HARRISHEALTH

AMBULATORY SURGICAL CENTER (ASC) AT LBJ GOVERNING BODY

Thursday, August 21, 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: Some 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**	**2 min**
II.	**Approval of the Minutes of Previous Meeting** • ASC at LBJ Governing Body Meeting – May 15, 2025	**Ms. Libby Viera-Bland**	**1 min**
III.	**Executive Session**	**Ms. Libby Viera-Bland**	**15 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***		*(5 min)*
B.	Report by the Vice President, 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***		*(5 min)*
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 ***– Dr. Matasha Russell, Dr. Scott Perry and Mr. Matthew Reeder***		*(5 min)*

IV. Reconvene — **Ms. Libby Viera-Bland** — **1 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***

2. Consideration of Approval of Changes to the ASC Nurse Practitioner Clinical Privileges ***– Dr. Scott Perry***

B. General Action Item(s) Related to Policies and Procedures

1. Consideration of Approval of Amended Policies and Procedures for the ASC at LBJ ***– Mr. Matthew Reeder***

   - Policy ASC-P-4008

2. Consideration of Approval of the Amended Quality Assessment and Performance Improvement Plan for the ASC at LBJ ***– Mr. Matthew Reeder***

   - Quality Improvement Program
   - Infection Control Program
   - Workplace Safety and Violence Reduction Plan

C. Miscellaneous General Action Item(s)

1. Consideration of Approval of Appointment/Re-Appointment of Key Positions to the Ambulatory Surgical Center at LBJ ***– Mr. Matthew Reeder***

   i. Administrator: Matthew Reeder
   ii. Clinical Manager(s): Randy Polanco, Rochelle Mariano, Jessica Larson
   iii. Medical Director: Dr. Scott Perry
   iv. Business Office Manager: Pollie Martinez
   v. QA/PI Officer: Gina Taylor
   vi. Medical Staff Privileges Officer: Jessey Thomas
   vii. Infection Control Coordinator: Jessica Palacios
   viii. Pharmacy Officer: Alvin Nnabuife
   ix. Risk Manager: Erica Reyes
   x. Compliance Officer: Anthony Williams
   xi. Safety Officer: Harold Sias
   xii. Radiation Officer: Patricia Svolos
   xiii. Privacy Officer: Catherine Walther
   xiv. Medical Records Officer: Michael Kaitschuck

VI.	**ASC at LBJ Medical Director and Administrator Reports**	**Ms. Libby Viera-Bland**	**5 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***		
VII.	**Adjournment**	**Ms. Libby Viera-Bland**	**1 min**

HARRISHEALTH

MINUTES OF THE HARRIS HEALTH
AMBULATORY SURGICAL CENTER AT LBJ GOVERNING BODY MEETING
May 15, 2025
9:00 AM

AGENDA ITEM	DISCUSSION	ACTION/RECOMMENDATIONS
I. Call to Order & Record of Attendance	The meeting was called to order at 9:00 a.m. by Ms. Libby Viera – Bland, Chair. It was noted that a quorum was present, and the attendance was recorded. 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 – February 20, 2025	**Motion No. 25.05 – 06** **Moved by Ms. Carol Paret, seconded by Dr. Glorimar Medina, and unanimously passed that the Governing Body approve the minutes of the February 20, 2025, meeting. Motion carried.**
III. Executive Session	At 9:02 a.m., Ms. Viera – Bland 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. 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	**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.**

AGENDA ITEM	DISCUSSION	ACTION/RECOMMENDATIONS
	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	**No Action Taken.**
IV. Reconvene	At 9:14 a.m., Ms. Viera – Bland 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 May 2025, there were five (5) initial appointments. A copy of the credentialing report is available in the permanent record.	**Motion No. 25.05 – 07** **Moved by Ms. Carol Paret, seconded by Dr. Glorimar Medina, and unanimously passed that the Governing Body approve V.A.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, ASC, presented the survey findings for American Association for Accreditation of Ambulatory Surgery Facilities (AAAHC), reporting that there were no deficiencies. He noted that the ASC will continue to prepare for its annual self-assessments through AAAHC and will undergo in-person site visits every three years as part of the ongoing accreditation process.	**As Presented.**
VII. Adjournment	There being no further business to come before the Governing Body, the meeting adjourned at 9:16 a.m.	

I certify that the foregoing are the Minutes of the Harris Health ASC at LBJ Governing Body Meeting held on May 15, 2025.

Respectfully Submitted,

Libby Viera – Bland, AICP, ASC at LBJ Governing Body Chair

Recorded by Cherry A. Joseph, MBA

Thursday, May 15, 2025
Harris Health Ambulatory Surgical Center (ASC) at LBJ Governing Body Attendance

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

HARRIS HEALTH EXECUTIVE LEADERSHIP, STAFF & SPECIAL INVITED GUESTS	
Alexander Barrie	John Matcek
Anthony Williams	Louis Smith
Carolynn Jones	Maria Cowles
Catherine Walther	Dr. Matasha Russell
Cherry Joseph	Olga Rodriguez
Cristina Torres	Randy Manarang
Daniel Smith	Randy Polanco
DeWight Dopslauf	Sara Thomas *(Harris County Attorney's Office)*
Ebon Swofford *(Harris County Attorney's Office)*	Shawn DeCosta
Dr. Esmaeil Porsa, *Harris Health System President & Chief Executive Officer*	Dr. Steven Brass
Dr. Jennifer Small	Dr. Tien Ko
Jennifer Zarate	

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, August 21, 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, August 21, 2025

Executive Session

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.

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BOARD OF TRUSTEES

Ambulatory Surgical Center at LBJ Governing Body

HARRISHEALTH

Thursday, August 21, 2025

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

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Ambulatory Surgical Center Governing Body

HARRISHEALTH

August 2025 Medical Staff Credentials Report

Medical Staff Initial Appointments: 8

Medical Staff Reappointments: 16

Medical Staff Resignations: 0

Other Business

Medical Staff Files for Discussion: 0

BOARD OF TRUSTEES

Ambulatory Surgical Center at LBJ Governing Body

HARRISHEALTH

Thursday, August 21, 2025

Consideration of Approval of Changes to the ASC Nurse Practitioner Clinical Privileges

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A request was made to revise the Ambulatory Surgical Center Nurse Practitioner Clinical Privileges to include Physician Assistants in the title of the document.

The Medical Executive Committee has approved the revisions to the ASC Nurse Practitioner Clinical Privileges and requests the approval of the ASC at LBJ Governing Body.

Record of Clinical Privileges Requested and Approved

Nurse Practitioner (NP) / Physician Assistant (PA)

Please date **each** box for the privileges you are requesting to perform at The Ambulatory Surgical Center (ASC) at LBJ. **Do not** date the first box and draw a line to request all of the below privileges.

