSONS LEARNED from the case be otherwise disseminated, after the review process for an individual Practitioner or APP has been completed. v1.1


HARRIS HEALTH
Ambulatory Surgical Center Medical Executive Committee (ASC MEC)
Clinical Case Review Algorithm
Case Presented to the ASC MEC by Clinical Specialty Review Committee ("CSRC") Chair or member, Assigned Reviewer, Medical Director, or member:
1. Brief description of case
2. Questions or concerns identified
3. Input obtained from Practitioner or APP under review
4. Discuss findings and conclusions with the ASC MEC
Should additional input be obtained from Practitioner or APP?
Yes
Table review
Identify input needed
PPE Specialists assist with letter
PEC resumes review once input obtained
No
Is additional expertise needed to assist with review of the case (e.g., Assigned Reviewer, CSRC member, external reviewer)?
Yes
Table review
Identify additional expertise needed
PPE Specialists assist with contacting reviewer, review form, Confidentiality Agreement, etc.
PEC resumes review once additional expertise obtained
No
Was there some cause for concern with the care provided by Practitioner or APP, or some other opportunity for improved care?
Yes
No
Review complete, no issue – case closed
Notify Practitioner or APP
Did Practitioner or APP intentionally disregard Bylaws, rules, protocols, or standards?
Yes
ASC MEC decides if Practitioner's or APP's disregard was justifiable
If not justifiable, ASC MEC options depending on circumstances:
Utilize ASC MEC interventions listed in this Algorithm if they would be effective;
Review under Professionalism Policy;
Review under Practitioner and APP Health Policy; or
Refer to Governing Body for review under Medical Staff Bylaws (for more egregious situations).
No
Is there any reason to think the Practitioner has a Health Issue?
Yes
Review under Practitioner Health Policy
No
Would peers have acted differently than Practitioner or APP in the care of the patient? (Substitution Test)
Yes
Identify appropriate ASC MEC action to address issue:
Educational Letter;
Collegial Counseling;
Voluntary Enhancement Plan ("VEP"); or
Referral to Governing Body if issue cannot be effectively resolved by ASC MEC.
If System Issues are also identified
No
Was there a system/process issue that could be addressed to improve care?
Yes
Refer to appropriate person, committee, or department
Keep on ASC MEC's agenda until resolved
Any "lessons learned" that would be helpful to other Practitioners and APPs?
If so, anonymize Practitioner or APP involved in case and disseminate lessons to others

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APPENDIX B

CONFLICT OF INTEREST GUIDELINES

Potential Conflicts	Levels of Participation					
	Provide Information	Committee Member			Hearing Panel	Governing Body
		CSRC	ASC MEC	Investigating Committee		
Employment/contract relationship with Harris Health	Y	Y	Y	Y	Y	Y
Self or family member	Y	R	R	N	N	R
Relevant treatment relationship	Y	R	R	N	N	R
Significant financial relationship	Y	Y	Y	N	N	R
Direct competitor	Y	Y	Y	N	N	R
Close friends	Y	Y	Y	N	N	R
History of conflict	Y	Y	Y	N	N	R
Provided care in case under review (but not subject of review)	Y	Y	Y	N	N	R
Involvement in prior VEP or disciplinary action	Y	Y	Y	N	N	R
Formally raised the concern	Y	Y	Y	N	N	R

Y ("Yes") – means the Interested Member may serve in the indicated role; no extra precautions are necessary.

Y ("Yes, with infrequent but occasional limitations") – means the Interested Member may generally serve in the indicated role. It is legally permissible for Interested Members to serve in these roles because of the check and balance provided by the multiple levels of review and the fact that CSRCs and ASC MEC have no disciplinary authority.

In addition, the Chair of each of these committees always has the authority and discretion to recuse a member in a particular situation if the Chair determines that the Interested Member's presence would (i) inhibit the full and fair discussion of the issue before the committee, (ii) skew the recommendation or determination of the committee, or (iii) otherwise be unfair to the Practitioner or APP under review.

N ("No") – means the Interested Member should not serve in the indicated role.

R ("Recuse") – means the Interested Member should be recused, in accordance with the guidelines on the next page.

RULES FOR RECUSAL	
STEP 1 Confirm the conflict of interest	The Committee Chair or Governing Body Chair should confirm the existence of a conflict of interest relevant to the matter under consideration.
STEP 2 Participation by the Interested Member at the meeting	The Interested Member may participate in any part of the meeting that does not involve the conflict-of-interest situation. When the matter implicating the conflict of interest is ready for consideration, the Committee Chair or Governing Body Chair will note that the Interested Member will be excused from the meeting prior to the group's deliberation and decision-making. Prior to being excused, the Interested Member may provide information and answer any questions regarding the following: (i) any factual information for which the Interested Member is the original source; (ii) clinical expertise that is relevant to the matter under consideration; (iii) any policies or procedures that are applicable to the committee or Governing Body or are relevant to the matter under consideration; (iv) the Interested Member's prior involvement in the review of the matter at hand (for example, an Investigating Committee member may describe the Investigating Committee's activities and present the Investigating Committee's written report and recommendations to the Medical Executive Board prior to being excused from the meeting); and (v) how the committee or Governing Body has, in the past, managed issues similar or identical to the matter under consideration.
STEP 3 The Interested Member is excused from the meeting	The Interested Member will then be excused from the meeting (i.e., physically leave the meeting room and/or disconnect from any telephone or other electronic connection) prior to the committee's or Governing Body's deliberation and decision-making.
STEP 4 Record the recusal in the minutes	The recusal should be documented in the minutes of the committee or Governing Body. The minutes should reflect the fact that the Interested Member was excused from the meeting prior to deliberation and decision-making.

REFERENCES/BIBLIOGRAPHY:

(To be updated)

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:
	1.0	08/22/2024	The Ambulatory Surgical Center (ASC) at LBJ Governing Body

HARRISHEALTH
AMBULATORY SURGICAL CENTER AT LBJ

Policy No: ASC-P-4015
Page Number: 1 of 29

Effective Date:
Board Motion No: n/a

TITLE: MEDICAL STAFF PROFESSIONALISM

PURPOSE: To establish guidelines for collegiality, collaboration, and professionalism at the Ambulatory Surgical Center (ASC) at LBJ in order to establish and maintain a culture of quality care and safety.

POLICY STATEMENT:

It is the policy of the Ambulatory Surgical Center (ASC) at LBJ to establish a process that will be used to evaluate and collegially resolve concerns that a physician or Advanced Practice Professional (APP) has engaged in inappropriate conduct. It is also the policy of the ASC to treat each other with respect, courtesy, and dignity, and we ask all to conduct themselves in a professional and cooperative manner.

POLICY ELABORATIONS:

~~I.~~ **REPORTS OF INAPPROPRIATE CONDUCT:**

I.

DEFINITIONS:

A.

1. **COLLEGIAL COUNSELING**: A formal, planned face-to-face discussion between a physician or APP and the ASC Medical Director. ~~Collegial Counseling only occurs after a physician/APP or has had an opportunity to provide input regarding a concern. If the Collegial Counseling results from a matter that has been reported to the PPE Specialists and reviewed through this Policy, it shall be followed by a letter that summarizes the discussion and, when applicable, the expectations regarding the physician's future practice at the ASC. A copy of the follow-up letter will be included in the physician/APP's file along with any response that the physician/APP would like to offer. In contrast, informal discussions, mentoring, counseling, sharing of comparative data, and similar efforts that do not meet the criteria for a Collegial Counseling are referred to as Initial Mentoring Efforts. This Policy encourages the use of Initial Mentoring Efforts to assist Practitioners and APPs in continually~~

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~~improving their practices. There is no requirement that input be obtained prior to Initial Mentoring Efforts or that they be documented. However, documentation is recommended particularly if a pattern of behavior may be developing. Any documentation will be maintained in physician/APP's confidential file.~~

2. **INAPPROPRIATE CONDUCT**: Conduct defined in Appendix B

3. **INVESTIGATION:** A non-routine, process to review concerns pertaining to a physician or APP. The ASC Medical Director has the authority to initiate and conduct an Investigation. The process to address issues of professional conduct as outlined in this Policy does not constitute an investigation.

4. **PROFESSIONAL PRACTICE EVALUATION (PPE) SPECIALIST(S)**: Staff who support the ASC Medical Director on the Professional Practice Evaluation ~~(PPE)~~ process generally and the review of issues related to professionalism described in this Policy. This may include Harris Health employees contracted through the Service Level Agreement.

5. **PROFESSIONALISM MANUAL:** Forms, checklists, template letters and other documents that assist with the implementation of this Policy. Such documents shall be developed and maintained by the PPE Specialists and approved for use by the ASC.

6. **PHYSICIAN/PRACTITIONER AND ADVANCED PRACTICE PROFESSIONAL (APP)**: Shall have the same meaning as those terms are defined in the Medical Staff Bylaws.

SEXUAL HARASSMENT AND OTHER IDENTITY-BASED HARASSMENT: Conduct defined in Appendix B of this Policy.

7.

~~B.~~ **REPORTS:**

B.

1. Collegial Counseling may only occur after a physician/APP has had an opportunity to provide input regarding a concern. If the Collegial

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Counseling results from a matter that has been reported to the PPE Specialist and reviewed through this Policy, it shall be followed by a letter that summarizes the discussion and, when applicable, the expectations regarding the physician's future practice at the ASC. A copy of the follow-up letter will be included in the physician/APP's file along with any response that the physician/APP would like to offer. In contrast, informal discussions, mentoring, counseling, sharing of comparative data, and similar efforts that do not meet the criteria for a Collegial Counseling are referred to as Initial Mentoring Efforts. This Policy encourages the use of Initial Mentoring Efforts to assist Practitioners and APPs in continually improving their practices. There is no requirement that input be obtained prior to Initial Mentoring Efforts or that they be documented. However, documentation is recommended particularly if a pattern of behavior may be developing. Any documentation will be maintained in physician/APP's confidential file.

ASC employees, Practitioners, or APPs who observe, or are subjected to, Inappropriate Conduct by a Practitioner or APP shall report the incident in

a timely manner by submitting a report through an approved Harris Health reporting mechanism. ~~:~~

~~a.~~ Individuals receiving such reports will forward it to the PPE Specialists.

~~b.~~ The PPE Specialists shall notify the ASC Medical Director of all reported concerns and log them in a confidential peer review database.

~~c.~~ Concerns involving Sexual Harassment or Other Identity-Based Harassment will be immediately referred for investigation in accordance with Section J.2. of this Policy.

2.

~~1. FOLLOW-UP WITH INDIVIDUAL WHO FILED REPORT:~~ The PPE Specialists shall follow up with individuals who file a report. A response to the individual reporting concerns about conduct is included in the Professionalism Manual.

3.

~~C.~~ **RESOLUTION OF MINOR CONCERNS:**

C.

~~1. CRITERIA FOR RESOLUTION OF MINOR CONCERNS:~~ A reported minor concern may be resolved without the need for further review under this Policy if the ASC Medical Director determines that ~~:~~

~~a.~~ ~~T~~the reported concern is minor in nature and ~~;~~

~~a.~~ ~~T~~there is no history or pattern with the Practitioner or APP in question.

1.

~~2. PROCEDURE FOR RESOLUTION OF MINOR CONCERNS:~~ For concerns that qualify as minor, the ASC Medical Director may resolve them through the procedure of ~~will communicate~~communicating with the

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Practitioner or APP about the matter. The purpose of this communication is to make the Practitioner or APP aware that another individual perceived the Practitioner's or APP's behavior as unprofessional and the Practitioner or APP may reflect and self-correct ~~as needed~~. No conclusions about the Practitioner's or APP's behavior are reached as a result of this process, so there is no need for fact-finding or input from the Practitioner or APP. The Medical Director may choose to follow up with a brief note to the Practitioner or APP memorializing any conversation.

~~a.~~ The ASC Medical Director will notify the PPE Specialists that a minor concern has been resolved in this manner. A Form to Document Resolution of Minor Concerns is included in the Professionalism Manual.

2.

3. ~~**REPORTS TO ASC MEC:**~~ The PPE Specialists will provide the ASC MEC with periodic reports of minor concerns that have been resolved under this section to allow for oversight of the process and consistency.

~~E.~~D. PROCEDURE FOR~~WHEN CONCERNS ARE MORE~~ SIGNIFICANT CONCERNS OR A PATTERN HAS DEVELOPED:

The steps set forth below apply to reported concerns about behavior that, as determined by the ASC Medical Director, involve more serious allegations or a pattern of behavior.

1.

~~1.~~2. ~~Preliminary Notification to Practitioner or APP:~~ The ASC Medical Director shall notify the Practitioner or APP that a concern has been raised and that the matter is being reviewed. Generally, this preliminary communication should occur via a brief telephone call, a personal discussion, or e-mail as soon as practical. The Practitioner or APP should be informed that they will be invited to provide input regarding the matter after further review of

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the reported concern has occurred and before any review by the ASC MEC. The Practitioner or APP should also be reminded to avoid any action that could be perceived as retaliation.

~~2.~~3. ~~Case Review by Service Chief:~~ A case review form will be sent to the Practitioner or APP's Service Chief by the ASC Medical Director to inform them of the reported concern and request their review of the matter.

~~3. Fact-Finding:~~ The ASC Medical Director shall, in their discretion, interview witnesses or others who were involved in the incident and gather necessary documentation or information needed to assess the reported concern. An Interview Tool for Fact-Finding: Script, Questions, and Guidance that may be used for such interviews is included in the Professionalism Manual.

4.

~~a.~~5. If an allegation involves Sexual Harassment or other Identity-Based Harassment, fact-finding will occur in accordance with Section J.2 of this Policy.

~~4.~~ Determination by the ASC Medical Director:

6.

~~a. No Further Review Required:~~ Following the investigation, the ASC Medical Director may determine that a reported concern does not raise issues that need to be addressed pursuant to this Policy. In such case, no input regarding the circumstances will be sought from the Practitioner or APP and the matter will be closed. A letter will be sent to the Practitioner or APP notifying them of the reported concern and that the case was closed without further review. The Practitioner or APP and the ASC MEC will be notified of this determination and documentation that the matter was closed will be maintained.

a)

~~b. Further Review Required:~~ The ASC Medical Director may determine that a matter should be reviewed further by the ASC MEC. In such

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case, the Practitioner's or APP's input and perspective will be obtained as set forth in Section E of this Policy. The matter shall then be referred to the ASC MEC. The PPE Specialists shall prepare a summary report of the matter for review by the ASC MEC and provide the ASC MEC with all supporting documentation.

b)

~~1.~~ If an allegation involves Sexual Harassment or Other Identify-Based Harassment, further review will be determined in accordance with Section J.2 of this Policy.

c)

~~F.~~ OBTAINING INPUT FROM THE PRACTITIONER OR APP:

E.

1. ~~General:~~ The ASC Medical Director or PPE Specialists on the behalf of the Medical Director will provide details of the concern, ~~(~~but not a copy of any reported concern,~~)~~ to the Practitioner or APP and ask the Practitioner or APP to provide a written explanation of what occurred and their perspective on the incident. A Cover Letter to Practitioner or APP Seeking Input Regarding Behavior Concern which may be used for this purpose is included in the Professionalism Manual. If an allegation involves Sexual Harassment or other Identity-Based Harassment, obtaining input from the Practitioner or APP will occur in accordance with Section J.2. of this Policy
2. ~~Sharing Identity of Any Individual Reporting a Concern:~~ Since this Policy does not involve disciplinary action or restrictions of privileges, the specific identity of any individual reporting a concern or otherwise providing information about a matter will not be disclosed to the Practitioner or APP unless the individual consents or the information is later used to support an adverse professional review action that results in a Medical Staff hearing.
3. ~~Reminder of Practitioner's or APP's Obligations:~~ The ASC Medical Director will remind the Practitioner or APP of the need to maintain confidentiality and the importance of avoiding any actions that could be

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viewed as retaliation as part of seeking their input. The Cover Letter to Practitioner or APP Seeking Input Regarding Behavior Concern set forth in the Professionalism Manual addresses these issues. If concerns about confidentiality and non-retaliation are more significant, the Practitioner or APP may be required to sign a Confidentiality and Non-Retaliation Agreement (a copy of which is included in the Professionalism Manual) prior to providing detailed information regarding the concern to the Practitioner or APP.

~~Failure of the Practitioner or APP to Provide Requested Input or Attend Meeting:~~ A Practitioner or APP is required to provide written input or attend a meeting as requested by the ASC Medical Director within the time frame specified. Failure to respond within the timeframe result in a review that will proceed without input from the Practitioner or APP.

4.

~~G.~~ **ASC MEDICAL EXECUTIVE COMMITTEE PROCEDURE:**

F.

1. ~~Initial Review:~~ The ASC MEC shall review, in Executive Session, the summary prepared by the PPE Specialists and supporting documentation, including the Service Chief's review, and response from the Practitioner or APP. If necessary, the ASC MEC may also meet with the individual who submitted the report and any witnesses to the incident. The ASC MEC may consult with or include in the review another physician or APP or any other individual who would assist in the review.

2. ~~Practitioner or APP and ASC MEC Meeting:~~ If either the ASC MEC or the Practitioner or APP believes it would be helpful prior to the ASC MEC concluding its review and making a determination, a meeting may be held between the Practitioner or APP and the ASC MEC to discuss the circumstances further and obtain additional facts. At its discretion, the ASC MEC may designate one or more committee members to attend the meeting rather than the full committee, regardless of who requested the meeting. The ASC MEC may also obtain additional written input from the

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Practitioner or APP as set forth in Section D of this policy. If an allegation involves Sexual Harassment or other Identity-Based Harassment, this meeting will occur in accordance with Section J.2. of this Policy.

~~Refusal to Provide Information or Meet with ASC MEC:~~ A Practitioner or APP who refuses to provide information or meet with the ASC MEC will be addressed as set forth in Section D of this policy~~.~~

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~~H.~~G. ASC MEC DETERMINATION:

1. After ~~its~~ review of relevant information, including input from the Practitioner or APP, the ASC MEC may:

   ~~a.~~a) Determine that no further review or action is required;

   ~~b.~~b) Send the Practitioner or APP an Educational Letter, providing guidance and counsel;

   ~~c.~~c) Engage in Collegial Counseling with the Practitioner or APP and provide education and coaching (a Collegial Counseling Checklist and Follow-Up Letter to Collegial Counseling are included in the Professionalism Manual);

   ~~d.~~d) Develop a Voluntary Enhancement Plan for Conduct (VEP), as described in Section H of this Policy (an Implementation Issues Checklist for VEPs for Conduct is included in the Professionalism Manual); or

   ~~e.~~e) ~~r~~Re~~e~~fer the matter for Corrective Action as set forth in the ASC Medical Staff Bylaws.

2. ~~ASC MEC Review Not an Investigation:~~ A review conducted by the ASC MEC or by any individual pursuant to this Policy shall not constitute an Investigation.

3. ~~Additional Reports of Inappropriate Conduct:~~ If additional reports of Inappropriate Conduct are received concerning a Practitioner or APP, the ASC MEC may continue to use the collegial and progressive steps outlined

in this Policy as long as it believes that there is a reasonable likelihood that those efforts will resolve the concerns.

~~Determination to Address Concerns through Practitioner/APP Health Policy:~~ The ASC MEC may determine to address the conduct concerns through the Practitioner Health Policy if it believes that there may be a legitimate, underlying health issue that is causing the concerns and the review process outlined in the Practitioner/APP Health Policy is more likely to successfully resolve the concerns.

4.

~~I.~~ **VOLUNTARY ENHANCEMENT PLAN ~~FOR CONDUCT~~:**

H.

1. ~~General:~~ The ASC MEC may determine it is necessary to develop a Voluntary Enhancement Plan (VEP) for the Practitioner or APP. One or more ~~members~~ of the ASC MEC members ~~should personally~~will discuss the VEP with the Practitioner or APP to help ensure a shared and clear understanding of the elements of the VEP. The VEP will ~~also~~ be presented in writing, with a copy being placed in the Practitioner's or APP's file, along with any statement the Practitioner or APP would like to offer.

2. ~~Voluntary Nature of a VEP:~~ If a Practitioner or APP agrees to participate in a VEP developed by the ASC MEC, such agreement will be documented in writing. If a Practitioner or APP disagrees with a recommended VEP developed by the ASC MEC, the Practitioner or APP is under no obligation to participate ~~in it~~. In such a case, the ASC MEC cannot compel the Practitioner or APP to agree with the VEP. Instead, the ASC MEC will refer the matter review and action pursuant to the Medical Staff Bylaws.

