HARRISHEALTH

AMBULATORY SURGICAL CENTER AT LBJ (ASC) GOVERNING BODY MEETING

Thursday, August 20, 2026 I 9:00 AM
4800 Fournace Place, Bellaire, Texas 77401 I 1st Floor Board Room

*Notice: The meeting may be viewed online at: **http://harrishealthtx.swagit.com/live**, and some members of the Governing Body may participate by videoconference.*

Mission

Harris Health is a public, integrated health system dedicated to improving the health of our communities by delivering high-quality, person-centered care in collaboration with community and academic partners.

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 Governing Body Meeting – May 21, 2026		
III.	**Executive Session**	**Ms. Libby Viera-Bland**	**15 min**
	A. Discussion Regarding Medical Staff Applicants and Privileges for the Ambulatory Surgical Center, 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 Consideration of Approval of Credentialing Changes for Members of the ASC Medical Staff Upon Return to Open Session ***Dr. Scott Perry***		*(5 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***		*(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, the ASC Quality Scorecard, 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**	**2 min**

V. General Action Item(s) — **Ms. Libby Viera-Bland** — **5 min**

A. General Action Item(s) Related to Quality: ASC Medical Staff

1. Consideration of Approval of Credentialing Changes for Members of the ASC Medical Staff ***Dr. Scott Perry***

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

1. Consideration of Approval of Revisions to the ASC Policy ASC-P-5004, Infection Control Plan ***Mr. Matthew Reeder***
2. Consideration of Approval of the ASC 2026-2027 Quality Assessment and Improvement Program ***Mr. Matthew Reeder***
3. Consideration of Approval of the ASC 2026-2027 Infection Control Program ***Mr. Matthew Reeder***
4. Consideration of Approval of the ASC 2026 Workplace Safety and Violence Reduction Plan ***Mr. Matthew Reeder***

C. Miscellaneous General Action Item(s)

1. Consideration of Approval to Appoint/Re-appoint Key Positions to the ASC ***– Mr. Matthew Reeder***
   - i. Administrator: Matthew Reeder
   - ii. Clinical Manager(s): Randy Polanco, Rochelle Mariano, and Jessica Larson
   - iii. Medical Director: 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 Leadership Reports — **Ms. Libby Viera-Bland** — **5 min**

A. Report Regarding ASC Medical Staff Operations, Clinical Operations, Statistical Analysis of Services Performed and Operational Opportunities ***Dr. Scott Perry and Mr. Matthew Reeder***

VII. Adjournment — **Ms. Libby Viera-Bland** — **1 min**

HARRISHEALTH

HARRIS HEALTH
AMBULATORY SURGICAL CENTER AT LBJ
GOVERNING BODY MEETING MINUTES
Thursday, May 21, 2026
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. A quorum was noted as present, and attendance was recorded. Some Board members attended in person while others participated by videoconference, in accordance with state law and the Harris Health Videoconferencing Policy. Only scheduled speakers were provided dial-in information; the public was able to view the meeting live via the Harris Health website at 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 19, 2026		**Motion No. 26.05 – 06** **Moved by Ms. Carol Paret, seconded by Mr. Matthew Reeder, and unanimously approved that the Governing Body adopt the minutes of the February 19, 2026 meeting. Motion carried.**
III. Executive Session	At 9:01 A.M., Ms. Viera – Bland announced that the ASC Governing Body would enter into Executive Session for Items A through C, as permitted by law under Tex. Occ. Code Ann. §160.007 and Tex. Health & Safety Code Ann. §161.032.	
	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. 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 9:11 A.M., Ms. Viera – Bland reconvened the meeting in open session, confirmed a quorum, and noted that no action was taken in Executive Session.	
V. General Action Item(s)		
	A. General Action Item(s) Related to Quality: ASC Medical Staff	
	1. Approval of Credentialing Changes for Members of the Harris Health ASC Medical Staff Dr. Scott Perry, Medical Director, ASC, presented Credentialing Changes for Members of the Harris Health Ambulatory Surgical Center Medical Staff. A copy of the credentialing report is available in the permanent record.	**Motion No. 26.05 – 07** **Moved by Dr. Glorimar Medina, seconded by Ms. Carol Paret, and unanimously passed that the Governing Body approve item V.A.1. Motion carried.**
	2. Approval of Changes to the ASC Otolaryngology Privileges Dr. Perry presented proposed changes to the ASC otolaryngology privileges, including an expansion of approved procedures for the ENT physician team. A copy of the privileges is available in the permanent record.	**Motion No. 26.05 – 08** **Moved by Ms. Carol Paret, seconded by Dr. Glorimar Medina, and unanimously passed that the Governing Body approve item V.A.2. Motion carried.**
	3. Approval of the Amended Governing Body Bylaws for the ASC Mr. Matthew Reeder, Administrator, ASC, presented the amended Governing Body Bylaws for the ASC. He noted that the bylaws had undergone the required periodic review and that the proposed amendments primarily consisted of grammatical and related revisions. A copy of the Governing Body Bylaws is available in the permanent record.	**Motion No. 26.05 – 09** **Moved by Dr. Glorimar Medina, seconded by Mr. Mattew Reeder, and unanimously passed that the Governing Body approve item V.A.3. Motion carried.**