Privilege Requested	Date Requested	Date Approved
Preoperative patient assessment, including placement of preoperative orders.		
Performing/Reviewing Patient History & Physical		
Treatment Plan Development		
Surgical assistance with hemostasis directed and supervised by the surgeon.		
Surgical assistance for operative exposure, which may require usage of a variety of instruments, including retractors, suction and sponge.		
Tissue handling as directed by the surgeon.		
Surgical closure of muscle, fascia, subcutaneous tissue and skin as directed by surgeon		
Placement of drains as directed by surgeon		
Postoperative patient assessment and placement of post-operative orders including medication orders		
Instruction, education and counseling of patients and families concerning health status, results of tests, disease process and discharge planning.		
Complete Medication Reconciliation Form		
Surgical Assistance as directed by the surgeon and within Scope of Practice		

BOARD OF TRUSTEES

Ambulatory Surgical Center at LBJ Governing Body

HARRISHEALTH

Thursday, August 21, 2025

Consideration of Approval of 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 ASC-P-4008: Change in context and appendix

TITLE: MEDICAL RECORDS

PURPOSE: To establish The Ambulatory Surgical Center (ASC) at LBJ's 's process for medical record documentation.

POLICY STATEMENT:

The Ambulatory Surgical Center (ASC) at LBJ will maintain its patients' records in accordance with state laws by maintaining patient records in a confidential, complete, and accurate fashion, and by including all elements necessary to provide patients with adequate care.

POLICY ELABORATIONS:

Documentation in the medical record must be sufficient to identify the patient, support the patient's diagnosis, justify the treatment, document the course and results of treatment, and promote continuity of care among health care providers. Medical record documentation is to be timely, meaningful, authenticated, and legible. All relevant documents and entries should be entered into the medical record at the time the service is rendered, treatment is given, or the observations to be documented are made, or as soon as possible thereafter. The electronic medical record (EMR) must be used for documentation in all areas where its implementation has been completed.

Each entry in the medical record must contain accurate and complete patient identifying data, such as the medical record number, name, and patient's date of birth. Every individual documenting in the medical record is responsible for the entire content of his/her documentation, whether the content is original, copied and pasted, imported, and/or reused. Those who document are responsible for the accuracy, medical necessity, and documentation requirements of each of their notes.

Additional documentation requirements can be found in the Medical Staff Bylaws.

I. DEFINITIONS:

A. **AUTHENTICATION**: The information security process that verifies a user's identity, authorizes the individual to access an information system, and assigns responsibility to the user for entries he or she creates, modifies, or views. Validation of each user's information is performed, which requires a unique identification (ID) and password combination to login to the medical record system.

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

C. **RESIDENT/INTERN/HOUSESTAFF/FELLOW - (HOUSESTAFF):** An individual who, licensed as appropriate, is a graduate of a medical, dental, osteopathic, or podiatric school and who is appointed to Harris Health's professional graduate training program and who participates in patient care under the direction of Medical Staff members who have Clinical Privileges for the services provided by the Housestaff.

D. **PROHIBITED ABBREVIATION:** Standard abbreviations commonly mistaken when interpreting a medical documentation and that can lead to errors in patient care.

E. **UNLICENSED ASSISTIVE PERSONNEL (UAP):** An individual who is trained to function in an assistive role to the licensed registered nurse in the provision of patient/client care activities as delegated by the nurse. The term includes, but is not limited to nurse aides, orderlies, assistants, attendants, or technicians.

II. MEDICAL RECORD DOCUMENTATION GUIDELINES:

Guidelines for documenting in the medical record are attached in Appendix "A."

III. RADIOGRAPHIC/DIAGNOSTIC IMAGES RETENTION:

Guidelines for the procedure for the retention of diagnostic images for the ASC at LBJ are attached in Appendix "B~~C~~".

IV. USE OF SYMBOLS AND ABBREVIATIONS:

Medical record entries must not contain prohibited abbreviations and symbols which are considered unsafe.

A. Prohibited Abbreviations and Symbols:
1. Any abbreviations, acronyms, or symbols that are on the Harris Health's Prohibited Abbreviations List. ~~(Appendix B).~~

2. If an abbreviation, acronym, or symbol has multiple meanings, its use should be avoided unless the intended meaning is clear from the content by which it is used.

B. Any documentation containing Prohibited Abbreviations or questionable entries shall be referred to the author, for clarification and prior to implementation.

C. Use of "Prohibited Abbreviations" shall be documented on the Adverse Drug Event Form.

D. Non-compliance shall be reported to the author's immediate supervisors for corrective action.

E. Events involving the use of Prohibited Abbreviations or symbols shall be communicated to the Medication Use Safety Committee (MUSC), service chiefs, directors, and/or administrators as deemed appropriate.

V. HEALTHCARE PROFESSIONALS AUTHORIZED TO MAKE ENTRIES:

Only LIPs, Housestaff, UAPs, Nursing staff, and Allied Health Care professionals authorized by the ASC may make entries into a patient's medical record.

Nursing, Allied Health Professional Agency, and/or students are authorized to make entries in the medical record following the documentation guidelines set forth in Appendix B~~C~~.

VI. LOOSE MEDICAL DOCUMENT HANDLING:

Hardcopy medical record documents approved for inclusion in the legal medical record are to be scanned into the EMR by Harris Health's Health Information Management Department (HIM) or responsible clinic or ancillary staff.

Once an official medical record document is added to a medical record, it should not be removed except by a trained HIM employee. Documents will only be removed if one of the following has occurred:

A. The document was filed in the wrong patient's record;
B. The document is a duplicate of an original that is already contained in the record;
C. The document is not an approved medical record document; or
D. HIM approves he removal of the document.

VII. LOOSE MEDICAL DOCUMENT HANDLING:

A. Every entry in the medical record or electronic medical record screen must identify the patient by name and complete medical record number.

B. If the HIM department receives documents with incomplete, illegible, and/or missing patient identification, an attempt will be made to properly identify the patient. Documents successfully identified will be incorporated into the medical record.

C. Documents on patients who cannot be identified will be returned to the originating department. If the originating department cannot be identified, HIM will forward the documents to the appropriate clinic/nursing administrator for resolution. Upon receipt in the department or administrative area, one of the following will occur:

a. The patient will be identified, demographic information added and the document returned to HIM for filing; or
b. If the patient cannot be identified, the document will be properly destroyed.

REFERENCES/BIBLIOGRAPHY:

DNV (NIACHO) National Integrated Accreditation for Healthcare Organizations Standards.