3. ~~VEP Options:~~ A VEP for conduct may include, but is not limited to, one or more of the actions in this Section. None of these actions entitles the Practitioner or APP to a hearing or appeal as described in the Medical Staff Bylaws, nor do they require that reports be made to any state licensing board or the National Practitioner Data Bank. A VEP Options for Conduct – Implementation Issues Checklist that may be used to assist with

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implementation of the following VEP options is included in the Professionalism Manual

~~a.~~a) ~~Education/CME (or equivalent for APPs):~~ Within a specified period of time, the Practitioner or APP, must arrange for education or CME related to behavioral matters of a duration and type approved by the ASC MEC;

~~b.~~b) ~~Meeting with Designated Group to Conduct Enhanced Collegial Counseling:~~ The Practitioner or APP may be invited to meet with a designated group to discuss the concerns with the Practitioner's or APP's conduct and the need to modify the conduct. An ad hoc group may include any combination of current or past Medical Staff Leaders, Harris Health leaders, outside consultants, if the ASC MEC determines that involvement is reasonably likely to impress upon the Practitioner or APP involved the seriousness of the matter and the necessity for the Practitioner's or APP's conduct to improve. A letter outlining the discussion and expectations for conduct shall be sent to the Practitioner or APP after the meeting;

~~c.~~c) ~~Periodic Meetings with Medical Staff Leaders or Mentors:~~ The ASC MEC may recommend that the Practitioner or APP be required to meet periodically with one or more medical staff leaders or a mentor designated by the ASC MEC. The purpose of these meetings is to provide input and updates on the Practitioner's or APP's performance, as well as to offer assistance and support with any challenging issues the Practitioner or APP may be encountering;

~~d.~~d) ~~Review of Literature Concerning the Connection Between Behavior and Patient Safety:~~ The ASC MEC may recommend that the Practitioner or APP review selected literature concerning the established connection between behavior and patient care and safety and then provide a report to the ASC MEC summarizing the

information reviewed and how it can be applied to the individual's practice;

~~e.~~e) ~~Behavior Modification Course:~~ The ASC MEC may recommend that the Practitioner or APP complete a behavior modification course that is acceptable to the ASC MEC. The cost of this external assistance shall be borne by the Practitioner or APP, unless the ASC MEC determines otherwise.;

~~f.~~f) ~~Personal Code of Conduct:~~ The ASC MEC may develop a personal code of conduct for the Practitioner or APP, which provides specific guidance regarding the expectations for future conduct and outlines the specific consequences of the Practitioner's or APP's failure to abide by it; and/or

~~g.~~g) ~~Other:~~ Elements not specifically listed above may be included in a VEP. The ASC MEC has wide latitude to tailor VEPs to the specific concerns identified, always with the objective of helping the Practitioner or APP to improve his or her performance and to protect patients and staff.

~~J.~~I. GOVERNING BODY

~~1.~~ ~~Governing Body:~~ The Governing Body shall receive reports and recommendations from the ASC MEC ~~,~~ as outlined in the ASC Governing Body Bylaws and ASC Medical Staff Bylaws.

~~K.~~J. REVIEW OF REPORTS OF SEXUAL HARASSMENT AND OTHER IDENTITY-~~-~~BASED HARASSMENT~~:~~

1. Sexual Harassment and other Identity-Based Harassment is defined in Appendix B of this Policy.

2. ~~Review Process for Sexual Harassment and Other Identity-Based Harassment Concerns:~~ All reports of potential Sexual Harassment and other Identity-Based Harassment will be immediately referred to the

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Practitioner or APP's affiliated medical school's Title IX Coordinator or designee to investigate. If the Practitioner or APP is not affiliated with a medical school, then the report of potential Sexual Harassment and other Identity-Based Harassment will be immediately referred to Harris Health's Office of Corporate Compliance to investigate. Upon completion of the investigation, the outcome of the investigation conducted by the affiliated medical school or the Office of Corporate Compliance will be communicated to the ASC MEC, with an opportunity for the ASC MEC to ask questions or seek clarity from the investigating body.

3. ~~Agreements to Voluntarily Refrain from Clinical Activities During Review:~~ While a Practitioner or APP may be asked to voluntarily refrain from exercising clinical privileges pending the review of any behavioral matter under this Policy, particular attention will be paid to whether it is necessary to utilize such a temporizing safeguard while an allegation of Sexual Harassment or other Identity-Based Harassment is being reviewed.

~~L.~~K. ADDITONAL PROVISIONS GOVENING THE PROFESSIONALISM REVIEW PROCESS:

1. ~~Confidentiality:~~ Maintaining confidentiality is a fundamental and essential element of an effective professional practice evaluation process.

~~1.~~ ~~Documentation:~~ All documentation that is prepared in accordance with this Policy shall be managed in a manner reasonably calculated to assure privacy and shall be maintained in appropriate Medical Staff files. All documents will be conspicuously marked with the notation "Confidential PPE/Peer Review" or words to that effect, consistent with their privileged and protected status under state or federal law. Failure to mark documents in

this manner shall not be viewed as an indication that the document is not privileged.

2.

~~1.~~ ~~Verbal Communications:~~ Telephone and in-person conversations should take place ~~in private,~~ at appropriate times ~~,~~ and in locations to minimize the risk of a breach of confidentiality.

3.

~~1.~~ ~~E-Mail:~~ Electronic correspondence ~~Harris Health e-mail~~ may be used to communicate between individuals participating in the professionalism review process, including with the Practitioner or APP in question. All ~~e-mails~~correspondence should include a standard convention, such as "Confidential PPE/Peer Review Communication," in the subject line. ~~Email~~Correspondence should not be sent to non-~~Harris Health~~ ASC accounts unless the e-mail directs recipients to check their institutional~~Harris Health e-mail~~ account.

4.

~~1.~~ ~~Participants in the Review Process:~~ All individuals involved in the review process will maintain ~~the~~ confidentiality of the process. All such individuals shall sign an appropriate Confidentiality Agreement. A Confidentiality Agreement – Medical Staff Leader and Confidentiality Agreement – Medical Staff Leader and Confidentiality Agreement – Harris Health Employee are included in the Professionalism Manual.

5.

~~c.~~6. ~~Practitioner or APP Under Review:~~ The Practitioner or APP under review must maintain all information related to the review in a strictly confidential manner. The Practitioner or APP may not disclose information to, or discuss it with, anyone outside of the review process set forth in this Policy without ~~first~~ obtaining the written permission of Harris Health, except for

any legal counsel who may be advising the Practitioner or APP. Violations of this provision will be reviewed under this Policy.

~~2.~~7. ~~Communications with Practitioner or APP that Include a Deadline: Before any paper or electronic c~~Correspondence that includes a deadline for a response is mailed or e-mailed to a Practitioner, ~~a text message should be sent or~~ a phone call should be made to alert the Practitioner or APP that the correspondence is being sent. The intent of any such ~~text message or phone call~~conversation is to make the Practitioner or APP aware of the correspondence so ~~that~~ the deadline is not missed. However, failure to ~~send a text message or make a phone call~~communicate a deadline shall not be cause for the Practitioner or APP to miss a deadline.

~~3.~~8. ~~Immediate Referrals for Review Pursuant to the ASC Medical Staff Bylaws:~~ This Policy outlines collegial and progressive steps (e.g., counseling, warnings, meetings, and behavior modification education) that can be taken to address concerns about Inappropriate Conduct by Practitioners or APPs. However, a single incident of Inappropriate Conduct or a pattern of Inappropriate Conduct may be of such concern that more significant action is required. Therefore, nothing in this Policy precludes an immediate referral of a matter being addressed through this Policy or the elimination of any particular steps in this Policy, to review pursuant to the ASC Medical Staff Bylaws.

~~4. Coordination with Other Policies that Govern Professional Conduct: If a report of unprofessional behavior involves an issue that is also governed by a policy outside the ASC such as a Harris Health policy that governs professional conduct, the ASC Medical Director will notify Harris Health's Chief Medical Executive.~~

~~5. No Legal Counsel or Recordings During Collegial Meetings:~~ To promote the collegial and educational objectives of this Policy, all discussions and meetings with a Practitioner or APP shall generally involve only the Practitioner or APP and the appropriate ASC personnel. No counsel representing the Practitioner or APP or the ASC shall attend any of these meetings. In their discretion, the ASC may permit a Practitioner or APP to

invite another Practitioner or APP to the meeting. In such case, the invited Practitioner or APP may not participate in the discussion or in any way serve as an advocate for the Practitioner or APP under review, must sign a Confidentiality Agreement, and may be required to leave the meeting at any time.

9.

~~8.~~10. ~~-~~Practitioners or APPs may not create an audio or video recording of a meeting. If a recording is made~~de in violation of this rule~~, the recording shall be destroyed. ~~In their discretion, t~~The ASC may require any and all portable electronic devices ~~that smart phones, iPads, and similar d~~, e.g., tablets, mobile cellular devices, laptops, ~~evices~~ be left outside the meeting room. In exceptional circumstances, the ASC may record a meeting ~~if necessary~~ to prepare accurate minutes for ~~or~~ an interview summary. Once the interview summary document is prepared, ~~however,~~ any such recording shall ~~also~~ be destroyed.

~~6.~~11. ~~Education Regarding Appropriate Professional Behavior:~~ The ASC shall partner with its medical school affiliates for appropriate education of~~e~~ Practitioners and APPs regarding appropriate professional behavior. The ASC, through its Service Level Agreement will partner with the appropriate Harris Health departments to educate ~~, make~~ employees and other ASC personnel awareness of this Policy, and ~~shall~~ encourage the prompt reporting of Inappropriate Conduct.

~~7.~~12. ~~Letters Placed in Practitioner's or APP's Confidential File:~~ Copies of letters sent to the Practitioner or APP as part of the efforts to address the Practitioner's or APP's conduct shall be placed in the Practitioner's or APP's confidential file. The Practitioner or APP shall be given an opportunity to respond, in writing, and the Practitioner's or APP's response shall also be kept in the Practitioner's or APP's confidential file.

~~8.~~13. ~~When Both Clinical and Behavioral Concerns are at Issue:~~ If a matter involves both clinical and behavioral concerns, the ASC MEC shall

coordinate reviews pursuant to~~of the~~ applicable policy(ies) and address such matters with the Practitioner or APP ~~in consolidated manner~~.

~~9.~~14. ~~Supervising Physicians and Advanced Practice Professionals:~~ Except as noted below, a physician who has a supervisory or collaborative relationship with an Advanced Practice Professional for state licensure purposes shall be kept apprised of any concerns that are reviewed pursuant to this Policy involving the Advanced Practice Professional. Without limiting ~~the foregoing, the supervising or collaborating~~the oversight of the collaborating physician, they will be copied on all correspondence that an Advanced Practice Professional is sent under this Policy and may be invited to participate in necessary~~any~~ meetings or interventions. The ~~supervising or~~ collaborating physician shall maintain, in a confidential manner, all information related to reviews under this Policy and may be required to sign a Confidentiality Agreement. Notification to the ~~supervising or~~ collaborating physician as described in this Section is not required, or may be delayed, if the individual or committee conducting the review determines that notification would be inconsistent with a fair and effective review.

~~10.~~15. ~~Delegation of Functions:~~ The ASC MEC is responsible for the professionalism/quality assurance process described in this Policy, subject to the oversight of the Governing Body. To promote a prompt and effective review process, the ASC MEC may expressly delegate to the PPE Specialist(s) the authority to perform functions described in this Policy on behalf of the ASC MEC. Actions taken by the PPE Specialist(s) ~~by these individuals~~ will be reported to and reviewed by the ASC MEC as set forth in this Policy.

~~a.~~a) When a function under this Policy is to be carried out by one of the individuals identified in the prior subsection, by an ASC leader, a Medical Staff member, or the ASC MEC, the individual may delegate performance of the function to a qualified designee who is a Practitioner, APP, or ASC employee. Any such designee must treat and maintain all information in a strictly confidential manner and is bound by all other terms, conditions, and requirements of this Policy.

In addition, the delegating party is responsible for ensuring that the designee appropriately performs the function delegated. Any documentation created by the designee are records of the committee that is ultimately responsible for the review in a particular matter.

~~b.~~b) When an individual assigned a function under this Policy is unavailable or unable to perform that function, one or more ASC MEC member may perform the function personally or delegate it to another appropriate individual as set forth in this Policy.

~~11.~~16. ~~Substantial Compliance:~~ While every effort will be made to comply with provisions of this Policy, substantial compliance is required. Technical or minor deviations from the procedures set forth within this Policy do not invalidate any review or action taken.

~~12.~~17. ~~Professionalism Issue Summary Form:~~ Once a professionalism concern is resolved, the PPE Specialists should complete the Professionalism Issue Summary Form and maintain this within the Practitioner's or APP's confidential file. These forms facilitate the identification of trends, inform the determinations made by the ASC MEC when assessing professionalism issues, and supplement both the ongoing performance data review and reappointment processes. A Professionalism Issue Summary Form is included in the Professionalism Manual.

~~13.~~18. ~~Reports to Practitioners, APPs, and the Governing Body:~~ The ASC MEC shall prepare reports at least annually that provide aggregate information regarding the professionalism review process (e.g., numbers of concerns reviewed by department or specialty; the types of dispositions for those concerns; etc.). These reports should be disseminated to all Practitioners and APPs at the ASC, and the Governing Body for the purposes of reinforcing the purpose of this Policy and permitting appropriate oversight. A sample Summary Report for Professionalism Review Activities to Be

Provided to All Practitioners, APPs, MEC, and Governing Body is included in the Professionalism Manual.

~~14.~~19. ~~Agreement to Voluntarily Refrain from Exercising Clinical Privileges or Other Practice Conditions:~~ At any point in the review process described in this Policy, the ASC MEC may ask a Practitioner or APP to voluntarily refrain from exercising clinical privileges while the review proceeds. As an alternative, the Practitioner or APP may also agree upon practice conditions that will protect the Practitioner or APP, patients, and the ASC during the review process. Prior to any such action, the Practitioner or APP shall be given the opportunity to discuss these issues with the ASC MEC or its representatives and provide written input regarding them.

~~a.~~a) These actions are not considered to be disciplinary actions and do not imply any admission by the Practitioner or APP or final finding of responsibility for the concerns that have been raised. They are temporary precautions and reflect professionalism and cooperation with the review process.

~~b.~~ In light of the voluntary and non-disciplinary nature of these actions, they do not generally represent matters that require any report to any State Board or to the National Practitioner Data Bank.

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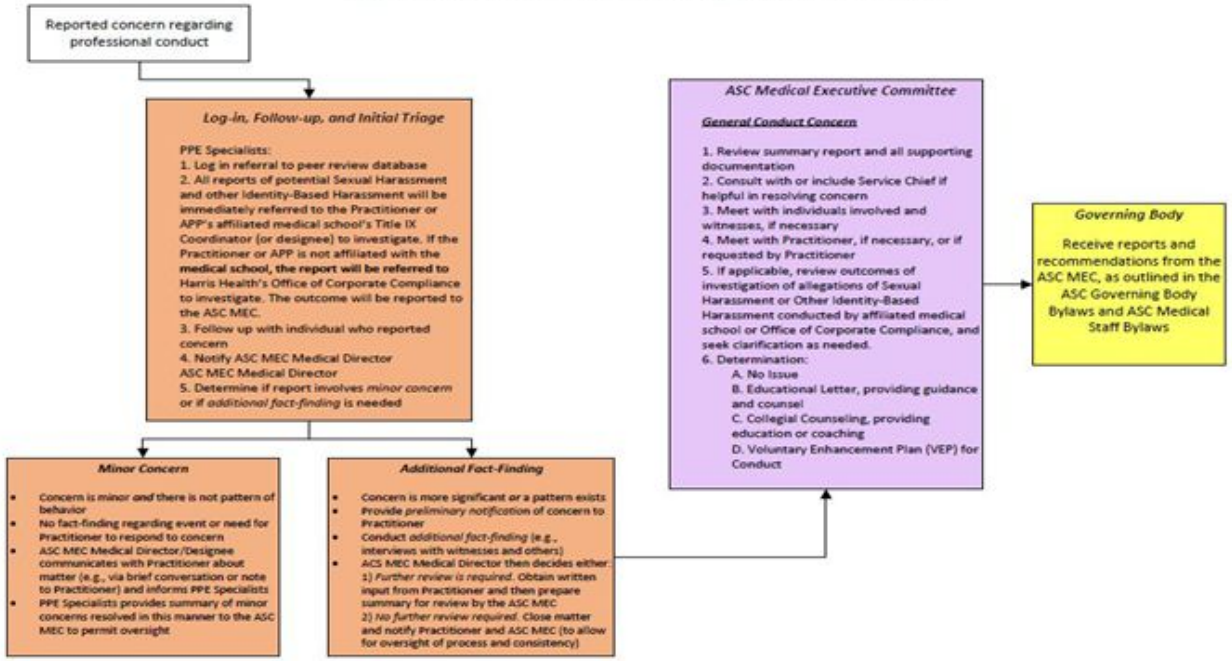
b)

Appendix A

Harris Health System
Ambulatory Surgical Center
Appendix A: Review Process for Concerns Regarding Professional Conduct



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APPENDIX B

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DEFINITION OF INAPPROPRIATE CONDUCT AND SEXUAL HARASSMENT/OTHER IDENTITY-BASED HARASSMENT

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~~1.~~ ~~"~~"***Inappropriate Conduct"*** means behavior that, as determined by the ASC MEC, adversely affects the healthcare team's ability to work effectively and/or has a negative effect on the communication and collaboration necessary for quality and safe patient care. To aid in both the education of Practitioners and APPs and the enforcement of this Policy, ***"Inappropriate Conduct"*** includes, but is not limited to:

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1.

~~(a)~~ A~~a~~busive or threatening language directed at patients, nurses, students, volunteers, visitors, ~~Harris Health personnel~~ASC Workforce members, Practitioners, or APPs ~~(e.g., belittling, berating, or~~

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~~non-constructive criticism that intimidates, undermines confidence, or implies stupidity or incompetence)~~;

a)

~~(b)~~ D~~d~~egrading, demeaning, or condescending comments regarding patients, families, nurses, Practitioners, APPs, ~~Harris Health~~ASC at LBJ personnel, or ~~Harris Health~~the ASC at LBJ;

b)

~~(c)~~ R~~r~~efusal or failure to answer questions, or return phone calls, or pages in a timely manner as defined in the Medical Staff Bylaws documents or other applicable policies;

c)

~~(d)~~ I~~i~~ntentional misrepresentation to ~~Harris Health~~ the ASC administration, Medical Staff ~~L~~leaders, other Practitioners or APPs, or their representatives, in an attempt to gain a personal benefit or to avoid responsibility for an action taken;

d)

~~(e)~~ O~~o~~ffensive language (which may include profanity or similar language) while ~~in Harris Health~~at the ASC ~~-~~or while speaking with patients, nurses, or other ASC~~Harris Health~~ personnel;

e)

~~(f)~~ R~~r~~etaliating against any individual who may have reported a quality or behavior concern about a Practitioner or APP, provided information related to such a matter, or otherwise been involved in the professional practice evaluation/peer review process in any way (this means a Practitioner or APP may not, under any circumstances, approach and discuss the matter with any such individual, nor may the Practitioner

or APP engage in any other retaliatory or abusive conduct such as confronting, ostracizing, or discriminating against such individual);

f)

~~(g)~~ ~~U~~unprofessional physical contact with another individual or other aggressive behavior that is threatening or intimidating;

g)

~~(h)~~ ~~T~~throwing an object of any kind, including but not limited to any medical/surgical instrument or supply;

h)

~~r~~Repeatedly failing to maintain and renew in a timely manner all credentials required by the Medical Staff Bylaws;

i)

~~(j)~~ ~~D~~derogatory comments about the quality of care being provided by ~~Harris Health~~the ASC, another Practitioner or APP, or any other individual outside of appropriate Medical Staff or ASC~~Harris Health~~ administrative channels;

j)

~~(k)~~ ~~u~~Unprofessional medical record entries impugning the quality of care being provided by ~~Harris Health~~the ASC, Practitioners or APPs, or any other individual, or criticizing ~~Harris Health or Harris Health'~~the ASC or the ASC's policies or processes, or accreditation and regulatory requirements;

k)

~~(l)~~ ~~a~~Altering or falsifying any medical record entry ~~or hospital~~or document ~~(including, but not limited to, incorrectly dating or timing an~~

~~entry or document to give the impression it was completed prior to when it was actually completed)~~;

l)

~~(m)~~ ~~c~~Completing medical record entries based on a template without considering the care actually provided to the patient, or using the "copy and paste" or "pull forward" functions of the medical record to populate fields without verifying that the information is accurate for the patient in question;

m)

~~(n)~~ ~~r~~Refusal or failure to use or use properly documentation technology (e.g., CPOE, EHR, and other approved technology);

n)

~~(o)~~ U~~u~~nprofessional access, use, disclosure, or release of confidential patient information;

o)

~~(p)~~ A~~a~~udio, video, or digital recording that is not consented to by others present, including patients and other members of the care team;

p)

~~(q)~~ ~~u~~Use of social media in a manner that involves Inappropriate Conduct as defined in this Policy or other Medical Staff or ~~Harris Health~~ASC policies;

q)

~~(r)~~D~~d~~isruption of ~~hospital~~ASC operations~~,~~; ~~hospital or~~ Medical Staff committees, or departmental affairs;

r)

~~(s)~~ ~~r~~Refusal to abide by Medical Staff requirements as delineated in this Policy, the Medical Staff Bylaws, Rules and Regulations, or other Medical Staff policies ~~(~~including, but not limited to, ~~emergency call issues,~~

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~~response times,~~ medical recordkeeping, other patient care responsibilities, failure to participate on assigned committees, failure to cooperate with utilization oversight activities, and an unwillingness to work cooperatively and harmoniously with other members of the Medical Staff and ~~Harris Health~~ASC employees~~)~~;

s)

t) ~~(t)~~ ~~C~~conduct that is inconsistent with the ethical obligations of health care professionals; and/or

u) ~~(u)~~ ~~E~~engaging in ***Sexual Harassment or other Identity-Based Harassment*** as defined in Section 2 of this Appendix.