AGENDA ITEM	DISCUSSION	ACTION/RECOMMENDATIONS
	4. Approval of the Amended Medical Staff Bylaws for the ASC Mr. Reeder presented the amended Medical Staff Bylaws for the ASC. He noted that the bylaws had undergone the required periodic review and included revisions consistent with the review process. A copy of the Medical Staff Bylaws is available in the permanent record.	**Motion No. 26.05 – 10** **Moved by Dr. Glorimar Medina, seconded by Ms. Carol Paret, and unanimously passed that the Governing Body approve item V.A.4. Motion carried.**
	B. General Action Item(s) Related to Policy and Procedures	
	1. Approval of Reviewed Policies and Procedures with No Recommended Changes for the ASC Mr. Reeder presented the reviewed ASC policies and procedures. He noted that the policies and procedures were included as part of the broader review process and were being presented for formal approval to ensure that the Governing Body's approval was appropriately documented. No changes were recommended. Copies of the policies and procedures are available in the permanent record.	**Motion No. 26.05 – 11** **Moved by Dr. Glorimar Medina, seconded by Mr. Mattew Reeder, and unanimously passed that the Governing Body approve item V.B.1. Motion carried.**
VI. ASC Leadership 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. Reeder presented the ASC leadership report regarding medical staff operations, clinical operations, statistical analysis of services performed, and operational opportunities at the ASC. Dr. Perry reported that the ASC remains affected by ongoing construction at the LBJ campus and that construction activities at the ASC include the refreshing of all five operating rooms, with the work expected to continue through approximately March 2027 as the rooms are addressed in rotation. Mr. Reeder also reported on continued collaboration with the Baylor team and anticipated expansion of ophthalmology services, including the allocation of operating room blocks based on block committee discussions. Mr. Reeder further reported on ongoing efforts by the ASC team to advance a smoke-free operating room environment. He noted that the initiative involves collaboration among anesthesia, nursing, physicians, and surgeons and is intended to support continued efforts toward a smoke-free OR environment.	**As Presented.**

AGENDA ITEM	DISCUSSION	ACTION/RECOMMENDATIONS
VII. Adjournment	There being no further business and without objection from the members of 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 21, 2026.

Respectfully Submitted,

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

Recorded by Cherry A. Joseph, MBA

HARRISHEALTH

Ambulatory Surgical Center at LBJ (ASC) Governing Body I Thursday, May 21, 2026
ATTENDANCE RECORD

PRESENT GOVERNING BODY MEMBERS	ABSENT GOVERNING BODY MEMBERS	OTHER PRESENT BOARD MEMBERS
Carol Paret, BS	Philip Sun, AIA, ACHA, NCARB	
Libby Viera-Bland, AICP *(Governing Body Chair)*		
Dr. Glorimar Medina		
Matthew Reeder		
Dr. Scott Perry		

PRESENT EXECUTIVE LEADERSHIP, STAFF & GUESTS	
Alexander Barrie	Lindsay "Katie" Rutherford *(Harris County Attorney's Office)*
Anthony Williams	Louis Smith
Catherine Walther	Maria Cowles
Cherry Joseph	Dr. Matasha Russell
Daniel Smith	Olga Rodriguez
Dr. Esmaeil Porsa *(President & Chief Executive Officer)*	Randy Manarang
Dr. Jennifer Small	Sara Thomas *(Harris County Attorney's Office)*
Jennifer Zarate	Shawn DeCosta
John Matcek	Dr. Thomas Cummins

Virtual Attendee Notice: *If you joined as a group and would like your attendance to be added to the official record, please submit an email to: BoardofTrustees@harrishealth.org before the close of business on the day of the meeting.*

BOARD OF TRUSTEES

HARRISHEALTH

Ambulatory Surgical Center at LBJ Governing Body

Thursday, August 20, 2026

Executive Session

Discussion Regarding Medical Staff Applicants and Privileges for the Ambulatory Surgical Center, 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 Consideration of Approval of Credentialing Changes for Members of the ASC Medical Staff Upon Return to Open Session.

- Pages 9 – 20 Were Intentionally Left Blank -

BOARD OF TRUSTEES

Ambulatory Surgical Center at LBJ Governing Body

HARRISHEALTH

Thursday, August 20, 2026

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, the ASC Quality Scorecard, 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 20, 2026

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

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The ASC Medical Executive Committee and Dr. Scott Perry, MEC Chair, reviewed the attached credentialing changes for the members of the Ambulatory Surgical Center. The report is being sent for approval.