Harris Health Policy 4612 Student Access and Documentation Requirements

Harris Health Policy 438 Order Processing

Harris Health Policy 7.11 Patient Identification

Harris Health Policy 4600 Transfer of Patients

Harris Health Form #280723 Adverse Drug Event

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:
8/5/16	1.0	8/5/16	The Ambulatory Surgical Center (ASC) at LBJ Governing Body
		Reviewed / Approved 03/29/2018	The Ambulatory Surgical Center (ASC) at LBJ Governing Body
		Reviewed / Approved 02/14/2019	The Ambulatory Surgical Center (ASC) at LBJ Governing Body
		Reviewed / Approved 02/13/2020	The Ambulatory Surgical Center (ASC) at LBJ Governing Body
		Reviewed / Approved 02/25/2021	The Ambulatory Surgical Center (ASC) at LBJ Governing Body
		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
		Revised / Approved 02/22/2024	The Ambulatory Surgical Center (ASC) at LBJ Governing Body
		Revised / Approved 02/20/2025	The Ambulatory Surgical Center (ASC) at LBJ Governing Body

APPENDIX "A"
GUIDELINES FOR MEDICAL RECORD ENTRIES

PAPER MEDICAL RECORDS	ELECTRONIC MEDICAL RECORDS
Documentation Timeline: Medical record entries must be completed in a timely manner. Entries shall be made when the treatment described is given or the observations to be documented are made, or as soon as possible thereafter. An entry should never be made in advance. Authors should review and sign their notes promptly.	*Documentation Timeline:* Medical record entries must be completed in a timely manner. Entries shall be made when the treatment described is given or the observations to be documented are made, or as soon as possible thereafter. An entry should never be made in advance. Authors should review and sign their notes promptly.
Date & Time: Every entry shall be dated and timed. Military time shall be used in 24-hour facilities. Standard time shall be used in ambulatory clinics.	*Date & Time:* Each electronic entry shall contain a system generated date and time
Error Corrections: Utilize the Line, Initial, Date (LID) concept as follows: a. Draw a single line through the entry or portion of entry to be corrected (the original entry must still be legible/visible); b. Initial and Date; c. State the reason for the error, as applicable; d. Document the correct information; and e. Authenticate entry.	*Error Corrections:* EMR information cannot be altered after it is electronically signed or the document closed. Appropriate EMR error corrections must include: a. An addendum; b. Documentation of the reason for the error correction; c. Documentation reflecting the correct information; and d. Authentication of the entry

Legibility: All entries must be legible. It is recommended that black or blue ink be used.	*Legibility:* Not applicable
PAPER MEDICAL RECORDS	ELECTRONIC MEDICAL RECORDS
Late Entries: If an entry is made retrospectively on a paper document, it must reflect the date and time the entry is actually made. Note the reason for the late entry, the current data and time, and authenticate the entry with a full signature.	*Late entries:* a. All entries on all flow sheets that are entered late will be documented by adding the appropriate column of time that the care or observation was actually completed. b. All entries in notes that are added late will be documented with the correct date and time when they are entered. If an entry is made retrospectively, document the reason for the late entry.
Authentication: Signatures must include first name or initial, last name, and employment/status (e.g., JMS) or licensure status (e.g., M.D.). Initials alone are not acceptable. For authenticating paper medical record documentation, handwritten signatures may be accompanied either by the author legibly writing his/her name in block print or by the use of a name stamp accompanied by a signature. The use of a signature stamp is not acceptable. In addition, the physician number or provider identification number should be documented. 3. Faxed signatures are acceptable.	*Authentication* For authenticating electronic medical record documentation, electronic signatures are used. a. Authentication is the information security process that verifies a user's identity and authorizes the individual to access an information system. b. Authentication assigns responsibility to the user for entries he or she creates, modifies, or views. c. Users shall not share their Harris Health System account(s), passwords, Personal Identification Numbers (PIN), security tokens (e.g., Smartcard), or similar information or devices used d. The individual identified by the electronic signature or method of electronic

	authentication is the only individual who may use it, as it denotes authorship of medical record documents in electronic medical records.
Data integrity: Entries shall not be altered, erased or removed (use of correction fluids and/or liquid paper is prohibited).	*Data integrity:* Electronic medical record information cannot be altered after it is electronically signed.

Functional Role: (source Harris Health System Policy 4410)
Attending Physician
Nurse Practitioner/Advanced Nurse Practitioner
Medical Student
Housestaff
Physician Assistant (PA)
Audiologist
Audiologist Technician
Cardiopulmonary Technician
Clinical Case Management (CCM) Program Coordinator
Certified Nurse Assistant (CNA)
Certified Nurse Anesthetist
Certified Nurse Midwife
Chaplain
Child Life Specialist
Clinical Clerical Specialist/Technician (CCT)
Clinical Nurse Case Manager (CNCM)

CSHCN Grant Social Worker II
Dietitian/Nutritionist/Technician
Genetics Counselor
Ethicist
Health Educator
Infant Feeding Counselor/Breast Feeding Counselors
Interpreter
Licensed Chemical Dependency Counselor/Insight Case Manager
Licensed Professional Counselor
Licensed Vocational Nurse (LVN)
Nursing Student
Occupational Therapist, Assistant, Student
Patient Care Technician I, II, and III (PCT)
Pharmacist
Physical Therapist, Assistant, Student
Pulmonary Function Technician, Technologist
Psychiatric Technician
Recreational Therapist
Risk Manager
Quality (QMS) Resource Manager

Quality QMS Coordinator
Quality Inpatient Director
Registered Nurse
Researcher
Respiratory Care Practitioner/Therapist
RN, Grants Implementation
Senior Clinical Nurse Case Manager
Social Worker Case Manager I, II
Speech Pathologist
T-Steps Clinician

APPENDIX B~~C~~

The ASC at LBJ shall retain all diagnostic imaging for the following time periods unless otherwise notified:

1. **ADULTS:** Imaging will be stored for a minimum of ten years from the date of service.
2. ~~**PEDIATRICS:** If a patient was less than 18 years of age at the time of last treated, the~~ ASC ~~hospita~~ may authorize the disposal of those medical records relating to the patient on or after the date of ~~his~~their 20th birthday or on or after the 10th anniversary of the date on which they ~~he was~~were last treated, whichever date is later.
3. ~~**MAMMOGRAPHY:** Facilities shall maintain original mammography images and reports in a permanent medical record of the patient for a period of not less than 5 years, or not less than 10 years if no additional mammograms of the patient are performed at the facility, or a longer period if mandated by State or local law.~~
4. ~~**RADIATION THERAPY:** Radiation treatment records shall be maintained permanently, or until termination of the Certificate of X-Ray Registration and Radioactive Materials License by the Texas Department of State Health Services.~~

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BOARD OF TRUSTEES

Ambulatory Surgical Center at LBJ Governing Body

HARRISHEALTH

Thursday, August 21, 2025

Consideration of Approval of the Amended Quality Assessment and Performance Improvement Plan 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 Quality Assessment and Performance Improvement Plan.

Listed below are the amended documents, including the attached back-up material.

- Quality Improvement Program
- Infection Control Program
- Workplace Safety and Violence Reduction Plan

ASC at LBJ

Quality Assessment and Improvement Program

2025-2026~~5~~

• Introduction

• Program Scope

The Ambulatory Surgical Center (ASC) at LBJ ("ASC") Quality Improvement Program ("Program") must include, but not be limited to, an ongoing demonstration of measurable improvement in patient health outcomes and patient safety and the ASC must measure, analyze, and track quality indicators, adverse patient events, infection control, and other aspects of performance that includes care and services furnished in the ASC.