ADDITIONAL NOTE REGARDING INAPPROPRIATE CONDUCT:

A. This policy is not intended to interfere with a practitioner's or app's ability to express, in a professional manner and in an appropriate forum:

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~~(1)~~ ~~O~~opinions on any topic that are contrary to opinions held by other Practitioners or APPs, Medical Staff Leaders, or ~~Harris Health~~ASC personnel;

1.

~~(2)~~ ~~d~~Disagreement with any Medical Staff ~~or Harris Health~~ Bylaws or , ASC policies, procedures, proposals, or decisions; or

2.

~~(3)~~ C~~c~~onstructive criticism of the care provided by any Practitioner or APP, nurse, or other ~~Harris Health~~ASC personnel.

3.

~~2.~~ **Sexual harassment and other identity-based harassment are a form of inappropriate conduct, and include verbal or physical conduct that:**

B.

~~(a)~~ ~~is~~Are unwelcome and offensive to an individual who is subjected to it or who witnesses it;

1.

~~(b)~~ ~~c~~Could be considered harassment from the objective standpoint of a "reasonable person"; and

2.

~~(c)~~ ~~I~~is covered by state or F~~f~~ederal laws governing discrimination. This includes, but is not limited to, sexual harassment and racial, ethnic, or religious discrimination.

3.

Tests and standards used by courts to determine if conduct violates federal or state law (e.g., Title VII of the Civil Rights Act) are ***not*** dispositive in determining whether conduct is Sexual Harassment or Other Identity-Based Harassment for purposes of this Policy. Instead, the standard set forth in this section shall govern, as interpreted by the Medical Executive Committee, and/or the Governing Body. The intent of this provision is to create higher

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expectations for professional behavior by Practitioners and APPs than the minimum required by federal or state law.

Sexual Harassment and Other Identity-Based Harassment include all of the following behaviors:

Verbal: innuendoes, epithets, derogatory slurs, off-color jokes, propositions, graphic commentaries, threats, and suggestive or insulting sounds.~~;~~

Visual/Non-Verbal: derogatory posters, cartoons, or drawings; suggestive objects or pictures; leering; and obscene gestures.~~;~~

Physical: unwanted physical contact, including touching, interference with an individual's normal work movement, and assault.~~;~~

Quid Pro Quo: suggesting that submission to an unwelcome sexual advance will lead to a positive employment action or avoid a negative employment action.~~; and~~

Retaliation: retaliating or threatening retaliation as a result of an individual's complaint regarding harassment.

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REFERENCES/BIBLIOGRAPHY:

Harris Health System Medical Staff Professionalism policy

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:
	1.0	08/22/2024	The Ambulatory Surgical Center (ASC) at LBJ Governing Body

HARRISHEALTH
AMBULATORY SURGICAL CENTER AT LBJ

Policy No: ASC-P-4016
Page Number: 1 of 10

Effective Date:
Board Motion No: n/a

TITLE: ONGOING PERFORMANCE DATA REVIEW

PURPOSE: To assist in the collection and maintenance of Physician~~/Practitioner~~ and Advanced Practice Professional's practice data.

POLICY STATEMENT:

It is the policy of the Ambulatory Surgical Center (ASC) at LBJ to establish a process that will be used to evaluate and gauge professional performance of P~~p~~hysicians~~/practitioners~~ and Advanced Practice Professionals (APP) at the ASC. The ASC makes an effort to provide educational opportunities that help all Physicians~~ractitioners~~ and APPs consistently provide quality, safe, and effective patient care.

POLICY ELABORATIONS:

I. DEFINITIONS

A. **MEDICAL STAFF LEADER:** The ASC Medical Director

B. **ONGOING PERFORMANCE DATA REVIEW (OPDR):** The ongoing review and analysis of data that helps to identify issues or trends in Practitioners and/or APPs performance that may impact quality of care and patient safety. OPDR promotes an efficient, effective and meaningful evidence-based reappointment process. A flow chart of the OPDR process is attached as Appendix A.

C. **PROFESSIONAL PRACTICE EVALUATION SPECIALIST(S):** Staff who support the ASC Medical Director on the Professional Practice Evaluation (PPE) process generally and the review of issues~~s~~ related to

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professionalism described in this Policy. This may include Harris Health employees contracted through the Service Level Agreement.

D. **PHYSICIAN/PRACTITIONER AND ADVANCED PRACTICE PROFESSIONAL (APP):** Shall have the same meaning as ~~those terms are~~ defined in the ASC Medical Staff Bylaws.

II. DATA TO BE COLLECTED:

~~A. Data Elements Specific to Clinical Service, or its Subdivisions, as Applicable: Each Clinical Service, or its subdivisions, as applicable, shall determine the OPDR data to be collected for each Practitioner and APP by clinical service, or its subdivisions, as applicable and, where appropriate, the expected parameters of performance for each data element. All data elements and parameters shall be approved by the ASC Medical Executive Committee (MEC).~~

~~A. Data Elements for All Practitioners and APPs: The ASC MEC shall also establish OPDR data (core) elements that are relevant to all Practitioners and APPs irrespective of clinical service and, where appropriate, the expected parameters of performance for each data element.~~

~~A. Guidelines: The following guidelines will be used in determining the OPDR data elements to be collected:~~

~~4. PPE Specialist will support the OPDR process at the direction of the ASC MEC;~~

~~5. Harris Health medical informatics/information technology department representatives will be consulted to determine the available information system capabilities at the direction of the ASC MEC through the Service Level Agreement;~~

~~6. For OPDR elements that are specific to the Clinical Service, or its subdivisions, as applicable, the type of data that would reasonably be expected to reflect clinically significant issues for the Clinical Service, or its subdivisions, as applicable, shall be considered; and~~

~~7.~~1. ~~When possible, the expected parameters of performance shall be based on relevant clinical literature.~~The ASC at LBJ will utilize the adverse outcomes, clinical occurrences, or complications as described by the accrediting body that oversees the ASC as events to dictate which data are to be collected.

B. ~~Examples of Data Elements:~~ Consistent with the ASC's ~~AAAHC~~ accrediting body's~~ation~~ standards~~ and the guidelines set forth above~~, data to be collected may

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include, but is not limited to, the following data elements and considerations~~:, if applicable to the Clinical Service, or its subdivisions:~~

1. Utilization data, Medical Record Delinquency, standard of care, patient outcomes;
2. Clinical care is selected for review on an ongoing basis;
3. The selection process for care to be reviewed applies to all similarly privileged healthcare professionals;
4. All clinical incidents are reviewed in accordance with the organization's peer review policies and procedures;
5. All privileged health care professionals are reviewed at least annually by a peer or supervising health care professional.

III. REPORTS:

A. The ~~F~~frequency and ~~C~~content of an ~~: An~~ OPDR report for each Practitioner and APP will be prepared by a PPE Specialist at least every 12 months. The PPE Specialist will provide a summary report of OPDR reports to the ASC Medical

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Director at least every 12 months. A Practitioner or APP OPDR report may include:

1. The activity during the OPDR period;~~:~~

2. Clinical performance as measured by the approved clinical service and other OPDR data elements;

3. The number of Educational Letters sent pursuant to ASC-P-4014 Professional Practice Evaluation Policy;

4. The number of cases reviewed pursuant to the ASC-P-4014 requiring action; and

5. The number of validated professionalism concerns requiring action and addressed pursuant to ASC-P-4015 Medical Staff Professionalism.

B. ~~Review by the ASC Medical Director:~~ The summary report will be prepared in a manner that allows the ASC Medical Director to review the data or other relevant information and shall make one of the following determinations:

1. Exceptional Performance or Significant Improvement. The data indicate that the Practitioner's or APP's performance has been exceptional or that there has been a significant improvement, in which case the Medical Director is encouraged to acknowledge the Practitioner's or APP's efforts.

2. Acceptable Performance. The data do not reflect a pattern or issue regarding the Practitioner's or APP's performance that requires further review.

3. Review the OPDR Report with Practitioner or APP allowing initial mentoring efforts. The data reflect an issue or concern with the Practitioner's or APP's performance, but the issue or concern is not ~~so~~ significant that further review is necessary under the PPE Policy or the Medical Staff Professionalism Policy. In such case, the Medical Director may engage in ~~I~~initial m~~M~~entoring e~~E~~fforts with the Practitioner or APP. Any such i~~I~~nitial m~~M~~entoring e~~E~~fforts should be documented via a

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follow-up letter or e-mail to the Practitioner or APP, with such documentation being included with the ongoing OPDR report.

4. Forward for rReview under anoOther aApplicable pPolicy. The data reflect a pattern or issue that requires further review. In such case, the Medical Director shall notify the PPE Specialist(s), who shall log the report and proceed in accordance with the PPE Policy or the Medical Staff Professionalism Policy, as applicable.

5. Insufficient Volume. The data reflect insufficient activity at the ASC to evaluate the Practitioner's or APP's practice, in which case the Medical Director shall document this finding on the OPDR report for consideration at reappointment. In these circumstances, the procedures set forth in the ASC Medical Staff Bylaws for low volume Practitioners and APPs swillhall be followed.

OPDR reports involving the Medical Director will be reviewed by an individual of like credentialing whom has clinical privileges at the ASC and of like specialty.

After the ASC Medical Director review of OPDR reports, and if in agreement with the report, will sign the summary report. The PPE Specialist shall retain copies of the signed summary report. The PPE Specialist shall provide a copy of the report to the Practitioner or APP or notify the Practitioner or APP how to access the report. OPDR reports will be provided at the time of reappointment for consideration of the Practitioner or APP's performance.

IV. DELEGATION OF FUNCTIONS

A. The ASC MEC is responsible for the OPDR process described in this Policy, subject to the oversight by the Governing Body. To promote a prompt and effective review process, the ASC Medical Director may delegate to the PPE Specialist the authority to perform the functions described in this Policy on behalf of the ASC MEC. Actions taken by

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these individuals will be reported to and reviewed by the ASC MEC as set forth in this Policy.

B. When a function under this Policy is to be carried out by a delegate of the ASC Medical Director, any such designee must treat and maintain all information in a strictly confidential manner and is bound by all other terms, conditions, and requirements of this Policy. In addition, the ASC Medical Director is responsible for ensuring that the designee appropriately performs the function in question. Any documentation created by the designee are records of the committee that is ultimately responsible for the review in a particular matter.

C. When an individual assigned a function under this Policy is unavailable or unable to perform that function, the ASC Medical Director may delegate it to another appropriate individual ~~as set forth above~~.

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Appendix A

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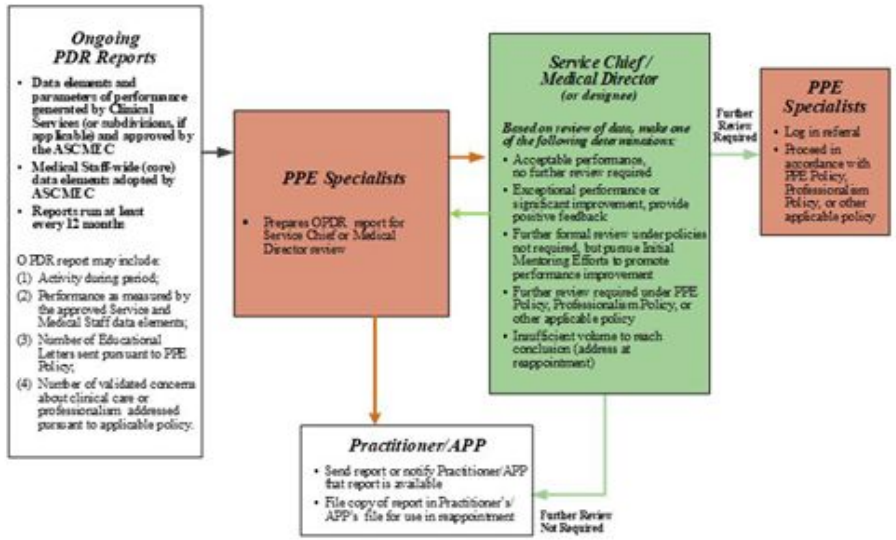
HARRIS HEALTH

Appendix A: Flowchart of Ongoing Performance Data Review ("OPDR") Process



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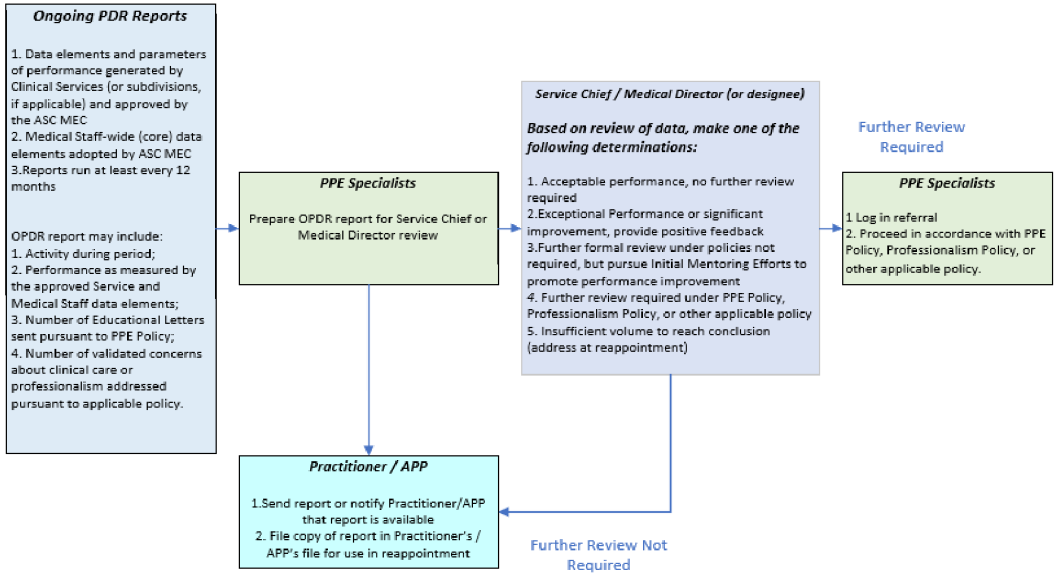
Harris Health System
Ambulatory Surgical Center
Appendix A: Flowchart of Professional Practice Evaluation Process



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REFERENCES/BIBLIOGRAPHY:

Harris Health System Ongoing Performance Data Review (OPDR~~pdr~~) Policy

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:
	1.0	08/22/2024	The Ambulatory Surgical Center (ASC) at LBJ Governing Body

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HARRISHEALTH
AMBULATORY SURGICAL CENTER AT LBJ

Policy No: ASC-P-4017
Page Number: 1 of 25

Effective Date:
Board Motion No: n/a

TITLE: THE AMBULATORY SURGICAL CENTER MEDICAL STAFF HEALTH POLICY

PURPOSE: The Ambulatory Surgical Center (ASC) at LBJ is committed to providing safe, quality care, which can be compromised if a Practitioner/Physician or Advanced Practice Professionals is afflicted by a health issue that is not appropriately addressed.

POLICY STATEMENT:

It is the policy of the ASC to outline the process that will be used to evaluate and collegially resolve concerns that a Practitioner/Physician or Advanced Practice Professionals (APP) may have a health issue. A flowchart that outlines the review process described in this Policy is set forth in Appendix A. The ASC is also committed to assisting Practitioners and (APP) in addressing health issues so they may practice safely and competently.

POLICY ELABORATIONS:

I. DEFINITIONS:

~~1.~~A. **EXECUTIVE SESSION:** A meeting or portion of a meeting, of any section, department, or committee of the Medical Staff at which privileged and/or

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confidential information regarding quality assessment and improvement and/or peer review information is presented or discussed.

~~2.~~B. **GOVERNING BODY:** The Governing Body of the ASC.

~~3.~~C. **HEALTH ISSUE:** A physical, mental, or emotional condition that could adversely affect a Practitioner's or APP's ability to practice safely and competently.

~~4.~~D. **INCAPACITATED PROVIDER:** An ASC medical staff member who is unable to provide care because of a physical or mental illness that requires immediate medical attention.

~~5.~~E. **IMPAIRED PROVIDER:** An ASC medical staff member with a physical, behavioral, or mental impairment that could affect their ability to perform their clinical privileges.

~~6.~~F. **MEDICAL STAFF LEADER:** The ASC Medical Director

~~7.~~G. **PROFESSIONAL PRACTICE EVALUATION SPECIALISTS:** Staff who support the ASC Medical Director on the Professional Practice Evaluation (PPE) process generally and the review of issues related to professionalism described in

this Policy. This may include Harris Health employees contracted through the Service Level Agreement.

~~8.~~H. **PHYSICIAN/PRACTITIONER AND ADVANCED PRACTICE PROFESSIONAL (APP):** Shall have the same meaning as those terms are defined in the Medical Staff Bylaws.

REPORTS OF POTENTIAL HEALTH ISSUES:

II.

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A. Duty to Self-Report:

1. ~~General Duty:~~ Practitioners or APPs who have a Health Issue are required to report it to the Medical Staff Leader.

2. ~~Exception:~~ The duty to self-report does not apply to;

   a. ~~-~~A Health Issue that will be fully resolved before the Practitioner or APP next exercises his or her clinical privileges; or

   b. A Health Issue that was evaluated as part of a Practitioner's or APP's application for appointment or reappointment to the Medical Staff.

B. Reports of Suspected Health Issues by Others:

1. ~~General:~~ Any Practitioner, APP, or ~~Harris Health~~ ASC employee who is concerned that a Practitioner or APP may be practicing with a Health Issue shall report the concern to the ASC leadership, which includes but is not limited to, the Administrator, Director, Medical Director, and/or Managers~~a Medical Staff Officer or another Medical Staff Leader~~.

2. ~~Reporting:~~ All concerns shall be entered into the Harris Health electronic incident reporting system. A Health Issue ~~R~~reporting ~~F~~form that may be used to report potential Health Issues is set forth in the Practitioner/APP Health Manual. The form outlines warning signs to facilitate the objective reporting of these issues.

3. Anonymous Reports: Practitioners, APPs, and employees may report concerns anonymously. However, all individuals are encouraged to identify themselves when making a report so that the PPE Specialists may contact

the reporter for additional information that may help the Practitioner or APP and safeguard patients, if necessary.

Reports by Those in Treatment Relationships: A Practitioner or APP who becomes aware of a Health Issue affecting another Practitioner or APP as a result of his or her treatment relationship with that Practitioner or APP is not expected to report the Health Issue internally pursuant to this Policy. However, the treating Practitioner or APP should encourage the Practitioner or APP to self-report the issue to the extent required by Section 2.A of this Policy.

4.

In addition, the treating Practitioner or APP should consider whether a mandatory report is required under state law to the applicable licensing board or any other state agency. If the treating Practitioner or APP believes a mandatory report is necessary pursuant to state law, he or she should notify the Practitioner or APP and encourage the Practitioner or APP to self- report prior to making the mandatory report. The treating Practitioner or APP may consult with the Chief Medical Executive ("CME") for assistance and resources in such matters, but should not disclose to the CME information that identifies the Practitioner or APP.

C.

III. RESPONSE TO IMMEDIATE THREATS

~~A.~~ If a potential Health Issue is reported that raises immediate concerns because either ~~:~~

~~2.~~ ~~T~~the Practitioner or APP is providing services at the ASC at that time~~;~~ or

~~3.~~A. ~~T~~ the Practitioner or APP is expected to provide services in the very near future such that the ASC MEC would not have time to meet prior to the Practitioner's or APP's provision of services.

By way of example, and not limitation, this section applies to an Incapacitated Practitioner or APP who is unable to practice medicine because of a physical or mental illness that requires immediate medical attention ~~(e.g., seems disoriented~~

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~~or displays erratic behavior while rounding on patients)~~ . ~~O~~or, an Impaired Practitioner or APP with a physical, behavioral, or mental impairment that could affect their ability to perform their clinical privileges. ~~(e.g., suspected of being under the influence of drugs or alcohol while working.)~~

B.

~~Interim Safeguards to Protect Patients and Others:~~ If a Practitioner or APP becomes incapacitated due to a physical or mental illness that requires immediate medical attention during a patient's surgery/procedure, the incapacitated Practitioner or APP must be assessed and given proper aid. The procedures outlined in Policy ASC-P-4005 will be followed.

If the ASC Medical Director or their designee believes the Practitioner or APP may have a Health Issue and that action is necessary to protect patients, the Practitioner or APP, or others, the Practitioner or APP should be asked to voluntarily refrain from exercising their~~his or her~~ clinical privileges or agree to conditions on his or her practice while the matter is being reviewed. Such a request may be made to the Practitioner or APP either before or after any tests or evaluations regarding the Practitioner or APP have been completed.

C.

~~1.~~D. ~~Agreement to Voluntarily Refrain:~~ If the Practitioner or APP agrees to voluntarily refrain from exercising his or her privileges, the ASC Medical Director or their designee may assign the Practitioner's or APP's patients to another individual with appropriate clinical privileges. Affected patients shall be informed that the Practitioner or APP is unable to proceed with their care due to an emergency situation. Any wishes expressed by the Practitioner or APP or patients regarding a covering Practitioner or APP will be respected to the extent possible. The Practitioner's or APP's agreement to voluntarily refrain is not reportable to the National Practitioner Data Bank or state licensing board. Such agreements should be documented in a letter or other correspondence to the Practitioner or APP that

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is maintained in the Practitioner's or APP's Confidential Health File, as described in the next section.