• Program Description

The program serves as the foundation of the ASC's commitment to continuously improve the services provided at the ASC. The ASC strives to ensure:
1. Treatment that provides and incorporates effective, evidence-based practices;

2. Services delivered are appropriate to the population served;

3. Risks to patients and workforce members are minimized and errors in the delivery of services are prevented;

4. Patient needs and expectations are respected and services are provided with sensitivity and kindness; and

5. Care is provided in a timely and efficient manner with appropriate coordination and continuity.

• Program Principles

Quality improvement at the ASC is a systematic process based on the following principles taken from the Harris Health Quality Manual:

Creating a culture of safety, including providing safe care and a safe environment, and continual improvement, is the work of the entire organization. Harris Health System has adopted the Institute of Medicine (IOM) six (6) domains of Health Care Quality as the guiding principles for our Quality Manual. These six (6) aims (S.T.E.E.E.P.) guide our work to facilitate performance excellence:

A. Safe: Avoiding harm to patients from care that is intended to help them.
B. Timely: Reducing waits and sometimes harmful delays for both those who receive and those who give care.
C. Effective: Providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and misuse, respectively).

D. Efficient: Avoid waste, including waste of equipment, supplies, ideas, and energy.
E. Equitable: Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.
F. Patient-Centered: Providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.

JUST AND ACCOUNTABLE CULTURE

It is inevitable that people will make mistakes. Thus, a Just and Accountable Culture creates an open, fair, and learning culture by recognizing that individuals demonstrate certain behaviors, which organizational leaders should identify and manage appropriately. Behavioral choices include human error, at-risk behavior, and reckless behavior.

A Just and Accountable Culture promotes learning so employees are engaged and encouraged to speak up and share near misses, etc. so that we could learn from the event and prevent future occurrences.

A Just and Accountable Culture recognizes that many errors represent predictable interactions between human operators and the systems in which they work. So, when mistakes are made, we must learn from them, and then design safer systems and processes to prevent them from occurring again.

A Just and Accountable Culture balances leadership management of behavioral choices with individual accountability. Human error and at-risk behavior will be managed appropriately, but there will be zero tolerance for reckless behavior.

Overview: Continuous Program Improvement Activities:

The ASC utilizes an improvement cycle to include but not limited to PDSA or DMAIC as the methodology for performance improvement. The ASC shall continually improve its quality management system through the use of the quality policy, quality objectives, audit results, analysis of data, corrective and preventative actions, and management review. Desired organizational performance results may be achieved through continuous education and involvement of the workforce at all levels. Quality improvement involves multiple activities such as:

1. Monitoring the effectiveness and safety of services and quality of care;

2. Measuring and assessing the performance of the ASCs services through the collection and analysis of data;

3. Conducting quality improvement initiatives;

4. Tracking and examining adverse events to educate on and implement improvements that are sustained over time;

5. Taking action when indicated, which includes, but is not limited to, the implementation of new services and/or improvement of existing services.

The tools used to conduct these activities are described in Appendix A Quality Improvement Tools.

Leadership and Organization

- **Overall Description**
  The ASC Quality Review Committee (QRC) with approval from the Governing Body must ensure the ASC conducts ongoing surveys and projects to monitor and evaluate the quality of patient care at the ASC that reflects the scope and complexity of services at the ASC.
- **QRC Membership**
  The QRC is a multidisciplinary team, including at a minimum, a team leader, a physician, and an ASC leadership facilitator. The team leader will be trained in facilitation skills, be responsible for leading QRC meetings and remaining on-task, and focus the QRC on the process of improvement. The team leader and facilitator will be responsible for creating an agenda before each meeting, keeping the meeting paced, evaluating the effectiveness of the meeting, and improving where necessary to facilitate meeting efficiency.
- **QRC Topic Selection**
  When a quality improvement (QI) study topic is presented, the QRC will define the purpose of the QI study topic. Defining it will include a description of the topic and the significance of the topic to the betterment of the ASC. Goals must be measurable, achievable, and verified by external or internal benchmarks if available.
- **QRC Responsibilities**
  The QRC will communicate to the Governing Body, workforce members, and other pertinent recipients of ongoing Quality Improvement Program topics. The QRC will solicit input into ongoing QI initiatives as a means of continually improving performance. Additionally, the QRC will be responsible for:

  1. Formation of a QRC:

  2. Identifying opportunities for quality improvement;

  3. Studying current ASC processes for the establishment of specific quality improvement initiatives;

  4. Establishing measurable, attainable, objectives based upon priorities identified through the use of established criteria for improving the quality and safety of ASC services;

  5. Developing outcome measures;

  6. Developing and approving the Quality Improvement Program;

7. Establishing a meeting schedule. At a minimum, the QRC will meet quarterly or as needed.

8. Coordinating planned communication of the results of QI topics to the ASC; and

9. Reporting to the Governing Body regularly

Examples of communication methods of the results of the QI topic(s) may include, but are not limited to the following:

1. Storyboards and/or posters displayed in common areas;

2. QRC reporting to recipient group(s);

3. Newsletters and or handouts; or

4. Electronic in-service presentations

- **ASC Leadership Responsibilities**
  ASC leadership, through a planned communication approach, will ensure the Governing Body, workforce members, and recipients have knowledge of and input into ongoing QI initiatives as a means of continually improving the performance and effectiveness of services provided at the ASC. Additionally, ASC leadership will:

  1. Support and guide implementation of quality improvement studies;
  2. Evaluate, review, and approve the Quality Improvement Plan annually; and
  3. Provide quality metrics to Harris Health System's Quality Governing Council

STRATEGIC GOALS AND QUALITY OBJECTIVES

- The ASC follows the development of strategic pillars related to quality and patient safety, people, population health management, and infrastructure optimization.
- Goals and objectives have also been developed to support the commitment to Safety, Quality, and Performance Improvement. Please refer to the scorecard and the different metrics as identified in QRC.
- Strategic Plan Overview;
- Quality and patient safety: The ASC demonstrates quality and patient safety as a core value where zero patient harm is not only a possibility but an expectation.

- People: The ASC will enhance the patient, employee, and medical staff experience and develop a culture of respect, recognition, and trust by actively listening to feedback and developing strategies to address high-impact areas of opportunity.
- Infrastructure optimization: The ASC will invest in and optimize infrastructure related to facilities, information technology (IT) and telehealth, information security, and health informatics to increase value, ensure safety, and meet the current and future needs of the patients we serve.
- As we look toward the future, our patient care priorities will be the implementation of strong quality and patient safety, people, health management, and infrastructure optimization. We will also continue the mission of training the next generation of healthcare professionals through teaching and development.

Quality Improvement Project Development

- **Program Goals and Objectives**
  The QRC identifies and defines goals and specific objectives to be accomplished each year. Progress in meeting these goals and objectives is part of the annual evaluation of quality improvement activities. The ongoing, long-term goals for the ASC QI Program and the objectives for accomplishing these goals for the year may include:
  1. Implementation of quantitative measurement to assess key processes or outcomes;

  2. Prioritization of identified problem-prone areas and goal-setting for their resolution;

  3. Achievement of measurable improvement in the high-risk, high-volume, high-priority areas;

  4. Adherence to internal and external reporting requirements;

  5. Education and training of managers, clinicians, and staff;

  6. Target specific patient populations and define the amount of time needed to achieve the goal; and

  7. Development and/or adoption of tools, such as practice guidelines, consumer surveys, and quality indicators to achieve defined goals.