~~2. Other Action:~~ If the Practitioner or APP will not agree to ~~:~~

~~a)~~ ~~V~~voluntarily refrain from exercising his or her privileges ~~;~~ or

~~a)~~ ~~C~~condition~~n~~s on his or her practice that are deemed necessary, an individual authorized by the Medical Staff Bylaws to impose a summary suspension will consider whether a summary suspension or some other measure is necessary as a safeguard while the Health Issue is assessed.

E.

~~C.~~F. ~~Referral for Log-In and Follow-Up:~~ Following the immediate response described above, this~~e~~ matter shall be referred to the PPE Specialist(s) for record keeping~~log-in~~ and incident management~~follow-up~~ as described in this Policy~~e next section.~~

IV. RECORD KEEPING AND REPORT MAANAGEMENT~~LOG-IN AND FOLLOW-UP~~:

A. ~~Logging of Reports and Creation of Confidential Health File:~~ The PPE Specialists will log any report of a Health Issue and create a Confidential Health File that is maintained separately from the credentials or quality files. ~~(~~however, the existence of the Confidential Health File will be noted in the credentials or quality file~~)~~. See Section XII. of this Policy for more information on Confidential Health Files.

B. ~~Follow-up with Individual Who Filed Report:~~ The PPE Specialist(s) will follow up with individuals who file a report. A r~~R~~esponse to i~~I~~ndividual the w~~W~~hom r~~R~~eported the ~~C~~concerns a~~A~~bout a h~~H~~ealth i~~I~~ssue form ~~that~~ may be used for this purpose and is included in the Practitioner/APP Health Manual.

C. ~~Fact-Finding:~~ The ASC Medical Director or their designee shall interview witnesses or others who may have information and will gather ~~any other~~ necessary documentation and ~~or~~ information needed to assess the reported concern. An

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~~I~~nterview ~~T~~ool for ~~F~~act-~~F~~inding is included in the Practitioner/APP Health Manual.

D. ~~Referral to the ASC MEC:~~ All suspected Health Issues will be referred to the ASC MEC for ~~its~~ review as set forth in this Policy~~e next section~~.

V. ASC MEDICAL EXECUTIVE COMMITTEE REVIEW

A. If during the course of the incident review ~~Individuals Participating in Review/Additional Clinical Expertise: If t~~the ASC MEC determines ~~that~~ it w~~ould~~ill be necessary ~~or helpful in~~to address~~ing~~ the reported concern, it may consult with a subject matter expert or ~~any~~ other individual with relevant expertise. Any individual who participates in a review is an integral part of Harris Health's ASC review process~~,~~ and will~~shall~~ be governed by the same responsibilities and legal protections that apply to other participants in the process.

B. ~~Additional Fact-Finding:~~ The ASC MEC may review any documentation relevant to the Health Issue. It may also meet with the individual who initially reported the concern and any other individual who may have relevant information. ~~An Interview Tool for Fact-Finding (Script and Questions) is included in the Practitioner/APP Health Manual.~~

C. ~~Meeting with Practitioner or APP:~~ If the ASC MEC believes that a Practitioner or APP may have a Health Issue, the ASC MEC shall meet with the Practitioner or APP. At this meeting, the Practitioner or APP will be advised of the nature of the concern, asked to provide input, and informed of the ASC MEC's recommendations. Talking P~~P~~oints for Meeting with Practitioner/APP About Health Issue that may be used to help the ASC MEC prepare for and conduct such meetings and is ~~are~~ included in the Practitioner/APP Health Manual.

D. ~~Practitioner's or APP's Refusal to Obtain Assessment:~~ If a Practitioner or APP refuses to obtain a health assessment that is recommended by the ASC MEC or provide the results to the ASC MEC, the process outlined in Section XI. of this Policy will be followed.

E. ~~Self-Disclosure to Other Entities:~~ In its discretion, the ASC MEC may encourage the Practitioner or APP to self-disclose the Health Issue to other entities where the Practitioner or APP practices. The ASC MEC may point out that Medical

Staff Bylaws and related documents typically require Practitioners or APPs to self-disclose such information. If applicable, documentation confirming that the self-disclosure occurred should be obtained.

VI. INTERIM SAFEGUARDS PENDING COMPLETION OF AN ASSESSMENT

A. If a Practitioner or APP agrees to obtain an assessment, the ASC MEC may also recommend that the Practitioner or APP voluntarily take one or more of the following actions while the assessment is pending:

1. Agree to specific conditions on his or her practice, which could include obtaining assistance from other Practitioners or APPs during patient care activities;
2. Refrain from exercising some or all privileges at the ASC; or
3. Take a leave of absence.

If a Practitioner or APP does not agree to take a temporary voluntary action recommended by the ASC MEC while the assessment is pending, an individual authorized by the Medical Staff Bylaws to impose a summary suspension will consider whether a summary suspension or some other measure is necessary as a safeguard while the Health Issue is assessed.

B.

VII. ASSESSMENT OF HEALTH STATUS

A. ~~General:~~ The ASC MEC may require the Practitioner or APP to undergo a physical, mental, cognitive, or other examination or other assessment by an appropriate clinician. This may include, but is not limited to, an assessment by the state Physicians Health Program or other applicable program. The ASC MEC may also ask the Practitioner or APP to provide a letter from his or her treating physician confirming the Practitioner's or APP's ability to safely and competently practice, and authorize the treating physician to meet or speak with the ASC MEC.

B. ~~Person to Conduct Assessment:~~ The ASC MEC shall select the health care professional or organization to perform any examination, testing, or evaluation, but may seek input from the Practitioner or APP. More than one health care

professional or organization may be asked to perform an examination, test, or evaluation, and this may occur either concurrently or serially.

C. ~~Cost of Assessment:~~ The Practitioner or APP shall be responsible for any costs associated with the assessments described in the prior section, unless the ASC MEC determines otherwise.

D. ~~Forms:~~ The Practitioner/APP Health Manual includes the following forms~~,~~ which should be used when implementing the provisions of this section~~:~~:

1. Consent for Disclosure of Information and Release from Liability~~,~~ which authorizes the ASC to release information to the health care professional or organization conducting the evaluation;

2. Authorization for Release of Protected Health Information~~,~~ which authorizes the health care professional or organization conducting the evaluation to disclose information about the Practitioner or APP to the ASC MEC; and

~~2.~~ Health Status Assessment Form~~,~~ which documents the results of an evaluation.

3.

VIII. REINSTATEMENT OR ~~/~~RESUMING PRACTICE

A. Request for Reinstatement from Leave of Absence or to Resume Practicing.

1. ~~Leave of Absence:~~ If a Practitioner or APP was granted a formal leave of absence to participate in a treatment program or otherwise address a Health Issue, the Practitioner or APP must apply for reinstatement of privileges using the process set forth in the Medical Staff Bylaws. However, prior to applying for reinstatement, the Practitioner or APP must first submit a written request to the ASC MEC for clearance to apply for reinstatement and be granted written permission by the ASC MEC.

2. ~~Agreement to Refrain Without Formal Leave of Absence:~~ In all other circumstances where the Practitioner or APP refrained from practicing~~,~~ ~~(e.g., voluntary agreement between Practitioner or APP and ASC MEC; Practitioner or APP was absent from Medical Staff duties while~~

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~~participating in a treatment program or otherwise addressing a Health Issue),~~ the Practitioner or APP must submit a written request to the ASC MEC and receive written permission to resume exercising his or her clinical privileges.

B. ~~Additional Information:~~ Before acting on a Practitioner's or APP's request for clearance to apply for reinstatement from a leave of absence or to resume practicing, the ASC MEC may request any additional information or documentation that it believes is necessary to evaluate the Practitioner's or APP's ability to safely and competently exercise clinical privileges. This may include requiring the Practitioner or APP to undergo a health assessment conducted by a physician or entity chosen by the ASC MEC in order to obtain a second opinion on the Practitioner's or APP's ability to practice safely and competently.

C. Determination by the ASC Medical Executive Committee: If the ASC MEC determines that the Practitioner or APP is capable of practicing safely and competently without conditions, this decision will be documented. The Practitioner or APP may then:

1. Proceed with the reinstatement process outlined in the Medical Staff Bylaws, if a leave of absence was taken;
2. Resume practicing, if no leave of absence was taken; or
3. If the ASC MEC determines that conditions should be placed on a Practitioner's or APP's practice as a condition of reinstatement or resuming practice; it will follow the process outlined in the following Section.

IX. CONDITIONS OF CONTINUED PRACTICE

A. ~~General:~~ The ASC MEC may ask the Practitioner or APP to agree to comply with certain conditions in order to receive clearance to apply for reinstatement of privileges from a leave of absence or to otherwise resume practicing. Examples of Conditions of Continued Practice are included in the Practitioner/APP Health Manual.

B. ~~Refusal to Agree to Conditions:~~ If the Practitioner or APP does not agree to conditions requested pursuant to the prior paragraph, the ASC MEC cannot

compel the Practitioner or APP to comply with them. In that situation, the ASC MEC will refer the matter review and action pursuant to the Medical Staff Bylaws.

C. ~~Reasonable Accommodations:~~ Reasonable accommodations may be made consistent with Human Resources policies, including, as applicable, such policies of ~~Harris Health~~the ASC, Baylor College of Medicine, The University of Texas Health Science Center at Houston's McGovern Medical School, or other third-parties with Practitioners or APPs on the ASC's~~Harris Health's~~ Medical Staff, to assist the Practitioner or APP in resuming his or her practice. Examples of reasonable accommodations include, but are not limited to, providing assistive technology or equipment or removing architectural barriers. The ASC MEC will consult with appropriate personnel to determine whether reasonable accommodations are feasible.

~~Voluntary Agreement to Conditions Not a Restriction:~~ A Practitioner's or APP's voluntary agreement to conditions similar to the Examples of Conditions of Continued Practice in the Practitioner/APP Health Manual generally does not result in a "restriction" of that Practitioner's or APP's privileges. Accordingly, such a voluntary agreement generally does not require a report to the National Practitioner Data Bank (NPDB) or to any state licensing board or other government agency, nor would it entitle a Practitioner or APP to a hearing under the Medical Staff Bylaws. However, the ASC MEC will assess each situation independently. If there is concern in a given situation that a condition may be reportable to the NPDB or a state licensing board or agency, the ASC MEC

will~~should~~ consult with ~~Harris Health~~ appropriate legal counsel and communicate with the Practitioner or APP about the matter prior to any such report being made.

D.

X. GOVERNING BODY

A. ~~Governing Body:~~ The ASC Governing Body shall receive reports and recommendations from the ASC MEC, as outlined in the ASC Governing Body Bylaws and ASC Medical Staff Bylaws.

XI. CONFIDENTIAL HEALTH FILES/REAPPOINTMENT PROCESS

A. ~~Creation of Confidential Health File:~~ Reports of potential Health Issues and documentation received or created pursuant to this Policy shall be included in the Practitioner's or APP's Confidential Health File, which shall be maintained on the ASC Medical Director's behalf by the PPE Specialist(s) as a separate file and will ~~shall~~ not be included in the credentials nor quality ~~file or the quality~~ file.

B. ~~Information Reviewed at Reappointment:~~ The information reviewed by those involved in the reappointment process will not routinely include the documentation in a Practitioner's or APP's Confidential Health File. Instead, the process set forth in this subsection will be followed.

1. When a reappointment application is received from an individual who has a Health Issue that is currently being reviewed or monitored by the ASC MEC, or that has been reviewed and resolved in the past reappointment cycle, the PPE Specialist(s) shall contact the ASC Medical Director.

2. The PPE Specialist(s) will prepare a Summary Health Report and submit it to the ASC Medical Director. The Summary Health Report shall be included in the credentials file and reviewed by the ASC Medical Director and the ASC MEC subject to any conditions on the review of health information set forth in the Medical Staff Bylaws.

~~2.~~ The ASC MEC's Summary Health Report will state that it is actively monitoring, or has monitored in the past reappointment cycle, a Health Issue involving the Practitioner or APP. It will not contain details or specifics regarding the Health Issue. The Summary Health Report will also

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include a recommendation regarding the Practitioner's or APP's ability to perform the duties of Medical Staff membership and safely exercise clinical privileges. A Sample Summary Health Report for Use at Reappointment is included in the Practitioner/APP Health Manual.

3.

XII. ADDITIONAL PROVISIONS GOVERNING THE REVIEW OF HEALTH ISSUES

A. ~~Confidentiality:~~ Maintaining confidentiality is a fundamental and essential element of an effective professional practice evaluation process.

1. ~~Documentation: A~~All documentation that is prepared in accordance with this Policy shall be maintained in the Practitioner's or APP's Confidential Health File. All documents will be conspicuously marked with the notation "Confidential PPE/Peer Review" or words to that effect, consistent with their privileged and protected status under state or federal law. However, failure to mark documents in this manner shall not be viewed as an indication that the document is not privileged. Access to the Confidential Health File for recredentialing purposes is governed by Section XII of this Policy. Any other request to manner shall not be viewed as an indication that the document is not privileged. Access to the Confidential Health File for recredentialing purposes is governed by Section XI of this Policy. Any other request to access the Confidential Health File must be approved by the ASC MEC.

2. ~~Verbal Communications:~~ Telephone and in-person conversations should take place in private at appropriate times and locations to minimize the risk of a breach of confidentiality.

3. ~~E-Mail: Harris Health or other s~~Secure institutional electronic correspondence methods, e.g. email, ~~mail~~ may be used to communicate between individuals participating in the health review process, including, with the Practitioner or APP in question. Electronic correspondence ~~All e-mails~~ should include a standard convention, such as "Confidential

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PPE/Peer Review Communication~~"~~, in the subject line. Electronic correspondence~~E-mail~~ should not be sent to personal e-mail accounts unless the e-mail merely directs recipients to check their Harris Health or other institutional secure e-mail.

4. ~~Participants in the Review Process: All i~~Individuals involved in the review process will maintain the confidentiality of the process. All such individuals shall sign an appropriate Confidentiality Agreement.

B. ~~Health Issues Identified During Credentialing Process: A~~ Health Issue that is identified during the credentialing process shall be addressed pursuant to the Medical Staff Bylaws. If a determination is made by the ASC MEC that the involving the Practitioner or APP is qualified for appointment and privileges, but has a Health Issue that should be monitored or treated, the matter shall undergo ongoing monitoring or oversight of treatment pursuant to this Policy.

C. ~~Immediate Referrals for Review Pursuant to the Medical Staff Bylaws: Nothing in t~~This Policy does not precludes the elimination of any particular step in the Policy ~~if necessary~~ to effectively address a Practitioner or APP Health Issue. Similarly, ~~nothing in~~ this Policy does not precludes referral of a matter to review pursuant to the Medical Staff Bylaws if a Practitioner or APP fails to abide by this Policy or any agreement reached with the ASC MEC.

D. ~~No Legal Counsel or Recordings During Collegial Meetings:~~ To promote the collegial and educational objectives of this Policy, ~~all~~ discussions and meetings with a Practitioner or APP shall generally involve only the Practitioner or APP and the appropriate Medical Staff Leader(s) and ASC personnel. No counsel representing the Practitioner or APP or the Medical Staff or the ASC shall attend ~~any of~~ these meetings. In their discretion, the ASC Medical Director may permit a Practitioner or APP to invite another Practitioner or APP to the meeting. In such case, the invited Practitioner or APP may not participate in the discussion or in any way serve as an advocate for the Practitioner or APP under review, must

sign a Confidentiality Agreement, and may be required to leave the meeting at any time.

1. Practitioners or APPs may not create an audio or video recording of a meeting. If a recording is made in violation of this rule, the recording shall be destroyed. In their discretion, the ASC Medical Director may require that smart phones, tablets, and similar devices be left outside the meeting room. In exceptional circumstances, the ASC Medical Director or ASC personnel may record a meeting if necessary to prepare accurate minutes or an interview summary. Once the document is prepared, however, any such recording shall also be destroyed.

E. Identity of Individual Who Reports a Health Issue

1. ~~General Rule:~~ Since this Policy does not involve disciplinary action or restrictions of privileges, the specific identity of an individual reporting a concern or otherwise providing information about a matter generally will not be disclosed to the Practitioner or APP.

2. Exceptions:

   a. ~~Consent:~~ The ASC MEC may, in its discretion, disclose the identity of the reporter to the Practitioner or APP if the reporter specifically consents to the disclosure with the reporter being reassured that he or she will be protected from retaliation.

   b. ~~ASC Medical Staff Hearing:~~ The identity of the reporter shall be disclosed to the Practitioner or APP if information provided by the reporter is used to support an adverse professional review action that results in an ASC Medical Staff hearing.

3. ~~Practitioner or APP Guessing the Identity of Reporter:~~ This section does not prohibit the ASC MEC from notifying a Practitioner or APP about a Health Issue concern that has been raised even if the description of the concern would allow the Practitioner or APP to guess the identity of the reporter. In such case, the ASC Medical Director or ASC MEC will not confirm the identity of the reporter, and will pay particular attention to

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reminding the Practitioner or APP to avoid any action that could be perceived as retaliation.

F. ~~Supervising Physicians and Advanced Practice Professionals:~~ Except as set forth in this Policy~~below~~, a physician who has a supervisory or collaborative relationship with an A~~dvanced Practice Professiona~~PP~~l~~ for state licensure purposes shall be notified if a concern is being reviewed pursuant to this Policy involving the ~~Advanced Practice Professional~~APP. The disclosure to the supervising or collaborating physician will be limited to a general statement that a Health Issue is currently being reviewed and that additional information will be forthcoming once the ~~Advanced Practice Professional~~APP has signed an appropriate authorization. The supervising or collaborating physician shall maintain in a confidential manner all information related to reviews under this Policy and may be required to sign a Confidentiality Agreement. Notification to the supervising or collaborating physician as described in this Section is not required, or may be delayed, if the individual or committee conducting the review determines that notification would be inconsistent with a fair and effective review.

G. ~~Redisclosure of Drug/Alcohol Treatment Information:~~ In the course of addressing a Health Issue pursuant to this Policy, the ASC may receive written or verbal information about the treatment of a Practitioner or APP from a federally-assisted drug or alcohol abuse program as defined by 42 C.F.R. Part 2. The ASC may not re-disclose such information without a signed authorization from the Practitioner or APP. An Authorization for Re-Disclosure of Drug/Alcohol Treatment Information that may be used for this purpose is included in the Practitioner/APP Health Manual.

H. ~~Educational Materials:~~ The ASC MEC shall recommend educational materials that address Practitioner/APP Health Issues and emphasize prevention, identification, diagnosis, and treatment of Health Issues. This Policy and ~~any~~ educational materials approved by the ASC MEC shall be made available to Practitioners, APPs, and ASC personnel.

I. ~~Delegation of Functions:~~ The ASC MEC is responsible for the health/quality assurance process described in this Policy, subject to the oversight of the ASC Governing Body. To promote a prompt and effective review process, the ASC

Medical Director and ASC MEC may expressly delegate to the PPE Specialist(s) the authority to perform the functions described in this Policy on behalf of the ASC Medical Director and MEC. Actions taken by these individuals will be reported to and reviewed by the ASC Medical Director and MEC as set forth in this Policy.

1. When a function under this Policy is to be carried out by one of the individuals identified in this Policy ~~the prior subsection~~, by a member of ASC leadership, by an ASC Medical Staff member, or by the~~an~~ ASC Medical Executive Committee, or the individual, may delegate performance of the function to a qualified designee who is a Practitioner, APP, or ASC employee. Any such designee must treat and maintain all information in a strictly confidential manner and is bound by all other terms, conditions, and requirements of this Policy. In addition, the delegating individual or committee is responsible for ensuring that the designee appropriately performs the function in question. Any documentation created by the designee are records of the committee that is ultimately responsible for the review in a particular matter.

2. When an individual assigned a function under this Policy is unavailable or unable to perform that function, the ASC Medical Direcrtor~~one or more Medical Staff Leaders~~ may perform the function personally or delegate it to another appropriate individual as set forth above.

J. ~~Practitioner/APP Health Manual:~~ The ASC MEC shall approve forms, checklists, template letters and other documents that assist with the implementation of this Policy. Collectively, these documents are known as the Practitioner/APP Health Manual. Such documents shall be developed and maintained by the PPE Specialists as delegated by the ASC Medical Director. Individuals performing a function pursuant to this Policy should use the document currently approved for that function and revise as necessary.

K. ~~Substantial Compliance:~~ While every effort will be made to comply with all provisions of this Policy, substantial compliance is required. Technical or minor

deviations from the procedures set forth within this Policy do not invalidate any review or action taken.

L. ~~Reports to the ASC Governing Body:~~ The ASC MEC shall prepare reports at least annually that provide de-identified information regarding the review of Health Issues as set forth in this Policy. These reports should be disseminated to the ASC Governing Body for the purposes of reinforcing the primary objectives outlined in Section I of this Policy and permitting appropriate oversight. A sample Summary Report for Practitioner/APP Health Issue Review Activities to Be Provided to Governing Body is included in the Practitioner/APP Health Manual.

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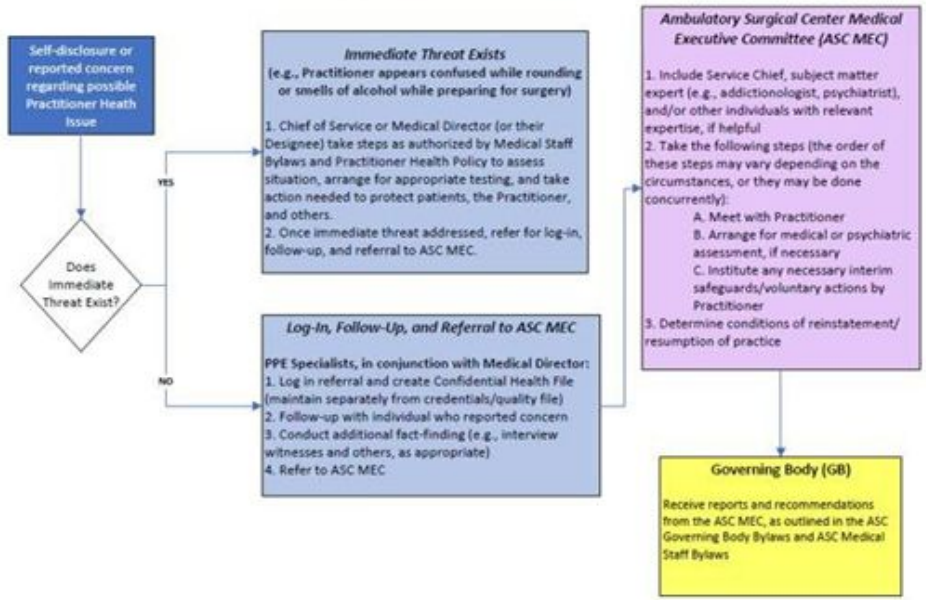
HARRIS HEALTH SYSTEM
AMBULATORY SURGICAL CENTER

APPENDIX A: REVIEW PROCESS FOR PRACTITIONER HEALTH ISSUES



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APPENDIX B – EXAMPLES OF HEALTH ISSUES

A Health Issue is any physical, mental, or emotional condition that could adversely affect a Practitioner's or APP's ability to practice safely and competently. Examples of Health Issues include, but are not limited to, the following:

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1. Substance or alcohol abuse;

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2. Use of any medication, whether prescription or over-the-counter, that can affect alertness, judgment, or cognitive function (such as, but not limited to, the use of pain or anti-anxiety medication);

2.

3. Any temporary or ongoing mental health concern, including, but not limited to, bipolar disorders or disorders caused by a major family event (e.g., death of spouse or child, divorce) or a major job-related event (e.g., death or significant injury to patient);

3.

4. Carotid, vertebral, or other brain surgery or intervention;

4.

5. Chemotherapy with a drug known to effect neurotoxicity (brain) or to have cardiac or neurotoxicity (peripheral nerves);

5.

6. Radiation therapy to head;

6.

7. Medical condition (e.g., stroke or Parkinson's disease), injury, or surgery resulting in temporary or permanent loss of fine motor control or sensory loss;

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~~8.~~ Shoulder surgery, brachial plexus surgery, hand or carpal tunnel surgery for a surgeon;

8.

~~9.~~ A back injury impacting ability to stand in the Operating Room or other procedure lab;

9.

~~10.~~ Major surgery;

10.

~~11.~~ Infectious/contagious disease that could compromise patient safety or jeopardize other health care workers; and/or

11.

~~12.~~ Any cognitive impairment or diagnosed dementia (e.g., Alzheimer's disease, Lewy body dementia).

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The Ambulatory Surgical Center (ASC) at LBJ

REVIEW/REVISION HISTORY:

Effective Date	Version # (If Applicable)	Review/ Revision Date (Indicate Reviewed or Revised)	Approved by:
	1.0	08/22/2024	The Ambulatory Surgical Center (ASC) at LBJ Governing Body

HARRISHEALTH
AMBULATORY SURGICAL CENTER AT LBJ

Policy No: ASC-P-4018
Page Number: 1 of 19

Effective Date:
Board Motion No: n/a

TITLE: **INITIAL PERFORMANCE DATA REVIEW AND ANNUAL PERFORMANCE PEER REVIEW**

PURPOSE: The Ambulatory Surgical Center (ASC) at LBJ is committed to providing safe, quality care and as such all Practitioners/Physicians and Advanced Practice Professionals (APP) who are granted clinical privileges at the Ambulatory Surgical Center (ASC) at LBJ are subject to initial performance data review (IPDR) and annual performance peer review (APPR) to validate clinical competence.

POLICY STATEMENT:

All Practitioners and APPs who are granted new clinical privileges at the Ambulatory Surgical Center (ASC) at LBJ are subject to IPDR and APPR. Practitioner's and APPs at the ASC will be asked to submit clinical competence validation in order to continue to exercise the clinical privileges that have been granted to them. Additionally, the process allows validation of professionalism, which includes the ability to work with others in a professional manner that promotes quality and safety; and the ability to satisfy all other responsibilities of Practitioners and APP's who are granted clinical privileges at the ASC. The process also validates continued clinical competence and professionalism through annual review by similarly privileged and/or similarly licensed peers as required by the Accreditation Association for Ambulatory Health Care (AAAHC) Standard 2.III. A.

I. POLICY ELABORATIONS:

~~I.~~A. Definitions:

1. **Annual Performance Peer Review (APPR):** Annual clinical competence and professionalism review of a Practitioner/Physician by a similarly privileged and/or similarly licensed peer. A flowchart that depicts the IPDR process to confirm competence and professionalism is attached as Appendix A.
2. **Initial Performance Data Review (IPDR):** A limited period during which a Practitioner/Physician's professional performance is evaluated. All initially-granted clinical privileges, whether at the time of initial

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appointment, reappointment, or during the term of appointment, shall be subject to IPPR. A flowchart that depicts the IPDR process to confirm competence and professionalism is attached as Appendix A.

~~3.~~ **Professional Practice Evaluation Specialists (PPE~~pe~~):** The clinical and non-clinical staff who support the professional practice evaluation (PPE) process and the IPDR process described in this Policy as designated by the ASC Medical Director.

3.

IPDR AND APPR CLINICAL ACTIVITY REQUIREMENTS:

II.

~~II.~~A. Development of Clinical Activity Requirements:

~~2.~~1. Each Surgical Service, or its subdivisions, as applicable, will determine the following IPDR clinical activity requirements:

~~a.~~a) For New Practitioners and APPs:

~~i.~~(1) The number and types of procedures or cases that will be reviewed to confirm a new Practitioner's or APP's competence to exercise the core and special privileges in his or her specialty;

~~ii.~~(2) How those reviews are to be documented; and

~~iii.~~(3) The expected time frame in which the evaluation will be completed.~~.~~

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~~III.~~B. For Practitioners and APPs with Existing Clinical Privileges who are Requesting New Privileges:

1. The number and types of procedures or cases that must be reviewed to confirm a Practitioner's or APP's competence to exercise a new privilege that is granted during a term of appointment or at reappointment;
2. How the reviews are documented; and

~~———~~The expected time frame in which the review will be completed.

3.

~~IV.~~ For Practitioners and APPs with Existing Clinical Privileges Who Require Annual Performance Peer Review:

C.

1. The number and types of procedures or cases that must be reviewed to evaluate a Practitioner's or APP's continued competence to exercise the core and special privileges in his or her specialty;
2. How the reviews are documented; and
3. The expected time frame in which the review will be completed.

~~IV.~~ In developing such determinations, the ASC, as applicable, should attempt to identify index procedures or cases that will demonstrate a Practitioner's or APP's competence to perform a bundle of privileges. The ASC Medical Executive Committee (MEC) may modify the IPDR requirements for a particular applicant

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if the applicant's credentials indicate that additional or different IPDR may be required.

D.

~~V.~~E. Gathering IPDR and APPR Data:

1. Mechanism for IPDR and APPR Review:

~~a.~~a) ~~Data to be reviewed:~~ The IPDR clinical activity requirements will utilize at least one of the following review mechanisms to confirm competence:

~~i.~~b) Retrospective chart review by internal or external reviewers selected by the ASC Medical Director or designee;

~~ii.~~c) Concurrent proctoring of procedures or patient care practices; ~~and/or~~

~~iii.~~d) Discussion with individuals involved in the care of the Practitioner's or APP's patients or who have observed the Practitioner during patient care activities; and/or~~.~~

~~iv.~~e) Review of available data from ASC-P-4016, other quality data, and concerns about professionalism may also be used to confirm competence.

~~b.~~2. ~~Selection of Cases:~~ The ASC Medical Director or designee will select the specific cases to be evaluated and the individuals who will be asked to provide information about the Practitioner or APP with the goal of being an effective and fair review process. The cases should be selected randomly or in a deliberate manner that ensures a representative sample is reviewed. Generally, IPDR should not be conducted on all~~the~~ first cases because of the possible selection bias that may result. Practitioners or APPs shall

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notify the ASC Medical Director or designee when cases subject to review are scheduled or have been completed.

~~c.~~3. ~~Cooperation of Practitioner and/or APP:~~ As a condition of Medical Staff appointment and clinical privileges, Practitioners and APPs are required to cooperate with the data gathering outlined in this Policy.

~~2.~~F. ~~IPDR and APPR Reviewers:~~ Practitioners and APPs who have completed the IPDR process described in this Policy and who hold applicable clinical privileges are obliged to provide a reasonable amount of service as an IPDR and APPR Reviewer through chart review, proctoring, direct observations, and/or discussions with others involved in the patient's care. Reviewers will be assigned by the ASC Medical Director. If no qualified Practitioners or APPs are available, the ASC Medical Director shall consult with the ASC Medical Executive Committee regarding the need for an external review. IPDR and APPR Reviewers act on behalf of, and their work product is a record of, the ASC Medical Executive Committee.

~~3.~~G. ~~Partners as IPDR and APPR Reviewers:~~ Consistent with the conflict-of-interest guidelines set forth in the Professional Practice Evaluation Policy (ASC-P-4014), partners and other individuals who are affiliated in practice with a Practitioner or APP may serve as IPDR and APPR reviewers and conduct chart review, proctoring, direct observations, and/or discussions with others involved in the patient's care. Such individuals shall comply with the standard procedures that

apply to all other individuals who serve as IPDR and APPR reviewers, such as the use of ASC forms and the requirements related to confidentiality.

~~VI.~~H. ~~IPDR for Professionalism:~~ In addition to assessing clinical competence, the IPDR process for new Practitioners and APPs will also assess the Practitioner's or APP's professionalism based on the following criteria:

~~a.~~1. Cooperation with the IPDR clinical activity requirements for the Practitioner's or APP's specialty and the monitoring process described in this Policy;

~~b.~~2. Compliance with the Medical Staff Professionalism Policy (ASC-P-4015), including appropriate interactions with ASC workforce members, Practitioner and/or APP colleagues, and patients and their families;

~~c.~~3. Compliance with medical record documentation requirements, including those related to use of the Electronic Health Record (EHR);

~~d.~~4. Completion of orientation and annual ASC requirements; and

Compliance with protocols that have been adopted by the ASC Medical Executive Committee.

5.

The ASC Medical Executive Committee may recommend that these criteria for professionalism be modified or expanded, with such modifications or expansions being reviewed and approved by the ASC Medical Executive Committee.

I.

~~VII.~~J. ~~Notice of IPDR Requirements:~~ When notified that a request for privileges has been granted, Practitioners and APPs shall be informed of the relevant IPDR clinical activity requirements and of their responsibility to cooperate in satisfying those requirements. New applicants will also be informed that the IPDR process will be used to assess their professionalism, as described above. An Initial

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Appointment Letter and a Reappointment Letter which inform Practitioners and APPs of their IPDR requirements are included in the IPDR Manual.

~~VIII.~~K. Review of IPDR and APPR Results:

1. ~~Review by PPE Specialist:~~ Information gathered for purposes of IPDR/APPR shall be reported to the PPE Specialist(s), whom shall compile the information and prepare it for subsequent review as set forth in this Policy.

~~a.~~2. If any information gathered for IPDR/APPR suggests that a concern may exist that requires expedited review, the IPDR/APPR Reviewer and/or the PPE Specialist shall notify the ASC Medical Director, who shall determine whether the concern should be referred for processing under the Professional Practice Evaluation Policy (ASC-P-4014), the Medical Staff Professionalism Policy (ASC-P-4015) or the ASC Medical Staff Bylaws.

~~b.~~3. The PPE Specialists shall determine whether a Practitioner's or APP's cases or activities have been reviewed pursuant to the Professional Practice Evaluation Policy or the Medical Staff Professionalism Policy. If so, a summary of these matters shall be included with the Practitioner's IPDR results.

~~2.~~4. ~~Review by the ASC Medical Director:~~ At the conclusion of the expected time frame for completion of the IPDR or APPR, the ASC Medical Director shall review the results of a Practitioner's or APP's IPDR and/or APPR and provide a report to the ASC Medical Executive Committee. As

noted in this Policy, the ASC Medical Director may assign a designee to perform these functions. The report shall address:

~~a.~~a) ~~–~~The Practitioner or APP fulfilled the clinical activity requirements;

~~b.~~b) The results of the IPDR confirmed the Practitioner's or APP's clinical competence;

~~c.~~c) ~~–~~The results of the IPDR confirmed the Practitioner's or APP's professionalism;

~~d.~~d) Additional IPDR is required to make an appropriate determination regarding clinical competence and/or professionalism; and/or

~~e.~~e) ~~–~~The results of the APPR confirmed the Practitioner's or APP's continued clinical competence.

I. The IPDR and APPR Review Forms will be used to document the review by the ASC Medical Director. The ASC Medical Director may engage in initial mentoring efforts with a Practitioner or APP where the IPDR/APPR results indicate that competence and professionalism are confirmed, but where there is an opportunity for the Practitioner or APP to improve upon an aspect of their clinical care or citizenship responsibilities.

~~3.~~1. ~~Review by ASC Medical Executive Committee:~~ Based on the assessment and report by the ASC Medical Director, review of the IPDR and APPR results, and ~~all~~ other relevant information, the ASC ~~Medical Executive Committee~~MEC will make one of the following determinations and notify the Practitioner.

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~~a.~~a) ~~Competence and Professionalism are Confirmed:~~ The IPDR and APPR process has confirmed clinical competence and professionalism for all clinical privileges and no further review is necessary.

~~b.~~b) Questions or Concerns Exist:

~~i.~~(1) ~~Extend IPDR Due to Questions:~~ Some questions exist and additional IPDR is needed to confirm clinical competence and/or professionalism with respect to some or all clinical

privileges. In such case(s), the ASC Medical Executive Committee will identify what additional IPDR is needed and the time frame necessary.

~~ii.~~(2) Conclude IPDR/APPR, but Use Collegial Counseling or Voluntary Enhancement Plan: Concerns exist about the Practitioner's or APP's competence to exercise some or all of the clinical privileges granted or the Practitioner's or APP's professionalism. In such case, the ASC Medical Executive Committee will identify the details of the Collegial Counseling or the Voluntary Enhancement Plan that should be pursued with the Practitioner or APP in order to adequately address the concerns. Prior to making such a determination, the ASC MEC ~~edical Executive Committee~~ will obtain the input of the Practitioner as set forth in Section I of this Policy.

~~iii.~~(3) ~~Recommendations to the Governing Body:~~ If more significant concerns exist about a Practitioner or APP, the Governing Body shall receive reports and recommendations from the ASC MEC, as outlined in the ASC Governing Body Bylaws and ASC Medical Staff Bylaws.

~~4.~~M. Low Volume Practitioners:

~~a.~~1. ~~Extend IPDR Due to Inactivity:~~ The time period for IPDR will be extended for up to six months because the individual did not fulfill the IPDR clinical activity requirements for some or all clinical privileges, thus preventing an adequate assessment of the individual's clinical competence or professionalism. The time frame for initial IPDR will generally not extend beyond 12 total months after the initial granting of privileges.

~~b.~~2. The ~~Automatic Relinquishment of Certain Privileges Due to Inactivity: The~~ individual shall automatically relinquish specific clinical privileges for which

the individual failed to meet the applicable requirements per the ASC Medical Staff Bylaws.

~~c.~~3. ~~Grant Exception to Certain Low Volume Practitioners and APPs: The~~ ASC Medical Executive Committee may determine that a low volume Practitioner or APP will be permitted, to the extent allowed under the Medical Staff Bylaws, to maintain appointment and clinical privileges beyond the initial IPDR period based on the limited availability of needed services in a specialty area, coverage requirements, the rare nature of a given procedure or treatment, or other relevant factors. In these circumstances, the Practitioner's or APP's competence and professionalism will be confirmed as follows:

~~i.~~a) Completion of the initial IPDR requirements over the duration of the Practitioner's or APP's three-year appointment term and/or reliance on the ongoing clinical and professionalism review processes that are conducted for all Practitioners and APPs.~~; and~~

~~ii.~~b) Review of any supplemental performance data regarding the Practitioner or that may be obtained from other entities where the Practitioner or APP maintains a more active practice.

~~iii.~~c) The ASC Medical Executive Committee may decide that IPDR has been completed with respect to certain clinical privileges while additional action will be taken with respect to other clinical privileges. Letters that can be used to inform the Practitioner or APP of the decision of the ASC Medical Executive Committee are included in the IPDR Manual.

~~5.~~4. ~~Governing Body:~~ The Governing Body shall receive reports and recommendations from the ASC MEC, as outlined in the ASC Governing Body Bylaws and ASC Medical Staff Bylaws.

~~6.~~5. Input by Practitioner or APP:

~~a.~~a) ~~General:~~ When concerns have been raised about the Practitioner or APP or other information is required, the Practitioner or APP shall be provided notice of the issue and shall respond in writing. Upon

the request of either the Practitioner or APP or the committee conducting the review, the Practitioner or APP may also provide input by meeting with appropriate individuals to discuss the issues.

~~b.~~b) The committee requesting input may also ask the Practitioner or APP to provide a copy of records from the Practitioner or APP that are relevant to a review being conducted under this Policy. Failure to provide such copies will be viewed as a failure to provide requested input. Any records obtained from the Practitioner or APP pursuant to this section will be maintained as part of the confidential PPE/peer review file.

~~7.~~6. ~~Decision Not an Adverse Action:~~ A decision that a Practitioner or APP will automatically relinquish his or her clinical privileges for failure to satisfy clinical activity requirements is not an adverse action that must be reported to the National Practitioner Data Bank or any state licensing board.

~~8.~~7. ~~Future Application for Privileges:~~ A Practitioner or APP who automatically relinquishes certain privileges will be ineligible to apply for the clinical privileges in question for two years from the date of automatic relinquishment.

~~IX.~~N. ~~Delegation of Functions:~~ The Medical Director and ASC Medical Executive Committee are responsible for the IPDR/quality assurance process described in this Policy, subject to the oversight of the Governing Body. To promote a prompt and effective review process, the ASC MECedical Executive Committee may delegate to the PPE Specialist(s) or other ASC workforce members, the authority to perform the functions described in this Policy on behalf of the ASC Medical Director and ~~Medical Executive Committee~~MEC. Actions taken by these individuals will be reported to and reviewed by the ASC MECedical Executive Committee as set forth in this Policy.

1. When a function under this Policy is to be carried out by one of the individuals identified in the prior ~~subsection~~subsection, they may delegate performance of the function to a qualified designee who is a Practitioner or APP credentialed to practice at the ASC or is bound by the Service Level

Agreement. Any such designee must treat and maintain all information in a strictly confidential manner and is bound by all other terms, conditions, and requirements of this Policy. In addition, the delegating individual is responsible for ensuring that the designee appropriately performs the function in question. Any documentation created by the designee are records of the committee that is ultimately responsible for the review in a particular matter.

2. When an individual assigned a function under this Policy is unavailable or unable to perform that function, they may delegate it to another appropriate individual as set forth above.