- **Steps**

  1. Study Current Processes
  The QRC shall use one of the tools in Appendix A to assist in the development of the Quality Improvement Plan.

  2. Conduct Research

The QRC will meet with leadership members, clinicians, and staff to review quantitative data and clinical adverse occurrences to identify areas for improvement efforts. The QRC will agree on a specific outcome for an improvement effort. The QRC will prepare a goal statement for establishing outcome measures and as the research is conducted the goal statement may be refined to be more specific.

3. Prioritize
The QRC will list and prioritize quality improvement topics to be in alignment with the overall goals of the ASC.

4. Benchmark
The QRC will participate in external benchmarking activities that compare key performance measures with other similar organizations, with recognized best practices, and/or with national or professional targets or goals.

5. Outcome Measurements
Outcome measures will be appropriate and patient-focused as well as consistent with the mission and goals of the ASC.

6. Operational Definitions
Operational definitions will be clear descriptions of specific clinical indicators and the methods by which they will be measured. The definitions will be reliable, and valid, and provide consistent and accurate results over time.

- ## Performance Measurement

Performance measurement is used to monitor aspects of the ASC's current QI programs, systems, and processes. The QRC will compare its current performance with the previous year's performance, as well as benchmarks, to identify opportunities for improvement.

- **Performance Measurement Steps**

1. Assessment of the stability of processes or outcomes to determine whether there is an undesirable degree of variation or a failure to perform at an expected level

2. Identification of problems and opportunities to improve the performance of processes;

3. Assessment of the outcome of the care provided; and

4. Assessment of whether a new or improved process meets performance expectations.

- **Measurement and Assessment**

1. Selection of a process or outcome to be measured, based on priority;

2. Identification and/or development of performance indicators for the selected process or outcome to be measured;

3. Aggregation of data to quantify the selected process or outcome;

4. Assessment of performance indicators at planned and regular intervals;

5. Taking action to address discrepancies when performance indicators show a process is not stable, is not performing at an expected level, or represents an opportunity for quality improvement; and

6. Reporting findings, actions, and conclusions as a result of performance assessment.

- **Selection of Performance Indicators**
  A performance indicator is a quantitative tool that provides information about the performance of a clinical process, service, function, or outcome. The selection of a performance indicator is based on the following considerations:

  1. Relevance to mission – whether the indicator addresses the population served; and

  2. Clinical importance – whether the indicator addresses a clinically important process that is, high volume, problem-prone, or high risk.

- **Characteristics of a Performance Indicator**
  Factors to consider in determining which indicator(s) to use include:
  1. Scientific Foundation – the relationship between the indicator and the process, system, or clinical outcome being measured;

  2. Validity – whether the indicator assesses what it purports to assess;

  3. Resource Availability – the relationship of the results of the indicator to the cost involved and the availability of staffing;

  4. Patient Preferences – the extent to which the indicator takes into account individual or group (e.g., racial, ethnic, or cultural) preferences; and

  5. Meaningfulness – whether the results of the indicator can be easily understood, the indicator measures a variable over which the program has some control, and the variable is likely to be changed by reasonable quality improvement events.

- **Performance Indicator Measurement Tools**
  Measurement tools can help the ASC gauge the current state of QI activities as well as help the ASC understand whether there is a need for modification of the QI activity. There are four main types of measurement tools:

1. Structural – Measures the ASC's capacity and the conditions in which care is provided by looking at factors such as the ASC's staff, facilities, and/or IT systems.

2. Process – Measures how services are provided, i.e., whether an activity proven to benefit patients was performed, such as writing a prescription or administering a drug.

3. Outcome – Outcomes measure the results of healthcare. This could include whether the patient's health improved or whether the patient was satisfied with the services received.

4. Balancing Measures – This tool ensures that if changes are made to one part of the system, it doesn't cause problems in another part of the system.

An example of a performance indicator measurement tool is presented in the following Table 1.

Prophylactic IV Antibiotic Timing	
Measure Type	**Process**
Description	This measure is used to assess whether intravenous antibiotics given for prevention of surgical site infection were administered on time.
Numerator/Denominator	**Numerator**: Number of Ambulatory Surgery Center (ASC) admissions with an order for prophylactic IV antibiotic for prevention of surgical site infection who received the prophylactic antibiotic on time. **Denominator**: All ASC admissions with a preoperative order for prophylactic IV antibiotic for prevention of surgical site infection.
Inclusion/Exclusions	Numerator Exclusions: None Denominator Exclusions: ASC admissions with a preoperative order for prophylactic IV antibiotic for prevention of infections other than surgical site infections (e.g., bacterial endocarditis); ASC admissions with a preoperative order for a prophylactic antibiotic not administered by the intravenous route.
Data Sources	ASC medical records, as well as medication administration records, and variance reports may serve as data sources. Clinical logs designed to capture information relevant to prophylactic IV

	antibiotic administration are also potential sources.
Data Element Definitions	Admission: completion of registration upon entry into the facility
	Antibiotic administered on time: Antibiotic infusion is initiated within one hour prior to the time of the initial surgical incision or the beginning of the procedure (e.g., introduction of endoscope, insertion of needle, inflation of tourniquet) or two hours prior if vancomycin for fluoroquinolones are administered.
	Intravenous: Administration of drug within a vein, including bolus, infusion or IV piggyback.
	Order: a written order, verbal order, standing order or standing protocol
	Prophylactic antibiotic: an antibiotic administered with the intent of reducing the probability of an infection related to an invasive procedure. For purposes of this measure, the following antibiotics are considered prophylaxis for surgical infections: Ampicillin/sulbactam, Aztreonam, Cefazolin, Cefmetazole, Cefotetan, Cefoxitin, Cefuroxime, Ciproflaxin, Clindamycin, Ertapenem, Erythromycin, Gatifloxacin, Gentamicin, Levofloxacin, Metronidazole, Moxifloxacin, Neomycin and Vancomycin.

- **Assessment**
  Assessment is accomplished by comparing the actual performance of an indicator with past performance over time, benchmark data, internal goals or self-established expected levels of performance, evidence-based practices, and/or similar service providers.

Testing for Improvement

The Model for Improvement, developed by the Associate in Process Improvement, provides a framework for developing, testing, and implementing change. This model is a tool for accelerating improvement and can successfully improve care processes and outcomes. The model is comprised of two parts:

A. Three fundamental questions that are essential for guiding improvement:

1. What is the ASC trying to accomplish? The ASC's response to this question helps to clarify which improvements the ASC should target and the ASC's desired results.

2. How will the ASC know that a change is an improvement? Actual improvement can only be proven through measurement. The ASC should determine how it wants things to be different when a change is implemented and agree on what data needs to be collected for measuring. A measurable outcome that demonstrates movement toward the desired result is considered improvement.

3. What changes can the ASC make that will result in improvement? Improvement occurs only when a change is implemented, but not all changes result in improvement. One way to identify whether a change will result in improvement is to test the change before implementing it.

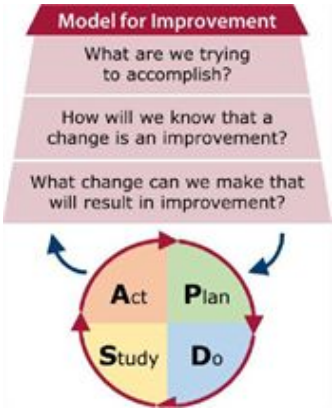

Figure 2.1: Model for Improvement

B. The "Plan-Do-Study-Act" (PDSA)

The PDSA cycle tests and implements a change in a real-work setting. The PDSA cycle is shorthand for testing a change by planning it, trying it, observing the results, and acting on what is learned. This is the scientific method used for action-oriented learning.

1. Plan – Before changes are tested, the team should secure the support of those individuals and departments that will be affected. Whether the reason for the change is due to patient challenges, unreliability, or a continual improvement opportunity, it is important to keep people informed. This ensures their cooperation and results in an effective test of change.

2. Do – Testing the changes that occur during the Do stage. The QI team tests the change and collects the required data to evaluate the change. Any problems and observations during the test are documented.

3. Study – In the Study stage, the QI team learns all it can from the data collected during the Do stage and considers the following:

- Is the process improved?
- If improved, by how much?

- Is the objective for improvement met?
- Is the process more difficult using new methods?
- Did anything unexpected happen?
- Is there something else to learn?

4. Act - The responses derived from the Study stage define the QI team's tasks for the Act stage. For example, if the process is not improved, the QI team may review the change tested to determine the reason, then further refine the process, or plan another test cycle. The QI team may choose to start again with a new test cycle based on the analysis. If the problem is unsolved, the QI team may return to the Plan stage to consider new options. If the process improves, the QI team should determine whether the improvement is adequate. For example, if the improvement speeds up the process, the QI team should evaluate the improvement to determine whether the change is fast enough to meet its requirements. If not, the QI team may consider additional methods to modify the process until its improvement objectives are met. It also may consider testing the same step of the process, or possibly a different step in the process, to reach its overall goal. Again, the QI team is back at the Plan stage of the PDSA cycle. For most system changes in health care, multiple small tests of change are needed to improve one system. These tests are performed in a very short time so overall improvements can be accomplished efficiently.

Evaluation

Measuring the actual change process is the only way to know if the change results in an improvement. The ASC's QI team actions are determined by what it learns from the change. This stage includes analyzing the test cycles, reflecting on what was learned, comparing predictions to the data collected, and making decisions. Since change in one area of the organization can impact another, it is important to review the entire system and ensure another area is not adversely affected.

An evaluation is completed at the end of each calendar year. The evaluation summarizes the goals and objectives of the Quality Improvement Program, the quality improvement activities conducted during the past year, including the targeted process, systems and outcomes, the performance indicators utilized, the findings of the measurement, data aggregation, assessment, and analysis processes, and the quality improvement initiatives taken in response to the findings. The evaluation will contain the following elements:

1. A summary of the progress towards meeting the goals/objectives.

2. A summary of progress towards goals, including progress in relation to overall ASC goal(s).

3. A summary of the findings for each of the indicators used during the year (the summaries should include both the outcomes of the measurement process, the conclusions, and actions taken in response to these outcomes)

4. A summary of progress in relation to Quality Initiative(s):

a. For each initiative, provide a brief description of what activities took place including the results on your indicator.

i. What are the next steps?

ii. How are the results sustained?

b. Describe the implications of the quality improvement process for actions to be taken regarding outcomes, systems, or outcomes at your program in the coming year.

5. Any recommendations based upon the evaluation of the quality initiatives, and the actions the QRC determines are necessary to improve the effectiveness of the QI Program moving forward.

Appendix A

Quality Improvement Tools

The following tools are available to assist in the Quality Improvement process.

Flow Charting: Use of a diagram in which graphic symbols depict the nature and flow of the steps in a process. This tool is particularly useful in the early stages of a project to help the QI team understand how the process currently works. The "as-is" flow chart may be compared to how the process is intended to work. At the end of the project, the QI team may want to then re-plot the modified process to show how the redefined process should occur. Two flow chart processes the QRC may consider are clinical pathways and Fail Mode Effects Analysis (FMEA).

Brainstorming: A tool used to bring out the ideas of each individual and present them in an orderly fashion. Essential to brainstorming is to provide an environment free of criticism. QI team members generate issues and agree to "defer judgment" on the relative value of each idea. Brainstorming is used when one wants to generate a large number of ideas about issues to tackle, possible causes, approaches to use, or actions to take.

Decision-making Tools: While not all decisions are made by QI teams, two tools can be helpful when QI teams need to make decisions.

1. Multi-voting is a group decision-making technique used to reduce a long list of items to a manageable number by means of a structured series of votes. The result is a short list identifying what is important to the QI team. Multi-voting is used to reduce a long list of ideas and assign priorities quickly with a high degree of QI team agreement.

2. Nominal Group is a technique used to identify and rank issues.

Affinity Diagram: The Affinity Diagram is often used to group ideas generated by brainstorming. The Affinity Diagram is a tool that gathers large amounts of data (ideas, issues, opinions) and organizes this data into groupings based on natural relationships. The affinity process is a good way to get people who work on a creative level to address difficult, confusing, unknown or disorganized issues. The affinity process is formalized in a graphic representation called an affinity diagram. As a rule of thumb, if less than 15 items of

information have been identified, the affinity process is not needed.

Cause and Effect Diagram (also called a fishbone or Ishikawa diagram): This is a tool that helps identify, sort, and display causes of a specific event. It is a graphic representation of the relationship between a given outcome and all the factors that influence the outcome. This tool helps to identify the basic root causes of a problem. The structure of the diagram helps QI team members think in a very systematic way. Cause and effect diagrams allow the QI team to identify and graphically display all possible causes related to a process, procedure or system failure.

Histogram: A histogram is a vertical bar chart that depicts the distribution of a data set at a single point in time. A histogram facilitates the display of a large set of measurements presented in a table, showing where the majority of values fall in a measurement scale and the amount of variation.

Pareto Chart: Named after the Pareto Principle which indicates that 80% of the trouble comes from 20% of the problems. It is a series of bars on a graph, arranged in descending order of frequency. The height of each bar reflects the frequency of an item. Pareto charts are useful throughout the performance improvement process by helping to identify which problems need further study, which causes to address first, and which problems are the "biggest problems."

Run Chart: A Run Chart shows how a process performs over time. Data points are plotted in temporal order on a line graph. Run charts are most effectively used to assess and achieve process stability by graphically depicting signals of variation. A run chart can help to determine whether or not a process is stable, consistent and predictable. Simple statistics such as median and range may also be displayed.