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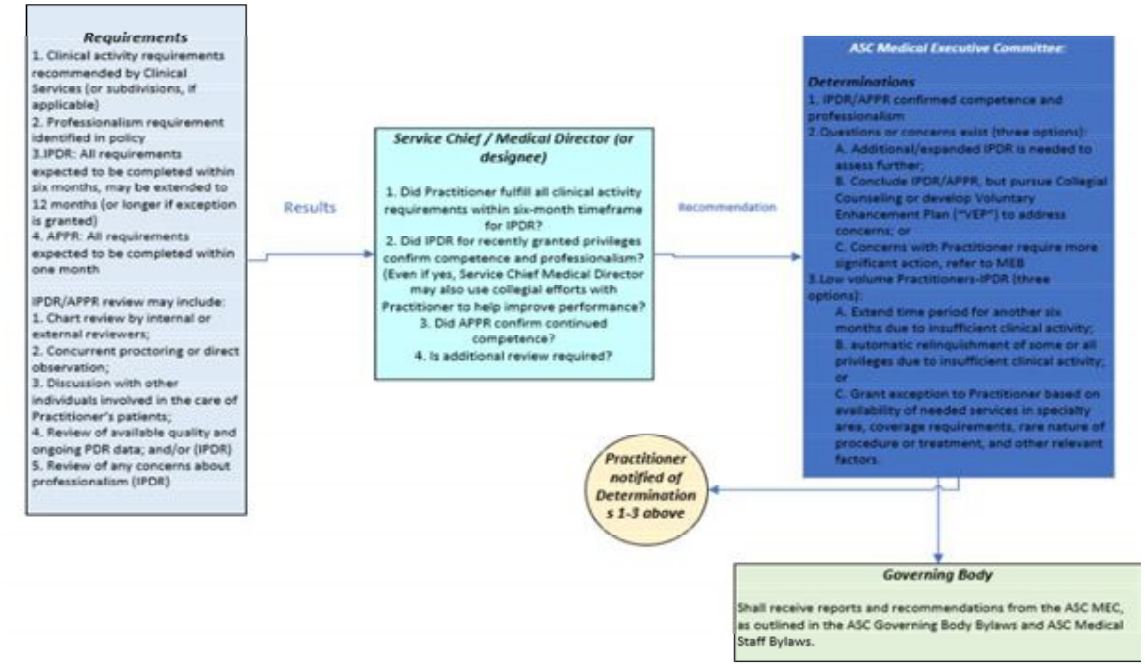
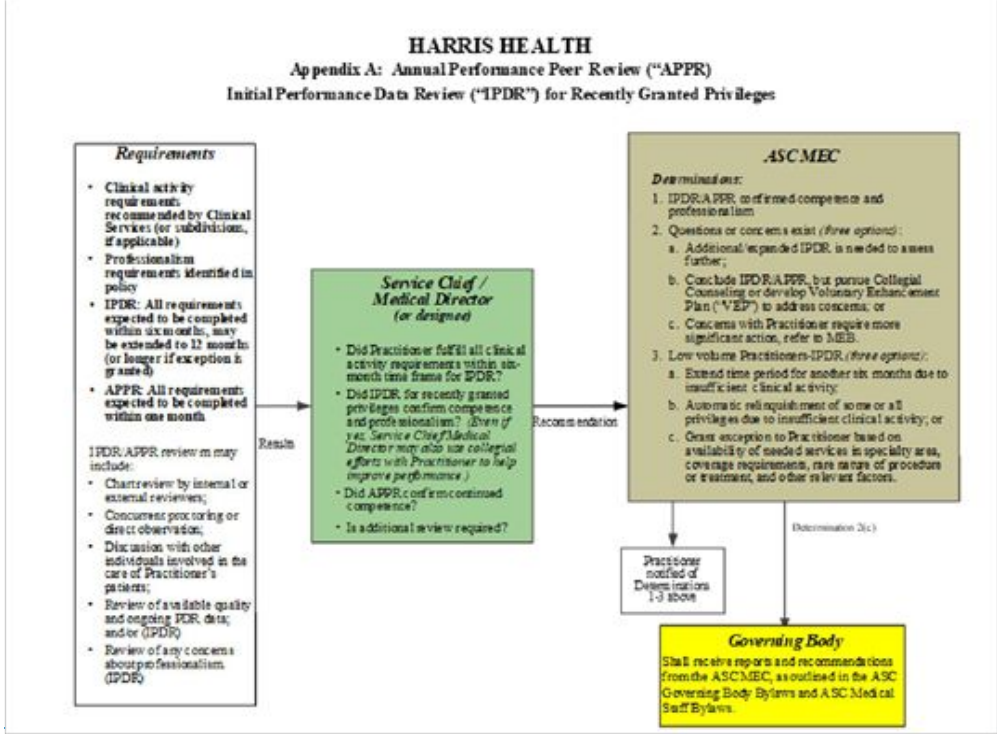
APPENDIX A

—Annual Performance Peer Review Initial Performance Data Review for Recently Granted Privileges

Harris Health System
Ambulatory Surgical Center
Appendix A: Flowchart of Professional Practice Evaluation Process




HARRIS HEALTH
Appendix A: Annual Performance Peer Review ("APPR")
Initial Performance Data Review ("IPDR") for Recently Granted Privileges
Requirements
Clinical activity requirements recommended by Clinical Services (or subdivisions, if applicable)
Professionalism requirements identified in policy
IPDR: All requirements expected to be completed within six months, may be extended to 12 months (or longer if exception is granted)
APPR: All requirements expected to be completed within one month
IPDR/APPR review may include:
Chart review by internal or external reviewers;
Concurrent proctoring or direct observation;
Discussion with other individuals involved in the care of Practitioner's patients;
Review of available quality and ongoing PDR data; and/or (IPDR)
Review of any concerns about professionalism. (IPDR)
Results
Service Chief / Medical Director (or designee)
Did Practitioner fulfill all clinical activity requirements within six-month time frame for IPDR?
Did IPDR for recently granted privileges confirm competence and professionalism? (Even if yes, Service Chief/Medical Director may also use collegial efforts with Practitioner to help improve performance.)
Did APPR confirm continued competence?
Is additional review required?
Recommendation
ASCMEC
Determinations:
1. IPDR/APPR confirmed competence and professionalism
2. Questions or concerns exist (three options):
a. Additional/expanded IPDR is needed to assess further;
b. Conclude IPDR/APPR, but pursue Collegial Counseling or develop Voluntary Enhancement Plan ("VEP") to address concerns; or
c. Concerns with Practitioner require more significant action, refer to MEB.
3. Low volume Practitioners-IPDR (three options):
a. Extend time period for another six months due to insufficient clinical activity;
b. Automatic relinquishment of some or all privileges due to insufficient clinical activity; or
c. Grant exception to Practitioner based on availability of needed services in specialty area, coverage requirements, rare nature of procedure or treatment, and other relevant factors.
Determination 2(c)
Practitioner notified of Determinations 1-3 above
Governing Body
Shall receive reports and recommendations from the ASCMEC, as outlined in the ASC Governing Body Bylaws and ASC Medical Staff Bylaws.

The Ambulatory Surgical Center (ASC) at LBJ

REVIEW/REVISION HISTORY:

Effective Date	Version # (If Applicable)	Review/ Revision Date (Indicate Reviewed or Revised)	Approved by:
	1.0	08/22/2024	The Ambulatory Surgical Center (ASC) at LBJ Governing Body

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:

GENERALLY

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 ~~System~~ Policy 3003)*
   ~~c)~~ d) Bloodborne Pathogen Post Exposure Management 3.55.11

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)*

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3. Hazardous Materials:

a) *Personal Protective Equipment (refer to Harris Health ~~System~~ Policy 3003)*
b) *Hazardous Materials (refer to Harris Health ~~System~~ Policy 7201)*

REFERENCES/BIBLIOGRAPHY:

~~Quad A 8.2~~
AAAHC v43

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	Approved 09/16/2016	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 / Approved 02/17/2022	The Ambulatory Surgical Center (ASC) at LBJ Governing Body
		Reviewed / Approved 02/16/2023	The Ambulatory Surgical Center (ASC) at LBJ Governing Body
		Reviewed / Approved 02/22/2024	The Ambulatory Surgical Center (ASC) at LBJ Governing Body

The Ambulatory Surgical Center (ASC) at LBJ Infection Control Plan ~~2024~~

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 placed in a bag to be laundered at home.

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)

~~Quad A Version 8.2~~
AAAHC Version 43
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		

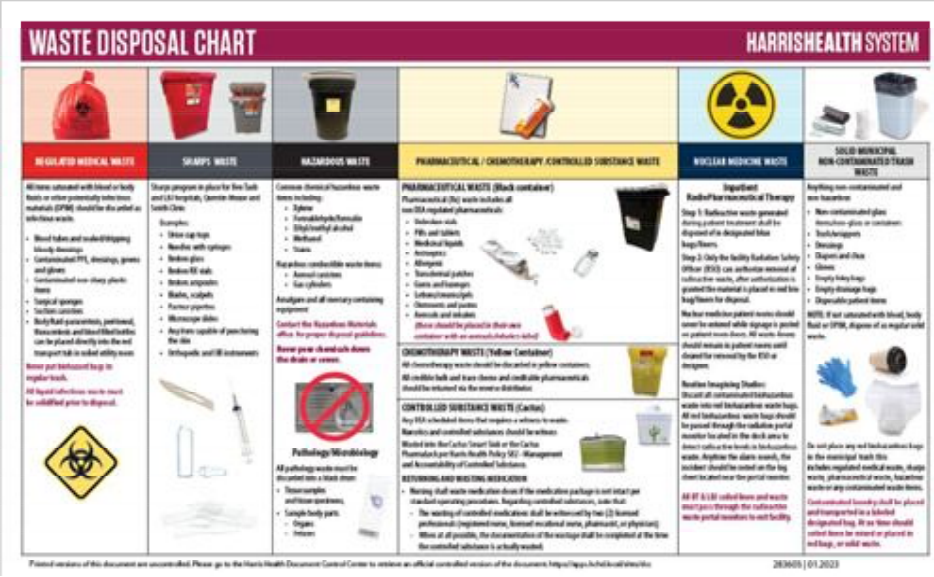
Modified from Rutala and Simmons. 15, 17, 18, 421 The selection and use of disinfectants in the healthcare field is dynamic, and products may become available that are not in existence when this guideline was written. As newer disinfectants become available, persons or committees responsible

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. Instructions for use will be followed per manufacturer's guidelines when using cleaning and disinfectant products.

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 50-60ₒC)
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 35ₒC.
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 50-56ₒC.
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 70ₒC 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

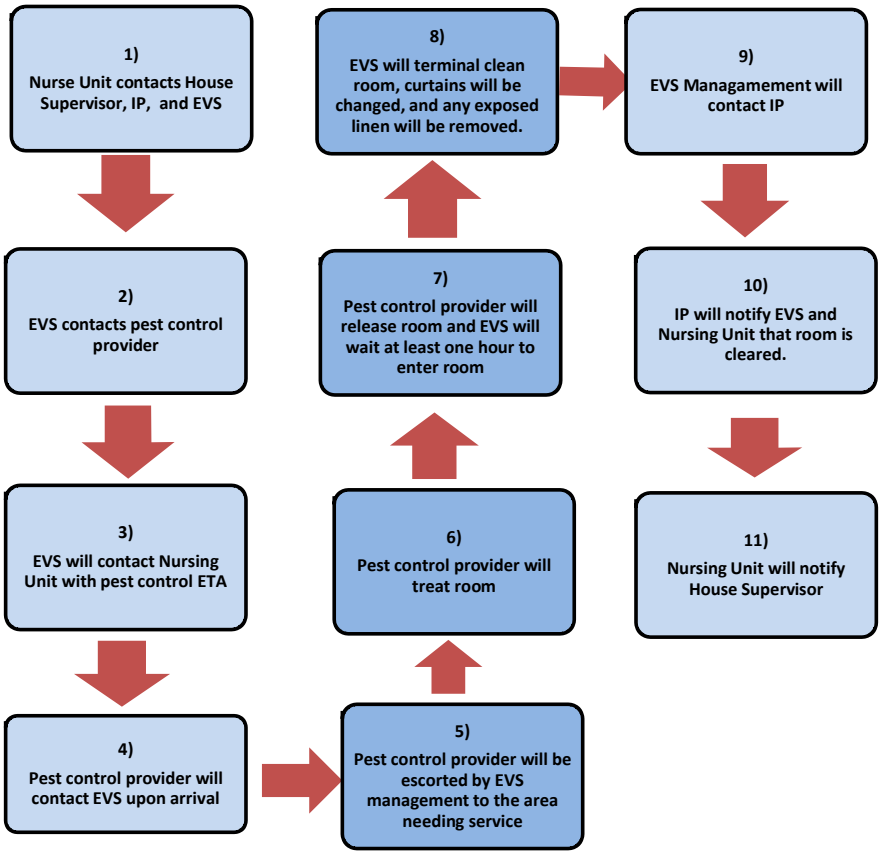
1 See text for discussion of hydrotherapy.
2 The longer the exposure to a disinfectant, the more likely it is that all microorganisms will be eliminated. Follow the FDA-cleared high-level disinfection claim. Ten-minute exposure is not adequate to disinfect many objects, especially those that are difficult to clean because they have narrow channels or other areas that can harbor organic material and bacteria. Twenty-minute exposure at 20ₒC 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 20ₒC) 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 35ₒC, 0.55% OPA at 5 min at 25ₒC 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"



LBJ Nursing, EVS, and ~~ECOLAB~~Pest Control Vendor

Bed Bug Protocol Process



1. Nurse Unit contacts EVS via email and via Phone at 713-566-6960 or 713-566-6961. 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 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.

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 pest control has been contacted and provide an ETA.

4. The pest control provider will contact EVS upon arrival to begin their service.

5. The pest control provider will then be escorted to the requested service area then proceed to inspect the room under EVS supervision.

6. The pest control provider will begin treatment based on their findings and guidelines.

7. The pest control provider will release room after treatment ends and instruct EVS to wait at least an hour before entering the room.

8. 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. EVS Management will contact the ACS Infection Prevention (IP) Department at 346-426-0144to 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. 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 per manufacturer's guidelines 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 per manufacturer's guidelines 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).

~~Quad A Version 8.2~~
AAAHC Version 43

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:

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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 twenty (20) 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:

AORN eGuidelines +

ATTACHMENT B

Hand Hygiene ~~Observations~~ Monitoring at the ASC

~~0. The ASC at LBJ will maintain three Secret Shoppers (SS) and Just in Time coaches (JITC)~~
~~0. The expectation of each SS is to document observations; totaling a combined number of 100 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.~~
~~0. There will also be Just in Time coaches who will be responsible for documenting 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.~~

~~0.~~ Harris Health collects hand hygiene compliance data on hand hygiene opportunities each month in each patient care unit using Secret Shoppers.

B. Harris Health uses Just-In-Time Coaches to provide individuals who have contact with patients or who have contact with items that will be used by patients in patient care units with feedback on both when they are and are not compliant with performing hand hygiene.

C. Direct observations meet all the following criteria:

1. Observations identify both opportunities for hand hygiene and compliance with those opportunities
2. Observations determine who practiced hand hygiene, verified when they practiced it, and if their technique was correct
3. Observations within a unit are conducted weekly or monthly across all shifts and on all days of the week proportional to the number of individuals who have contact with patients or who have contact with items that will be used by patients on duty for that shift
4. Observations are conducted to capture a representative sample (proportional to the number of individuals who have contact with patients or who have contact with items that will be used by patients in the department) of the different roles of individuals who have contact with patients or who have contact with items that will be used by patients (e.g., nurses, physicians, techs, environmental services workers)

D. The observations are entered into an electronic application that houses all of the audit tools. The data from this electronic application feeds into the Hand Hygiene Quality Analytics dashboard that is accessible to all staff.


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:

~~Quad A Version 8.2~~

AAAHC Version 43
42 Code of Federal Regulations (C.F.R.) §416.51.

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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.~~i.e., care at either Lyndon B. Johnson Hospital or Ben Taub General Hospital.

2. Harris Health's ~~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:

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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's ~~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 6.03.

REFERENCES/BIBLIOGRAPHY:

42 Code of Federal Regulations (C.F.R.) §416.51(b).

~~Quad A Version 8.2~~
AAAHC Version43
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 A:
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 B:

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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:

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).

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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:

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.

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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:

WORKFORCE: The members of the governing body of the Ambulatory Surgical Center (ASC) at LBJ, employees, Medical Staff, trainees, contractors, volunteers, and vendors.

I. RESPONSIBILITIES AND PROCEDURES:

A. The ASC Infection Prevention ~~Manager~~ Team 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:

   a. Review of Workforce member records for the presence of vaccinations or antibody titers; and
   b. 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.

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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~~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:

    a. Affected and probable affected; and
    b. 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~~ ~~Manager~~'Team through the following:

a. Laboratory reports;
b. Medical staff;
c. Nursing staff; and
d. Others as appropriate.

2. Investigate cases that may have occurred retrospectively or concurrently:

a. Laboratory reports;
b. Medical reports;
c. Patient charts;
d. Physicians and nursing staff;
e. Public health data; and
f. 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's ~~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.

REFERENCES/BIBLIOGRAPHY:

42 Code of Federal Regulations (C.F.R.) §416.51(b).

Association for Practitioners in Infection Control, APIC Text, Online 2014.

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APICTEXT http://text.apic.org/item-5/chapter-4-outbreak-investiation.

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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.
Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic

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 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 to assist HCP with anxiety and stress. Strategies to mitigate staffing shortages are available.

Please access the link below for the most up to date guidance from the CDC on these key concepts:
Infection Control: Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) | CDC

Attachment B

Harris Health Ambulatory Surgical Center Risk Assessment ~~2024~~2025

PURPOSE:

The purpose of the Harris Health ~~System~~ infection control risk assessment is to identify and review annually potential risk factors for infection related to the care, treatment, and services provided and to the environment of care in the ambulatory surgical center. The identified risks of greatest importance and urgency are then selected and prioritized. Based on these identified risks, an infection prevention plan is developed to address. risk factors categories:

- Geographic;
- Community;
- Populations served;
- Potential for specific infections;
- General Infection Prevention Practices;
- Healthcare Workers;
- Environment of care; and
- Emergency management.

The ASC at LBJ Risk Assessment is reviewed and approved annually by the Governing Body.

ASSESS AND SCORE EACH CRITERION:

a. Probability of the event/condition occurring determined by evaluating the risk of the potential threat actually occurring. Information regarding historical data, infection surveillance data, the scope of services provided by the facility, and the environment of the surrounding area (topography, interstate roads, chemical plants, railroad, ports, etc.) are considered when determining this score.
b. Potential Severity (magnitude vs mitigation) if the risk occurs, takes into consideration the potential for human impact, property impact and business impact.

c. Potential Change in Care, Treatment, Services on patients and personnel, determined by evaluating the potential to impact the organization's ability to function/remain open; and degree of clinical and financial impact. Organization's preparedness to deal with the event/condition determined by considering preplanning, resources, community and mutual aid and supplies.

PRIORITIZE:

After risk scores are assigned, scores are totaled to provide a numerical risk level for each event/ condition. Select the risks with the highest scores for priority (trigger 10 % or higher) to focus on for developing the annual Infection Prevention Plan.

Harris Health Ambulatory Surgery Center Risk Assessment _2025 Worksheet

ISSUE	PROBABILITY *Likelihood this will occur:* 0 = Never 1 = Low 2 = Moderate 3 = High 4 = Certain	SEVERITY (MAGNITUDE vs MITIGATION) HUMAN IMPACT *Possibility of Death or Injury:* 0 = Never 1 = Low 2 = Moderate 3 = High 4 = Certain	PROPERTY IMPACT *Physical Losses and Damages:* 0 = Never 1 = Low 2 = Moderate 3 = High 4 = Certain	BUSINESS IMPACT *Interruption of services:* 0 = Never 1 = Low 2 = Moderate 3 = High 4 = Certain	PREPARED-NESS *Preplanning & Prevention:* 0 = None 1 = Low 2 = Moderate 3 = High 4 = Certain	INTERNAL RESPONSE *Time, Effectiveness, Resources:* 0 = Never 1 = Low 2 = Moderate 3 = High 4 = Certain	EXTERNAL RESPONSE *Community & Mutual Aid staff and supplies:* 0 = Never 1 = Low 2 = Moderate 3 = High 4 = Certain	RISK *Relative Threat *:* *0 - 100%*
***Device related infection**								
- Implant from Surgical Procedure	2	2	0	1	3	3	3	3%
- Drain or Tube - Temporary	1	2	1	1	2	3	2	3%
Resistant Microbes								
- MRSA	2	2	1	1	3	3	3	4%
- VRE	1	2	1	1	3	3	3	2%
- Clostridium difficile	1	2	1	1	3	3	3	2%
- other	1	2	1	1	3	3	3	2%
Surgical Site Infection								
- Superficial	2	1	1	1	3	3	3	3%
- Deep	1	2	1	1	3	3	3	2%
- Organ space	1	2	1	1	3	3	3	2%
Extrinsic Infection								
- Patient-to-Patient Transmission	1	1	1	1	3	3	3	2%
*- Worker-to-Patient Transmission	3	1	1	1	3	3	3	5%
- Visitor-to-Patient Transmission	1	1	1	1	3	3	3	2%
- Foodborne / Waterborne	1	1	1	1	3	3	3	2%
- Vectorborne / Vermin	1	1	1	1	3	2	2	3%
- Airborne Environmental Source	1	1	1	2	3	2	2	3%
- Waterborne / Aerosol Source	1	1	1	2	3	2	2	3%
*- Surface / Immediate Environment	3	2	2	1	3	2	2	13%
-Infection from inadequate air handling	2	1	1	2	2	2	2	8%
*- Contaminated Instrument/Equip	2	2	2	2	3	3	3	6%
-Improper handling of hazardous waste	1	2	1	1	2	2	2	4%
-Improper storage or disposal of supplies	1	1	1	1	2	2	2	3%
-Contaminated Med / Product	1	1	1	1	2	2	2	3%
-Inadequate Sterilization	2	2	1	1	3	3	2	6%
Special Populations								
- Elderly	2	2	1	1	3	2	2	7%
- Pediatrics	1	1	1	1	3	3	3	2%
- Chronic Conditions	1	1	1	1	3	2	2	3%
-Non english speaking	2	2	1	1	2	2	2	8%
- Other not specified above								0%
Failure of Prevention Activities								

ISSUE	PROBABILITY *Likelihood this will occur:* *0 = Never* *1 = Low* *2 = Moderate* *3 = High* *4 = Certain*	SEVERITY (MAGNITUDE vs MITIGATION) HUMAN IMPACT *Possibility of Death or Injury:* *0 = Never* *1 = Low* *2 = Moderate* *3 = High* *4 = Certain*	PROPERTY IMPACT *Physical Losses and Damages:* *0 = Never* *1 = Low* *2 = Moderate* *3 = High* *4 = Certain*	BUSINESS IMPACT *Interruption of services:* *0 = Never* *1 = Low* *2 = Moderate* *3 = High* *4 = Certain*	PREPARED-NESS *Preplanning & Prevention:* *0 = None* *1 = Low* *2 = Moderate* *3 = High* *4 = Certain*	INTERNAL RESPONSE *Time, Effectiveness, Resources:* *0 = Never* *1 = Low* *2 = Moderate* *3 = High* *4 = Certain*	EXTERNAL RESPONSE *Community & Mutual Aid staff and supplies:* *0 = Never* *1 = Low* *2 = Moderate* *3 = High* *4 = Certain*	RISK *Relative Threat *:* *0 - 100%*
- Lack of Hand Hygeine	3	2	1	1	2	2	2	13%
- Lack of Respiratory Hygeine/cough etiquette	2	2	1	2	2	2	2	10%
- Lack of childhood Immunization	1	1	1	1	3	3	3	2%
Policy and Procedure								
- Lack of Standard Precautions	1	1	1	1	3	3	2	2%
- Lack of Current Policy and Procedures	1	1	1	1	3	3	2	2%
- Failure to follow established policy and procedures	1	1	1	1	3	2	2	3%
Occupational Health								
- Bloodborne Pathogen Exposure	1	1	1	1	3	3	3	2%
- Tuberculosis Exposure	1	1	1	1	3	3	2	2%
- Vaccine Preventable Comm Dis	1	1	1	1	3	3	3	2%
Building / Facility								
- Water intrusion	1	2	4	4	2	2	2	10%
- Construction & Renovation	2	1	3	3	2	2	2	15%
- Utilities loss (refer to facility HVA)	2	2	2	2	2	2	2	13%
- Surge capacity	1	2	3	3	2	2	2	8%
Community								
-Menigitis (viral, bacterial)	1	3	1	2	2	2	2	2%
-Zika Virus	1	1	1	2	1	1	2	2%
-Norovirus	1	1	1	2	3	3	3	2%
- Bioterrorism	1	3	2	3	2	2	2	8%
- Epidemic/Pandemic	1	2	2	2	2	3	3	4%
TOTAL AVERAGE RISK SCORE:								5%

** RISK increases with percentage.*

*** Indicates that the issue presents a heightened opportunity for MDRO infection.*

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, AAAHC ~~Quad A~~.