Control Chart: A control chart is a statistical tool used to distinguish between variation(s) in a process that results from (a) common causes and (b) special causes. Common cause variation is a variation that results simply from the numerous, ever-present differences in the process. Control charts can help to maintain stability in a process by depicting when a process may be affected by special causes. The consistency of a process is usually characterized by showing whether data falls within control limits based on plus or minus specific standard deviations from the center line.

Bench Marking: A benchmark is a point of reference by which something can be measured, compared, or judged. A benchmark may be an industry standard against which a program indicator is monitored and found to be above, below, or comparable to the benchmark.

Root Cause Analysis: A root cause analysis is a systematic process for identifying the most basic factors/causes that underlie variation in performance.

References

Accreditation Handbook for Medicare Deemed Status, V43

Institute for Healthcare Improvement, https://www.ihi.org/resources/how-improve-model-improvement

Effective Date	Review/Revision Date	Approved by:
	08/22/2024	The Ambulatory Surgical Center (ASC) at LBJ Governing Body
	12/10/2024 (Review & Revision)	
	08/22/2024 Review	
	05/2024 Revision	
	08/21/2025 Review	

ASC at LBJ
Infection Control Program
2025~~6~~42~~-~~-2026~~5~~53~~-~~

I. INTRODUCTION

A. Program Description

The Ambulatory Surgical Center at LBJ ("ASC") Infection Control Program ("Program") must maintain a program that minimizes infections and communicable diseases. The Infection Control Program (Program) at a minimum:

1. Provides a functional and sanitary environment for the provision of surgical services by adhering to professionally acceptable standards of practice;
2. Maintains an ongoing program designed to prevent, control, and investigate infections and communicable diseases; and
3. Documents the consideration, selection, and implementation of nationally recognized infection control guidelines.

B. Program Principles and Goals

The ASC Program, under the direction of a designated and qualified professional who has training in infection control, works to accomplish the goals of:

1. Preventing, identifying, and managing infections and communicable diseases;
2. Immediately implementing corrective and preventative measures that result in improvement of infection control; and
3. Protecting the patients, workforce members, visitors, and others in the ASC.

The Ambulatory Surgical Center at LBJ (ASC) accomplishes the Program goals through a coordinated approach to risk reduction of infections. The Program incorporates the analysis of surveillance data to assure ongoing quality assessment and improvement and reports results of the assessment of surveillance data to the appropriate oversight agencies. Workforce members are oriented to the policies and procedures designed to control infections as well as infection control techniques.

II. PROCEDURE

The ASC must provide a functional and sanitary environment for the provision of surgical services by adhering to professionally acceptable standards of practice. The procedures the ASC follows to maintain the environment include:

1. Utilization of Standard Precautions. Workforce members are expected to maintain an awareness of infection risks and to be on continual surveillance for process improvements;
2. Workforce members adherence to the ASC's Infection Control Plan and its associated policies;
3. Conduction of an annual Infection Control Risk Assessment which serves to guide the quality management activities for the Program; and
4. Analysis of trends and risk factors if infections are identified during surveillance, which will include but not limited to staff, environment and work processes.

Microbiology data, medical records, patient interviews, patient call back information, and physician information will contribute to assessment of Program improvement processes. Adherence to the Program includes but is not limited to:

a. Surveillance for healthcare acquired infections, antibiotic resistant pathogens, and infectious disease outbreaks;
b. Cleaning, disinfection, and sterilization procedures; and
c. Disposal of waste products.

Recommendations for Guidelines for Environmental Infection Control in ASC include but are not limited to:

a. The active involvement of infection preventionist during all phases of a healthcare facility's demolition, construction, and renovation. Activities should include performing a risk assessment of the necessary types of construction barriers.
b. Monitor and document with environmental rounds the negative airflow/ positive airflow in rooms.
c. Document / identify water damage. Repair and drying of wet structural materials within 72 hours, or removal of the wet material if drying is unlikely within 72 hours.
d. Results of infection analysis are reported to the appropriate ASC committees and workforce members to ensure accountability.

III. PROJECTS

A. Hand Hygiene Surveillance
   1. Results will average at or above 95% compliance each quarter
   2. Measurements will be through audits

B. Surgical Site Infections (SSI)
   1. Goal is to be at 0% each quarter.

C. ATP Monitoring
   1. Test the operating room suites, pre-operative bays, and post-operative bays
   2. Results will be maintained at a 95% pass rate each quarter

HARRISHEALTH
AMBULATORY SURGICAL CENTER AT LBJ

The Ambulatory Surgical Center at LBJ

WORKPLACE SAFETY AND VIOLENCE REDUCTION PLAN

June 2025~~4~~

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I. INTRODUCTION:

The Occupational Safety and Health Administration (OSHA) has made a determination that Healthcare workers face an increased risk of work-related assaults resulting primarily from violent behaviors of their patients. The National Institute for Occupational Safety and Health (NIOSH) lists three groups of risk factors that lead to violence in healthcare: clinical, environmental, and organizational. The Ambulatory Surgical Center (ASC) at LBJ Workplace Safety and Violence Prevention Plan (Plan) addresses these factors and describes the parameters within which a safe environment of care is established, maintained, and improved. The elements listed within the plan are directed toward managing the activities of the employees in order to reduce the risk of injuries to patients, visitors, and the workforce and to help employees respond appropriately after incidents of workplace violence.

The following workplace safety and violence prevention plan has been developed to protect health care providers and employees from violent behavior and threats of violent behavior that may occur within the facility. This ~~Workplace Safety and Violence Prevention~~ Plan conforms to requirements set forth in Section 331.004 of the Texas Health and Safety Code.

~~III.~~II. PURPOSE:

~~B.~~A. The purpose of the P~~p~~lan is to mitigate obstacles impacting the ability of the organization to provide a safe environment for ~~Ben Taub Hospital's~~the ASC's patients, visitors, and ~~its~~ workforce.

~~D.~~B. This occurs through:

Annual workplace violence prevention education;

~~3.~~2. Standardized system for responding to and investigating violent or potentially violent incidents;~~.~~

~~4.~~3. Environmental Assessment; and

~~5.~~4. Review and evaluation of current workplace safety processes.

~~IV.~~III. WORKPLACE VIOLENCE:

~~B.~~A. The definition of Workplace Violence utilized within ~~Ben Taub Hospital~~the ASC is in alignment with Texas Health and Safety Code §-331.004 ~~and Harris Health Policy 6.27 Workplace Violence Prevention~~ and includes the following:~~.~~

~~2. Any violation of the Texas Penal Code, or acts that create a risk to the health and safety of another including threats, threatening behaviour, stalking, or acts of violation by or against patients, their family members, visitors, or a Workforce Member.~~

1. An act or threat of physical force against a health care provider or employee that results in, or is likely to result in, physical injury or psychological trauma; and

~~3.~~2. ~~a~~An incident involving the use of a firearm or other dangerous weapon, regardless of whether a health care provider or employee is injured by the weapon.;

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Training/Education

~~2.~~1. Workplace safety education begins with the new employee orientation program for all new employees. Employees entering areas in which they may encounter patients with behavio~~u~~ral issues are required to take an additional course related to workplace violence prevention techniques.