POLICY ELABORATIONS

~~I.~~ The ASC will comply with all reporting requirements set forth by either state or federal law or by AAAHC V43~~Quad A~~.

II. For a detailed description of the ASC's reporting obligations please see Attachments A through C below.

REFERENCES/BIBLIOGRAPHY:

Texas Health and Safety Code §98.10

25 Texas Administrative Code §135.26

25 Texas Administrative Code §200.2

AAAHC Accreditation Handbook for Medicare Deemed Status, v43~~Quad A 8.2~~

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

REVIEW/REVISION HISTORY:

Effective Date	Version # (If Applicable)	Review/ Revision Date (Indicate Reviewed or Revised)	Approved by:
5/11/2017	1.0	5/11/2017	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
		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
		Revised / Approved 02/17/2022	The Ambulatory Surgical Center (ASC) at LBJ Governing Body
		Reviewed / Approved 02/16/2023	The Ambulatory Surgical Center (ASC) at LBJ Governing Body
		Reviewed / Approved 02/22/2024	The Ambulatory Surgical Center (ASC) at LBJ Governing Body

ATTACHMENT "A"

Reportable Incident	State Reporting Requirement	AAAHC~~Quad A~~ Reporting Requirement
Death of patient under the care of the ASC at LBJ	Report within 10 business days of the incident to Texas Health and Human Services Department ~~of State Health Services~~ using form in "Attachment D"	N/A~~Report to Quad A within 5 business days of incident~~. ~~*death must also be reported as an Unanticipated Operative Sequela (see Attachment "E").~~
~~**Death of patient within thirty (30) days of surgical procedure**~~	~~N/A~~	N/A~~Report to Quad A within 5 business days of incident~~ ~~*death must also be reported as an Unanticipated Operative Sequela (see Attachment "E").~~
~~**Patient Safety Data Reporting including Random Case Review and Unanticipated Operative Sequelae**~~	~~N/A~~	~~Report to Quad A 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 days of the incident to Texas Health and Humans Services Department ~~of State Health Services~~ using form in "Attachment D"	N/A~~Report to Quad A within established reporting period using form in Attachment "E""~~
Transfer of patient to hospital	Report within 10 business days of the incident to Texas Health and Human Services Department ~~of State Health Services~~ using form in "Attachment D"	N/A~~Report to Quad A within established reporting period using form in Attachment "E"~~
Patient stay exceeding 23 hours~~**Extended stay of patient – i.e. a patient stay that exceeds 23 hours**~~	Report within 10 business days of the incident to Texas Health and Human Services Department ~~Department of State Health Services~~ using form in "Attachment D"	N/A~~Report to Quad A within established reporting period using form in Attachment "E""~~
Fire Occurence~~**in the ASC**~~	Report within 10 business days of the incident to Texas Health and Human Services Department ~~Department of State Health Services~~ using form in "Attachment D"	N/A
Fire causes injury to a person	Report no later than the next business day of the incident to	N/A

	Texas Health and Human Services Department using form in "Attachment D"	
Occurrence of surgical fires if flammable germicides, including alcohol-based products, are used for preoperative surgical skin preparation	Report within two business days of the incident to Texas Health and Human Services Department using form in "Attachment D"	N/A
Any t~~T~~heft of drugs, gs~~/~~diversion of controlled drugs or both~~substances~~	Report within 10 business days of the incident to Texas Health and Human Services Department ~~Department of State Health Services~~ using form in "Attachment D"	N/A
~~**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.~~
Within 15 calendar days of significant organizational, ownership, operational, or quality of care events, the organization notifies AAAHC of the event in writing	N/A	Report within 15 days to AAAHC
~~**Illegal, Unprofessional or Unethical Conduct Related to Operation of Facility Services**~~	~~Report within 10 business days of the incident to Texas Health and Human Services Department using form in "Attachment D"~~	~~N/A~~
~~**Abuse and Neglect**~~	Report within 10 business days of the incident to Texas Health and Human Services Department using form in "Attachment D"	N/A
Neglect	Report within 10 business days of the incident to Texas Health and Human Services Department using form in "Attachment D"	

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Exploitation	Report within 10 business days of the incident to Texas Health and Human Services Department using form in "Attachment D"	
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.	N/A
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.	N/A

	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.	
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 Patient Safety~~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"~~

~~Quad A Patient Safety Data Reporting DOCUMENTS~~

~~https://www.aaaasf.org/documents/outpatient-surgical/~~

HARRISHEALTH
AMBULATORY SURGICAL CENTER AT LBJ

Policy No:	ASC-P-6003
Page Number:	1 of 6
Effective Date:	8/5/16
Board Motion No:	n/a

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's ~~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. ~~x~~ *37800, give exact location and announce to the ASC that a "Code Red" exists;

   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:

Commented [MRM1]:

Commented [MRM2R1]: New way to dial an extension is to have * (asterisk)

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 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:

~~Quad A Version 8.2~~ AAAHC V43

Emergency Preparedness Guide

BTGH Fire Safety Plan Policy FP

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:

Effective Date	Version # (If Applicable)	Review/ Revision Date (Indicate Reviewed or Revised)	Approved by:
8/5/16	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
		Reviewed / Approved 02/17/2022	The Ambulatory Surgical Center (ASC) at LBJ Governing Body
		Revised / Approved 02/16/2023	The Ambulatory Surgical Center (ASC) at LBJ Governing Body

		Revised / Approved 02/22/2024	The Ambulatory Surgical Center (ASC) at LBJ Governing Body

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):

1. Date of this report: _____
2. Date of incident: _____
3. 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
AMBULATORY SURGICAL CENTER AT LBJ

Ambulatory Surgical Center (ASC) at LBJ

Policy No: ASC-P-6014
Page Number: 1 of 83

Effective Date: 4/13/2017
Board Motion No: n/a

Facility Safety Manual of the Ambulatory Surgical Center (ASC) at LBJ

Printed versions of this document are uncontrolled. Please go to the Harris Health ~~Document Control~~Document Control Center ~~to retrieve~~to retrieve an ~~official controlled~~official controlled version of the document:. https://sp2019apps.hchd.local/sites/dcc

Table of Contents

TITLE: FIRE DRILL/ALARM PROCEDURE

PURPOSE: To establish the protocol to be followed in the event of a fire alarm or scenario-based 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's ~~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~~*3-7800, 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 or designee must document the ASC's response to a drill or actual fire, including the scenario for a fire drill, on the Code Red Form (attached here to as Attachment A).
2. The ASC Administrator or designee 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:

AAAHC Deemed Status Handbook v42CFC §416.41(C)

DNV Healthcare NIAHO PE.2. Life Safety Management System

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:

Effective Date	Version # (If Applicable)	Review/ Revision Date (Indicate Reviewed or Revised)	Approved by:
8/5/2016	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
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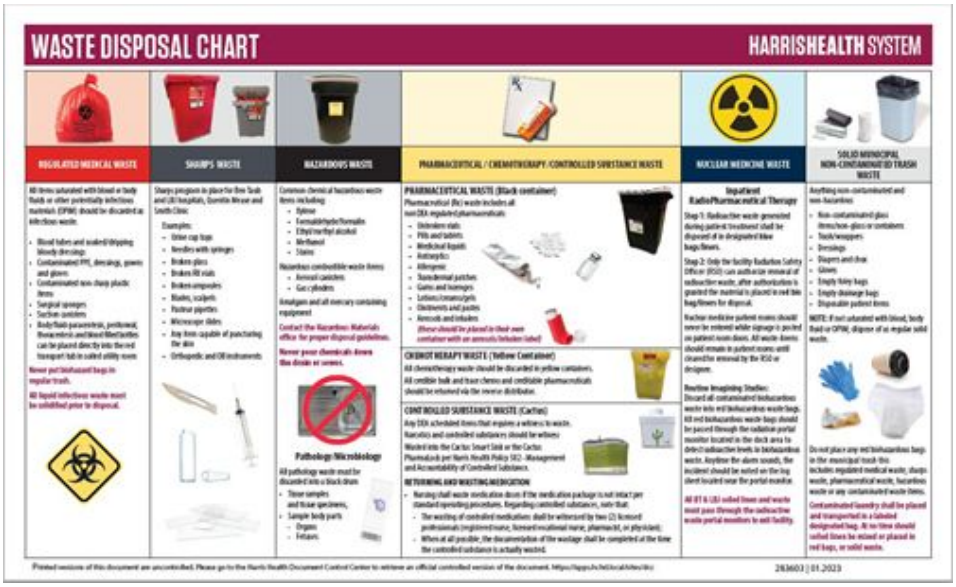
ATTACHMENT "A"

Link to the Harris Health ~~System~~ Code Red Report form



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 or designee 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.*

AAAHC Deemed Status Handbook v42

Conditions for Coverage §416.50

OFFICE OF PRIMARY RESPONSIBILITY:

The Ambulatory Surgical Center (ASC) at LBJ

REVIEW/REVISION HISTORY:

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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:

AAAHC Deemed Status Handbook v42

OFFICE OF PRIMARY RESPONSIBILITY:

The Ambulatory Surgical Center (ASC) at LBJ

REVIEW/REVISION HISTORY:

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		Revised / Approved 05/23/2024	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:

AAAHC Deemed Status Handbook v42

OFFICE OF PRIMARY RESPONSIBILITY:

The Ambulatory Surgical Center (ASC) at LBJ

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		Revised / Approved 05/23/2024	The Ambulatory Surgical Center (ASC) at LBJ Governing Body

TITLE: ABOVE CEILING WORK AND FIRE/SMOKE BARRIER MANAGEMENT

PURPOSE: To direct the appropriate action for work conducted above ceiling level or involving penetrations of fire and smoke barriers at the Ambulatory Surgical Center (ASC) at LBJ.

POLICY STATEMENT:

It is the policy of the Ambulatory Surgical Center (ASC) at LBJ ("ASC") to follow the requirements of work performed above ceiling level or involving penetration of fire or smoke barriers shall require the issuance of an Above Ceiling Work and Fire/Smoke Barrier Penetration Permit prior to the beginning of any work. In order to meet this ~~requirement~~requirement, the ASC adopts Harris Health's ~~System policy~~Policy Above Ceiling Work ~~And~~and Fire/Smoke Barrier Management Policy 7406.

REFERENCES/BIBLIOGRAPHY:

AAAHC Deemed Status Handbook v42

Texas Health and Safety Code §502.001, *et seq.*

OFFICE OF PRIMARY RESPONSIBILITY:

The Ambulatory Surgical Center (ASC) at LBJ

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.

VI. Alcohol Based Hand Sanitizer

A. Harris Health shall have available a SDS available for all Alcohol Based Hand Sanitizer used throughout the ASC.
B. All mounted ABHS shall be installed properly and within the guidelines as defined my by NFPA 101 Life Safety Code.

REFERENCES/BIBLIOGRAPHY:

AAAHC Deemed Status Handbook v42

Texas Health and Safety Code §502.001, *et seq.*

OFFICE OF PRIMARY RESPONSIBILITY:

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		Revised / Approved 05/23/2024	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~~*3-2538 or ~~x6~~*6-5566.

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;

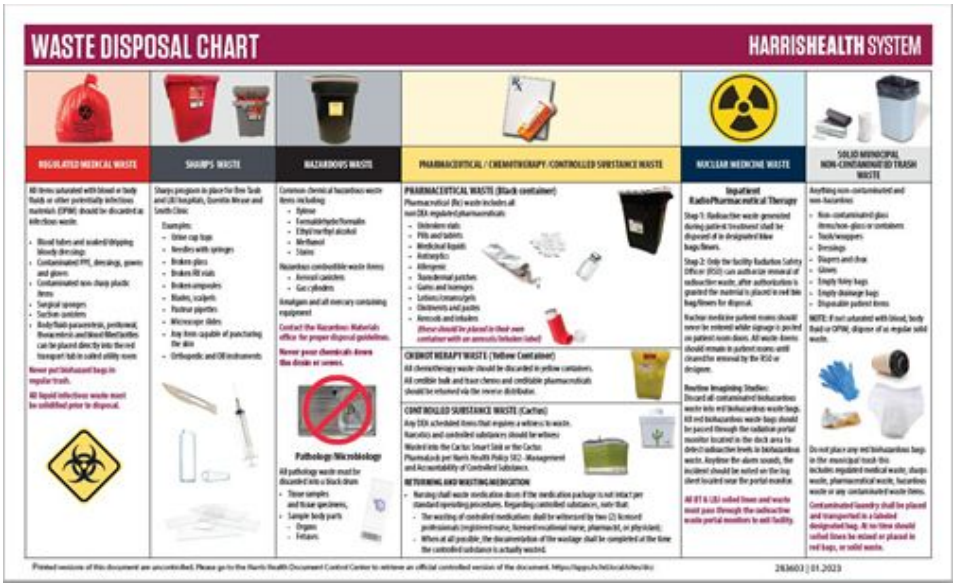
4. Spills located outside the ASC facility will be managed by the Houston Fire Department or HAZMAT authorities.

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's ~~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.


WASTE DISPOSAL CHART
HARRISHEALTH SYSTEM
REGULATED MEDICAL WASTE
SHARPS WASTE
HAZARDOUS WASTE
PHARMACEUTICAL / CHEMOTHERAPY / CONTROLLED SUBSTANCE WASTE
NUCLEAR MEDICINE WASTE
SOLID MUNICIPAL NON-CONTAMINATED TRASH WASTE
PHARMACEUTICAL WASTE (Black container)
CHEMOTHERAPY WASTE (Yellow Container)
CONTROLLED SUBSTANCE WASTE (Cactus)
RETURNING AND WASTING MEDICATION
Pathology Microbiology
Inpatient
Radiopharmaceutical Therapy
2836031 | 01.2023

HARRISHEALTH SYSTEM

HAZARD REPORT

1. Please Complete All Fields
2. Forward Original Copy to Pavilion Safety Office
3. Please Retain A Copy Within Your Department

FACILITY
☐ BT ☐ LBJ ☐ QM ☐ ACS (name of clinic) _____
☐ HOLLY HALL ☐ KIRBY

DATE OF EVENT: _____

TIME EVENT STARTED: _____ TIME EVENT ENDED: _____

DEPARTMENT OF SPILL: _____

SPECIFIC LOCATION OF SPILL: _____

WAS A CODE YELLOW CALLED? ☐ YES ☐ NO
WAS THE HAZARDOUS SUBSTANCE RELATED TO CHEMOTHERAPY DRUGS? ☐ YES ☐ NO
WHAT IS THE NAME OF THE HAZARDOUS SUBSTANCE? _____
DID ANYONE INVOLVED REFER TO THE SAFETY DATA SHEET FOR THE HAZARDOUS CHEMICAL? ☐ YES ☐ NO
DID THE STAFF USE THE APPROPRIATE PERSONAL PROTECTION EQUIPMENT (PPE)? ☐ YES ☐ NO
DID THE DEPARTMENT CLEAN-UP THEIR OWN SPILL? ☐ YES ☐ NO
DID EVS/HK CLEAN-UP THE RESIDUAL OF THE SPILL? ☐ YES ☐ NO

In your own words below, please explain your experience with the spill?

_____
_____
_____
_____

List names of workforce members involved with the spill.

_____
_____
_____
_____

Reference Policy 7100 – Emergency Codes, Conditions and Response, Appendix I

Printed versions of this document are uncontrolled. Please go to the Harris Health Document Control Center to retrieve an official controlled version of the document. https://hcsp.hchd.local/sites/dcc

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H. _____

REFERENCES/BIBLIOGRAPHY:

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		Revised / Approved 05/23/2024	The Ambulatory Surgical Center (ASC) at LBJ Governing Body

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~~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.~~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:

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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's ~~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.

B. **Frozen Specimens**:

1. The following procedures must be followed when handling frozen specimens:

i. Harris Health's ~~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's ~~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's ~~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's ~~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:

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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's ~~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

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Attachment A

Approved Procedures for the Ambulatory Surgical Center (ASC) at LBJ
Approved February 2023

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/SURGICAL	STRYKER INSTRUMENTS	0408-655-000	1524502453		
62001145	ASPIRATOR/SURGICAL	STRYKER INSTRUMENTS	0408-655-000	1524502423		
62001146	ASPIRATOR/SURGICAL	STRYKER INSTRUMENTS	0408-655-000	1524409913		
62001147	ASPIRATOR/SURGICAL	STRYKER 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	ARTHROSCOPESTRYKER ENDOSCOPY DIV STRYKER CORP			502-104-030	905126
SN-907277	ARTHROSCOPESTRYKER ENDOSCOPY DIV STRYKER CORP			502-104-030	907277
SN-910402	ARTHROSCOPESTRYKER ENDOSCOPY DIV STRYKER CORP			502-904-070	910402
SN-910680	ARTHROSCOPESTRYKER 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	
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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	
62000976	WARM UNIT/PATIENT/FORCED-AIR	ARIZANT HEALTHCARE INC A 3M Co	875	45974	
62000977	WARM UNIT/PATIENT/FORCED-AIR	ARIZANT HEALTHCARE INC A 3M Co	875	45997	
62000978	WARM UNIT/PATIENT/FORCED-AIR	ARIZANT HEALTHCARE INC A 3M Co	875	45992	
62000979	WARM UNIT/PATIENT/FORCED-AIR	ARIZANT HEALTHCARE INC A 3M Co	875	45970	
62000980	WARM UNIT/PATIENT/FORCED-AIR	ARIZANT HEALTHCARE INC A 3M Co	875	45982	
62000981	WARM UNIT/PATIENT/FORCED-AIR	ARIZANT HEALTHCARE INC A 3M Co	875	45978	
62000982	WARM UNIT/PATIENT/FORCED-AIR	ARIZANT HEALTHCARE INC A 3M Co	875	45969	
62000983	WARM UNIT/PATIENT/FORCED-AIR	ARIZANT HEALTHCARE INC A 3M Co	875	45994	
62000984	WARM UNIT/PATIENT/FORCED-AIR	ARIZANT HEALTHCARE INC A 3M Co	875	45966	
60003296	ULTRASOUND SYSTEM PORTABLE	SonoSite Inc	P15000-13	03VZTC	
60003301	ANESTHESIA UNIT	Drager Medical	APOLLO	ASEF-0273	
60003302	ANESTHESIA UNIT	Drager Medical	APOLLO	ASEF-0275	
60003303	ANESTHESIA UNIT	Drager Medical	APOLLO	ASEF-0276	
60003304	ANESTHESIA UNIT	Drager Medical	APOLLO	ASEF-0278	
60003305	ANESTHESIA UNIT	Drager Medical	APOLLO	ASEF-0220	
60003514	MONITOR PATIENT MX700	Philips Medical Systems	865241	DE12521110	