~~3.~~2. The ASC~~Ben Taub hospital~~ provides annual workplace violence prevention education within the annual required training or education provided to the facility's health care providers and employees who provide direct patient care. Educational opportunities are provided in the event of modification to workplace safety processes or introduction of new equipment.

~~4.~~3. Satori Alternatives to Managing Aggression (SAMA) ~~: T~~training is provided to all nursing ~~and nursing aide staff in the emergency room and inpatient units and other workforce members who ar~~who are ~~e~~ at an increased risk of caring for aggressive patients.

~~G. Crisis Intervention~~

~~0. To assist in the urgent needs of Harris Health patients experiencing agitated or aggressive behaviours the workforce can call a "Crisis Intervention." The response team responding to this page consists of individuals with psychiatric expertise, security personnel, hospital leadership and medical providers.~~

~~0. Workforce members can call a Crisis Intervention by calling extension 37800.~~

~~0. Consultation with Crisis Intervention Team (CIT) member is available for high-risk patients manifesting early signs of aggression by calling extension 37930 (Cisco Phone).~~

~~M.~~C. Incident Reporting and Investigations

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2.1. Facility health care providers and employees ~~A workforce member~~ who witnesses or experience~~s~~ a workplace violence incident shall immediately report the incident following the guidelines set forth in ASC-P-4004 and Harris Health System Policy 6.27 Workplace Violence Prevention.

3.2. All incidents of workplace violence sh~~ould~~all be documented in the ~~Harris Health~~ Electronic Incident Reporting System (eIRS) or documented using downtime forms when the eIRS is not available.

4.3. Incidents of workplace violence shall~~ould~~ be investigated timely by the ~~unit's leadership,~~ASC ~~and in collaboration with Security leadership along with Risk Management~~.

~~O.~~D. Post-~~-~~Incident Responsibilities

2.1. It is the responsibility of the ~~unit leadership~~ASC to consider adjusting patient care assignments ~~(to the extent possible)~~ following an occurrence of workplace violence. This may prevent~~s~~ a health care provider or employee of the ~~facility~~ASC from treating or providing services to ~~the~~a patient whom has physically abused or threatened them.

3.2. ASC ~~S~~supervisors are encouraged to refer employees who exhibit job stress or anger management or who may be a victim of workplace violence to the Employee Assistance Program. ASC ~~S~~supervisors ~~shall~~may request assistance, when necessary, from Harris Health's Department of Public Safety and/or Harris Health's Human Resources Department when workplace violence issues arise.

~~4. Activate Code Lavender protocol.~~

5.3. The ASC's health care providers and/or employees ~~employee is~~are empowered to pursue criminal charges via the responding law-enforcement agency.

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~~6.~~4. Patients identified as disruptive will be flagged in Epic according to ~~Harris Health System's Management of Disruptive Patients and Visitors Behaviour (policy 4201).~~applicable policies.

~~P.~~E. Environmental Safety

~~2.~~1. Patients who are at increased risk of harming themselves or others have their environment assessed routinely for environmental hazards including ligature risks. ~~(Refer to Harris Health System Policy 464 Suicide/Homicide Screening, Assessment and Intervention).~~

~~3.~~2. Supervisors are to assess the~~ir department~~ASC's workspace to ensure that safety measures and equipment are functioning appropriately.

~~0. Patients who are identified in Epic as high risk for aggressive behaviour upon arrival, are screened by security officers.~~

~~0. Patients who meet the BT.EC.DG.101 Green Check criteria shall follow that process.~~

~~0. Units that routinely have a higher risk for incidents shall be equipped with extra security measures; such as personal duress alarms, security officers, and sound intelligence cameras.~~

~~U.~~F. Management of Disruptive Patients and Visitor Behavio~~u~~r

~~2.~~1. ~~Ben Taub Hospital~~The ASC has a zero-tolerance stance against workplace violence~~;~~ including verbal and physical acts of violence. The ~~leadership~~ASC takes ~~all~~ threats seriously and ~~will~~shall take action as appropriate to assure the safety of facility health care providers, employees ~~staff and~~ and patients.

~~3.~~2. The zero-tolerance policy is indicated with signage and patient education.

~~4.~~3. Security shall be contacted for any anticipated disruptive behavio~~u~~r.

~~VI.~~IV. **WORKPLACE SAFETY AND VIOLENCE PREVENTION COMMITTEE:**

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~~Ben Taub~~ The ASC will partner with the Harris Health ~~Hospital~~ Workplace Safety and Violence Prevention Committee (Committee). The Committee is comprised of security, nursing, providers, and ancillary personnel. This interdisciplinary group meets monthly and operates as a subcommittee to Harris Health System Workplace Safety and Violence Prevention Committee. The objectives of the committee are:

~~ii.~~1. Regularly assess workplace violence prevention processes and alignment with policy;~~.~~

~~iii.~~2. Assess and improve prevention strategies to decrease workplace violence by workforce members, patients, families, or visitors;~~.~~

~~iv.~~3. Establish processes to provide education and support learning from events to inform practice changes; and~~.~~

~~v.~~4. Solicit information when developing and implementing this Workplace Safety and Violence Prevention Plan.

~~**REVIEW AND APPROVAL OF THE WORKPLACE VIOLENCE PREVENTION SAFETY PLAN:**~~

~~A. The Workplace Safety and Violence Prevention Plan is approved by the Ben Taub Hospital Workplace Safety and Violence Prevention Committee and by the Harris Health Workplace Safety and Violence Prevention Committee. The plan is reviewed annually and revised for significant changes as applicable. Any changes made to the plan will be approved by the aforementioned committees.~~

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~~VIII.~~V. REFERENCES/BIBLIOGRAPHY:

Harris Health System Policies and Procedures 6.27 Workplace Violence Prevention

~~Harris Health System Policies and Procedures 4201 Management of Disruptive Patients and Visitors Behavior~~

Harris Health System Policies and Procedures 3.63 Incident Reporting and Response

Harris Health System Policy 464 Suicide/Homicide Screening, Assessment and Intervention

~~Harris Health System Policy Code Lavender: Program Information~~

~~eIRS Downtime Reporting Form 280952: Form~~

~~Harris Health System Ben Taub Emergency Center Departmental Guidelines and Procedures Ben Taub Department Green Check Screening Procedure: Policy~~

Harris Health System Code of Conduct

Texas Health and Safety Code § 331.004.

~~XI.~~VI. REVISION HISTORY:

Effective Date	Version # (If Applicable)	Review or Revision Date (Indicate Reviewed or Revised)	Reviewed or Approved by: (Directors, Committees, Managers, and Stakeholders etc.)
		Reviewed June 2024	ASC at LBJ Governing Body

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