60003515 MONITOR PATIENT MX700 Philips Medical Systems 865241 DE12521105
60003516 MONITOR PATIENT MX700 Philips Medical Systems 865241 DE12521098
60003517 MONITOR PATIENT MX700 Philips Medical Systems 865241 DE12521108
6003535 MONITOR PATIENT M5 Philips Medical Systems M8105A DE21075164
60003543 PATIENT MONITOR MX700 Philips Medical Systems 865241 DE12521109
60003548 LARYNGOSCOPIC CHIP VIDEO SYS Karl Storz Endoscopy-America I 8402ZX-KT VW6389
60003549 LARYNGOSCOPIC CHIP VIDEO SYS Karl Storz Endoscopy-America I 8402ZX WW6570
SN-2160064 FLEX INTUBATION VIDEO 60XKarl Storz Endoscopy-America I 11302BD2 2160064
61005816 PRINTER/VIDEO SONY ELECTRONICS INC MEDICAL SYS DI UP-897MD 281095
61005920 WARM UNIT/BLOOD/SOLUTION SMITHS MEDICAL ASD INC HL-90 S101A02049
61005921 WARM UNIT/BLOOD/SOLUTION SMITHS MEDICAL ASD INC HL-90 S101A02050
61005926 MOD/PHYSIOLOGIC/MULTI MEASURE Philips Healthcare Cardiac & Monitoring Systems Div M3001A DE9070CZLR
61005927 SATELLITE RACK PHILIPS MEDICAL SYS CARDIAC & MONIT 865243 DE12321945
61005928 MOD/PHYSIOLOGIC/BIS PHILIPS MEDICAL SYS CARDIAC & MONIT M1034A DE11025040
61005929 MOD/PHYSIOLOGIC/RECORDER PHILIPS MEDICAL SYS CARDIAC & MONIT M1116B 4227A90209
61005930 MOD/PHYSIOLOGIC/MULTI MEASURE Philips Healthcare Cardiac & Monitoring Systems Div M3001A DE9070CZPD
61005931 SATELLITE RACK PHILIPS MEDICAL SYS CARDIAC & MONIT 865243 DE12325638
61005932 MOD/PHYSIOLOGIC/BIS PHILIPS MEDICAL SYS CARDIAC & MONIT M1034A DE11025042
61005933 MOD/PHYSIOLOGIC/RECORDER PHILIPS MEDICAL SYS CARDIAC & MONIT M1116B 4227A90211
61005934 MOD/PHYSIOLOGIC/MULTI MEASURE Philips Healthcare Cardiac & Monitoring Systems Div M3001A DE9070CYDB
61005935 SATELLITE RACK PHILIPS MEDICAL SYS CARDIAC & MONIT 865243 DE12325659
61005936 MOD/PHYSIOLOGIC/BIS PHILIPS MEDICAL SYS CARDIAC & MONIT M1034A DE11025051
61005937 MOD/PHYSIOLOGIC/RECORDER PHILIPS MEDICAL SYS CARDIAC & MONIT M1116B 4227A90212
61005938 MOD/PHYSIOLOGIC/MULTI MEASURE Philips Healthcare Cardiac & Monitoring Systems Div M3001A DE9070CZPM
61005939 MOD/PHYSIOLOGIC/VUELINK PHILIPS HEALTHCARE NORTH AMERICA M3012A DE83758332
61005940 SATELLITE RACK PHILIPS MEDICAL SYS CARDIAC & MONIT 865243 DE12321944
61005941 MOD/PHYSIOLOGIC/BIS PHILIPS MEDICAL SYS CARDIAC & MONIT M1034A DE11025041
61005942 MOD/PHYSIOLOGIC/RECORDER PHILIPS MEDICAL SYS CARDIAC & MONIT M1116B 4227A90208
61005990 SATELLITE RACK PHILIPS MEDICAL SYS CARDIAC & MONIT 865243 DE12321937
61005991 MOD/PHYSIOLOGIC/MULTI MEASURE PHILIPS MEDICAL SYS CARDIAC & MONIT M3001A DE9070CZM9
61005992 MOD/PHYSIOLOGIC/MULTI MEASURE Philips Healthcare Cardiac & Monitoring Systems Div M3001A DE9070CZPK
61005993 MOD/PHYSIOLOGIC/VUELINK PHILIPS HEALTHCARE NORTH AMERICA M3012A DE83758333
61005994 SATELLITE RACK PHILIPS MEDICAL SYS CARDIAC & MONIT 865243 DE1322271

61005995	MOD/PHYSIOLOGIC/BIS	PHILIPS MEDICAL SYS CARDIAC & MONIT	M1034A	DE11025048		
61005996	MOD/PHYSIOLOGIC/RECORDER	PHILIPS MEDICAL SYS CARDIAC & MONIT	M1116B	4227A90213		
61006094	INFUSION PUMP/GENERAL-PURPOSE	CAREFUSION ALARIS	8015	14001250		
61006095	INFUSION PUMP/GENERAL-PURPOSE	CAREFUSION ALARIS	8015	14004101		
61006096	INFUSION PUMP/SYRING	CAREFUSION ALARIS	8110	13992565		
61006097	INFUSION PUMP/SYRING	CAREFUSION ALARIS	8110	13993028		
61006098	INFUSION PUMP/GENERAL-PURPOSE	CAREFUSION ALARIS	8100	14004362		
61006099	INFUSION PUMP/GENERAL-PURPOSE	CAREFUSION ALARIS	8100	14004556		
62000889	WARM UNIT/PATIENT/FORCED-AIR	ARIZANT HEALTHCARE INC A 3M Co	775	49909		
62000890	WARM UNIT/PATIENT/FORCED-AIR	ARIZANT HEALTHCARE INC A 3M Co	775	49911		
62000891	WARM UNIT/PATIENT/FORCED-AIR	ARIZANT HEALTHCARE INC A 3M Co	775	49913		
62000892	WARM UNIT/PATIENT/FORCED-AIR	ARIZANT HEALTHCARE INC A 3M Co	775	49917		
62000893	WARM UNIT/PATIENT/FORCED-AIR	ARIZANT HEALTHCARE INC A 3M Co	775	49915		
62000894	WARM UNIT/PATIENT/FORCED-AIR	ARIZANT HEALTHCARE INC A 3M Co	775	49918		
62000993	DESFLURANE ANESTHESIA UNIT VAPORIZER	DRAGER MEDICAL INC	M35500-14	ARWF-0238		
62000994	DESFLURANE ANESTHESIA UNIT VAPORIZER	DRAGER MEDICAL INC	M35500	ARZE-0530		
62000995	DESFLURANE ANESTHESIA UNIT VAPORIZER	DRAGER MEDICAL INC	M35500	ARZC-0224		
62000996	DESFLURANE ANESTHESIA UNIT VAPORIZER	DRAGER MEDICAL INC	M35500	ASBF-0096		
62000997	DESFLURANE ANESTHESIA UNIT VAPORIZER	DRAGER MEDICAL INC	M35500	ARZD-0155		
62001061	SEVOFLURANE ANESTHESIA UNIT VAPORIZER	DRAGER MEDICAL INC	M35170	ARUB-0058		
62001062	SEVOFLURANE ANESTHESIA UNIT VAPORIZER	DRAGER MEDICAL INC	M35170	ARSH-0396		
62001063	SEVOFLURANE ANESTHESIA UNIT VAPORIZER	DRAGER MEDICAL INC	M35170	ARTD-0500		
62001064	SEVOFLURANE ANESTHESIA UNIT VAPORIZER	DRAGER MEDICAL INC	M35170	ARUF-0646		
62001065	SEVOFLURANE ANESTHESIA UNIT VAPORIZER	DRAGER MEDICAL INC	M35170	ARUF-1253		
SN-03WY5Y	TRANSDUCER/ULTRASONIC	SONOSITE INC P07682-20	03WY5Y			
SN-03X8LC	TRANSDUCER/ULTRASONIC	SONOSITE INC P07680-30	03X8LC			
SN-0N2470038	STIM/ELEC/PERIPHERAL NERVE	LIFE-TECH INC	MS-IV	A0N2470038		
SN-0N2470045	STIM/ELEC/PERIPHERAL NERVE	LIFE-TECH INC	MS-IV	A0N2470045		
SN-0N2470075	STIM/ELEC/PERIPHERAL NERVE	LIFE-TECH INC	MS-IV	A0N2470075		
SN-0N2470077	STIM/ELEC/PERIPHERAL NERVE	LIFE-TECH INC	MS-IV	A0N2470077		
SN-0N2830006	STIM/ELEC/PERIPHERAL NERVE	LIFE-TECH INC	MS-IV	A0N2830006		
SN-0N2830008	STIM/ELEC/PERIPHERAL NERVE	LIFE-TECH INC	MS-IV	A0N2830008		
SN-0N2830009	STIM/ELEC/PERIPHERAL NERVE	LIFE-TECH INC	MS-IV	A0N2830009		
SN-0N2830013	STIM/ELEC/PERIPHERAL NERVE	LIFE-TECH INC	MS-IV	A0N2830013		
SN-0N2830016	STIM/ELEC/PERIPHERAL NERVE	LIFE-TECH INC	MS-IV	A0N2830016		
SN-0N2830018	STIM/ELEC/PERIPHERAL NERVE	LIFE-TECH INC	MS-IV	A0N2830018		
SN-18691	VIDEO SYS/ENDOSCOPIC/VIDEO ADAPT	KARL STORZ ENDOSCOPY-AMERICA INC	8401BX	18691		

SN-18692	VIDEO SYS/ENDOSCOPIC/VIDEO ADAPT	KARL STORZ ENDOSCOPY-AMERICA INC	8401BX 18692
SN-20211	VIDEO SYS/ENDOSCOPIC/VIDEO ADAPT	KARL STORZ ENDOSCOPY-AMERICA INC	8401HX 20211
SN-20407	VIDEO SYS/ENDOSCOPIC/VIDEO ADAPT	KARL STORZ ENDOSCOPY-AMERICA INC	8401GXC 20407
SN-21536	VIDEO SYS/ENDOSCOPIC/VIDEO ADAPT	KARL STORZ ENDOSCOPY-AMERICA INC	8401KXC 21536
SN-21847	VIDEO SYS/ENDOSCOPIC/VIDEO ADAPT	KARL STORZ ENDOSCOPY-AMERICA INC	8401AX 21847
SN-21975	VIDEO SYS/ENDOSCOPIC/VIDEO ADAPT	KARL STORZ ENDOSCOPY-AMERICA INC	8401HX 21975
SN-43844	VIDEO SYS/ENDOSCOPIC/VIDEO ADAPT	KARL STORZ ENDOSCOPY-AMERICA INC	8401AX 43844
SN-BX68525	MONITOR/BED/EEG/LEVEL-OF-CONS	ASPECT MEDICAL SYS INC	M1034-60021 BX68525
SN-BX75007	MONITOR/BED/EEG/LEVEL-OF-CONS	ASPECT MEDICAL SYS INC	M1034-60021 BX75007
SN-BX75094	MONITOR/BED/EEG/LEVEL-OF-CONS	ASPECT MEDICAL SYS INC	M1034-60021 BX75094
SN-BX75110	MONITOR/BED/EEG/LEVEL-OF-CONS	ASPECT MEDICAL SYS INC	M1034-60021 BX75110
SN-BX75299	MONITOR/BED/EEG/LEVEL-OF-CONS	ASPECT MEDICAL SYS INC	M1034-60021 BX75299
SN-WK250W	TRIPLE TRANSDUCER CONNECT/ULTRASONIC	SONOSITE INC	P16535-02 WK250W
SN-WW5585	ELECTRONIC IMAGING MODULE WITH 8 PIN CONNECTOR	KARL STORZ ENDOSCOPY-AMERICA INC	8402X WW5585
SN-WW5800	ELECTRONIC IMAGING MODULE WITH 8 PIN CONNECTOR	KARL STORZ ENDOSCOPY-AMERICA INC	8402X WW5600
SN-WW82430-H	CAMERA/VIDEO/ENDOSCOPE	KARL STORZ ENDOSCOPY-AMERICA INC	20290132 WW82430-H

HARRISHEALTH SYSTEM

ASC Disaster Preparedness Plan

~~2023~~2024-~~2024~~2025

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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's ~~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's ~~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's ~~System's~~ *Facility Alert, Utilities Failure Procedure,* attached. During a power failure staff will safely complete or stop any procedure they have currently started if the physician deems it is safe to do so. No additional procedures will begin until ASC has returned to normal power.

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's ~~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:

a. Fire/Explosion;

b. Hazardous Material Incidents;
c. Structural Damage/Failure;
d. Extended Utility Failure;
e. Medical Gases Failure;
f. Infectious Outbreak; and
g. 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)

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:

a. Emergency preparedness knowledge among Workforce members;
b. Workforce members' emergency preparedness skills;
c. Workforce members' participation levels;
d. Inspection activities;
e. Emergency and incident reporting procedures; and
f. 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:

~~Quad A Version 8.2~~AAAHC V.43

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
		Revised / Approved 02/17/2022	The Ambulatory Surgical Center (ASC) at LBJ Governing Body
		Revised / Approved 02/16/2023	The Ambulatory Surgical Center (ASC) at LBJ Governing Body

ATTACHMENT A

HAZARD VULNERABILITY ANALYSIS (HVA) RISK RATING

Ambulatory Surgical Center Top 10 Rated Events

2025~~3~~ HAZARD VULNERABILITY ANALYSIS RISK RATING

Top 10 ASC Scored Events (Average)

Updated January 2024~~3~~

	Type Of Event	Risk
Rank	**Top Rated Events from ACS HVAs**	**Relative Threat 0 – 100%**
1	Power Outage	52%
2	Hurricane tropical Storm	39%
3	Epidemic / Pandemic	38%
4	Flood, External	23%
5	Cyber Attack	30%
6	Water Disruption / Contamination	30%
7	Communication/ Telephony Failures	27%
8	Hazmat Incident MCI 5 OR More	27%
9	Fire, Internal	25%
10	Chemical Exposure, External	24%

Commented [HSA1]: Please update this section with the following HVA information

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:

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:**

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:**

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:**

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:**

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.

REFERENCES/BIBLIOGRAPHY:

~~Quad A Version 8.2~~AAAHC Version 43

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
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		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
		Revised / Approved 02/17/2022	The Ambulatory Surgical Center (ASC) at LBJ Governing Body
		Reviewed / Approved 02/16/2023	The Ambulatory Surgical Center (ASC) at LBJ Governing Body
		Revised / Approved 02/22/2024	The Ambulatory Surgical Center (ASC) at LBJ Governing Body

ATTACHMENT A

HAZARD VULNERABILITY ANALYSIS (HVA) RISK RATING

Ambulatory Surgical Center Top 10 Rated Events

2024 HAZARD VULNERABILITY ANALYSIS RISK RATING

Top 10 ASC Scored Events (Average)

Updated 12/27/2023

	Type Of Event	Risk
Rank	Top Rated Events from ASC HVAs	Relative Threat 0 – 100%
1	Power Outage	52%
2	Hurricane / Tropical Storm	39%
3	Epidemic / Pandemic	38%
4	Flood, Internal	35%
5	Cyber Attack	30%
6	Water Disruption / Contamination	30%
7	Communication / Telephony Failure	27%
8	Hazmat Incident MCI 5 or More	27%
9	Fire, Internal	25%
10	Chemical Exposure, External	24%

TITLE: EXTRACORPOREAL SHOCK WAVE LITHOTRIPSY (ESWL) IN THE AMBULATORY SURGICAL CENTER (ASC) AT LBJ

PURPOSE: To specify the procedures that must be followed to safely perform ESWL in the Ambulatory Surgical Center (ASC) at LBJ.

POLICY STATEMENT:

It is the policy of the Ambulatory Surgical Center (ASC) at LBJ to safely perform ESWL procedures in the ASC.

POLICY ELABORATIONS:

I. ESWL PROCEDURES:

A. Unilateral or bilateral lithotripsy can be performed on patients with documented renal and ureteral calculi.

B. Urologist Responsibility:

- Schedule patients for lithotripsy;
- Order pre-procedure testing;
- Obtain consent;
- Provide patient's history and physical;
- Examine the patient immediately prior to the procedure and document in the medical record; and
- Perform the lithotripsy procedure and be present during the treatment.

C. The following staff will participate in the provision of lithotripsy services:

- A qualified anesthesiologist or certified registered nurse anesthetist to provide anesthesia services;
- A qualified urologist specially trained in lithotripsy, who will perform the procedure; and
- A qualified radiologic technologist licensed by the State of Texas and registered by the American Registry of Radiologic Technologists who will assist the urologist by operating the lithotripter.

D. Policies and procedures will be developed by the facility for the completion and documentation of the following:

- History and physical examination including presence, location, and size of stone;
- Pre-procedure testing;
- Pre-procedure diagnosis; and
- Procedure and post procedure notes including a description of procedures and fragmentation, patient's condition, any unusual events occurring during the procedure, post procedure diagnosis, and the names of urologist and clinical staff present during the procedure.

E. The Lithotripsy Treatment Record will be completed and signed by the urologist and radiologic technologist.

F. Patients and family will receive written and verbal education concerning lithotripsy, including but not limited to the following:

- ESWL pre-treatment patient instructions;
- Information regarding ESWL treatment; and
- ESWL post-treatment patient instructions.

G. Each lithotripter utilized should be inspected and approved by the ASC. Serial numbers will be provided to and maintained on file by the ASC.

H. Each lithotripter will be maintained in good, clean, working order. A service contract shall be maintained for each lithotripter. The lithotripters will be inspected quarterly by a qualified person in accordance with the manufacturer's recommendations. All preventative maintenance will be documented and

submitted by the provider to the facility to be maintained in the lithotripsy services manual.

I. Equipment malfunctions will be corrected, documented, and submitted by the provider to the facility.

J. Equipment and supplies appropriate to the treatment needs of lithotripsy patients for the types and ages served will be provided.

K. Performance Improvement/Quality Assurance activities will include evaluation of services and outcomes.

L. Continuing education relating to lithotripsy will be provided to the facility staff by the contracted vendor, initially and as requested.

II. OPERATIONAL POLICIES:

A. Shocks: Maximum 3000 shocks. In cases where two stones (distal and upper ureteral or renal) are treated simultaneously, maximum shock numbers may be delivered to both treatment areas.

B. Shock Voltage 9 (Power Setting): Shock voltage is restricted to the 14-26 KV range

C. Patient Position: The physician, in conjunction with the transportable lithotripsy service provider, while adhering to will determine patient positioning on the lithotripter table.

D. Bilateral Lithotripsy: Patients may undergo bilateral lithotripsy and should have one renal unit stented or vented.

E. Females of Reproductive Age: Pregnant patients will not be treated. Women of childbearing age with a distal or mid-ureteral calculus may be treated.

F. Weight Limitation: Patients exceeding the safe operating limits of the ESWL machine are not candidates for ESWL.

G. Pacemakers and Automatic Implantable Cardiac Defibrillator Devices: Patients with pacemakers or implantable defibrillators are candidates for ESWL. Specific protocols must be followed.

H. Post ESWL Follow-up Care: Patients will be instructed to follow up with the urologist according to the urologist's orders.

I. Contraindicated Medications: Patients taking anticoagulants and platelet inhibiting medications should have their coagulation status reviewed by the

urologist who will instruct the patients regarding the discontinuance of such medications prior to lithotripsy.

J. Pre-Admission Testing Requirements: Pre-admission requirements per facility policy.

K. Pre and Post ESWL Calls: All patients will receive pre and post lithotripsy calls, per facility policy.

L. Pediatric Cases: Patients under the age of 10 will not be treated.

M. Treatment Criteria: All patients should have a KUB to verify the presence and location of a stone in the renal pelvis or ureter.

N. Retreatment Time: A period of two weeks for renal calculi and one week for ureteral calculi is required between treatments.

O. Safety Protocols: All safety protocols, including mechanical and radiation, will be followed. A record of lithotripter calibration/equipment checks will be maintained by the transportable provider and available upon request.

P. Utilization of Equipment: The facility will adhere to all manufacturer guidelines related to use of equipment; cystoscopy procedures may be performed on the lithotripter treatment table.

Q. Treatment Simulation: Simulations will not be performed.

R. Administration of Anesthesia: The patient will be examined and assessed, using the ASA classification by an anesthesiologist prior to treatment to determine the type of anesthesia to be administered.

S. Cancellation Criteria: Cases will be cancelled if any of the above is not met.

REFERENCES/BIBLIOGRAPHY:

AAAHC Deemed Status Handbook v42

ASC-P-1005

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:
	1.0		The Ambulatory Surgical Center (ASC) at LBJ Governing Body
		New 05/23/2024	The Ambulatory Surgical Center (ASC) at LBJ Governing Body

BOARD OF TRUSTEES

HARRISHEALTH

Ambulatory Surgical Center at LBJ Governing Body

Thursday, February 20, 2025

Consideration of Approval of Reviewed Policies and Procedures with No Recommended Changes for the ASC 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 reviewed policies with no changes, other than a global change of the system name and a change of reference from Quad A to AAAHC.

- Policies 1000-1002
- Policies 1006-1010
- Policies 2000-2023
- Policies 3000-3005
- Policies 4000-4001
- Policies 4003-4004
- Policies 4006-4013
- Policies 5000-5001
- Policy 5003
- Policies 5005-5007
- Policies 6000-6002
- Policies 6004-6013
- Policies 6017-6018
- Patient Safety Plan

BOARD OF TRUSTEES

Ambulatory Surgical Center at LBJ Governing Body

HARRISHEALTH

Thursday, February 20, 2025

Consideration of Approval of the 2025 Annual Meeting Schedule of the ASC and LBJ Governing Body

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2025 Ambulatory Surgical Center Governing Body Meeting Series:

DAY:	DATE:	TIME:
Thursday	February 20, 2025	9:00 AM – 10:00 AM
Thursday	May 15, 2025	9:00 AM – 10:00 AM
Thursday	August 21, 2025	9:00 AM – 10:00 AM
Thursday	November 20, 2025	9:00 AM – 10:00 AM