ASC Governing Body

HARRISHEALTH

August 2026 Medical Staff Credentials Report

Medical Staff Initial Appointments: 11

Medical Staff Reappointments: 0

Medical Staff Changes in Clinical Privileges: 0

Medical Staff Resignations: 1

Other Business:

Medical Staff Leave of Absence - 1

For Information:

Medical Staff Files for Discussion: 1

BOARD OF TRUSTEES

Ambulatory Surgical Center at LBJ Governing Body

HARRISHEALTH

Thursday, August 20, 2026

Consideration of Approval of Revisions to the ASC Policy ASC-P-5004, Infection Control Plan

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As part of the regulatory requirements of the Ambulatory Surgical Center (ASC), the Governing Body is to review and approve policies for the ACS annually.

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

- Minor changes in formatting and context
- Updated references and charts

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

Table of Contents

Statement of Adherence:

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

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

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

TITLE: SANITARY ENVIRONMENT PROTOCOL

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

POLICY STATEMENT:

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

POLICY ELABORATIONS:

I. VENTILATION & WATER SYSTEMS

A. Ventilation Systems:

1. It is the policy of the ASC that all ventilation system(s) be evaluated on a routine basis to prevent the deployment of reservoirs of infection.
2. The following must be verified and documented in the evaluation of the ASC ventilation system(s):

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

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

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

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

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

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

B. Water Systems:

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

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

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

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

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

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

C. Prevention, Management, and Treatment of Legionella:

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

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

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

i. Review medical and microbiological records to verify diagnosis;
ii. Initiate active surveillance to identify other possible cases;
iii. Develop a line listing by person, place, and time;
iv. Form a multidisciplinary team, if indicated to guide remediation efforts;
v. Examine possible sources and collect water samples;
vi. Initiate water treatment;

vii. Consider restrictions from showering for high-risk patients if water is proven to contain legionella; and
viii. After water has been treated, continue surveillance to monitor the effectiveness of the treatment.

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

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

D. Treatment, Prevention and Management of Aspergillosis:

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

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

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

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

i. Review medical and microbiological records to verify diagnosis;

ii. Initiate active, prospective surveillance to identify other possible cases;
iii. If there is no evidence of a continuing transmission, continue routine maintenance procedures;
iv. If evidence of continuing infection is present, conduct environmental investigations to find the source;
v. Develop a line listing by person, place, and time;
vi. Form a multidisciplinary team, if indicated, to guide remediation efforts; and
vii. During and after remediation, continue surveillance to monitor effectiveness.

II. CLEANING AND DISINFECTING THE ASC:

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

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

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

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

III. DISPOSAL OF WASTE:

A. Generally:

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

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

3. All medical and infectious/biohazardous waste must be separated from ordinary trash at the point of generation.

~~. 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.

10. The ASC will conduct active surveillance of safe injection practices to assess compliance with nationally recognized guidelines. Surveillance activities

may include direct observation, audit of medication preparation and administration practices, review of sharps handling and disposal practices, and documentation of findings. Identified opportunities for improvement will be addressed through staff education, corrective action, and follow-up monitoring.

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.~~i. when ~~possible~~possible, with screens; and
   ~~iii.~~ii. 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

Guideline for Environmental Cleaning *DOI: 10.6015/psrp.15.01.009*

Guideline Summary: Cleaning and Care of Surgical Instruments

Guideline for Sterilization: *DOI: 10.6015/psrp.15.01.665*

Safe Injection Practices to Prevent Transmission of Infections to Patients | Injection Safety | CDC

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)

AAAHC Version 43
Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (2007)

OFFICE OF PRIMARY RESPONSIBILITY:

The Ambulatory Surgical Center (ASC) at LBJ

REVIEW/REVISION HISTORY:

Effective Date	Version # (If Applicable)	Review/ Revision Date (Indicate Reviewed or Revised)	Approved by:
6/14/16	1.0		The Ambulatory Surgical Center (ASC) at LBJ Governing Body
		Reviewed / Approved 03/29/2018	The Ambulatory Surgical Center (ASC) at LBJ Governing Body
		Revised and Approved 02/14/2019	The Ambulatory Surgical Center (ASC) at LBJ Governing Body
		Reviewed / Approved 02/13/2020	The Ambulatory Surgical Center (ASC) at LBJ Governing Body
		Revised / Approved 02/25/2021	The Ambulatory Surgical Center (ASC) at LBJ Governing Body
		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 08/17/2023	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
		Revised / Approved 02/20/2025	The Ambulatory Surgical Center (ASC) at LBJ Governing Body

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"

WASTE DISPOSAL CHART

HARRISHEALTH

REGULATED MEDICAL WASTE

Dispose in Red Biohazard Bag if item is:
- Saturated or soiled with liquid or semi-liquid blood or body fluids
- Heavily coated with dried blood or body fluids and capable of release
- Contaminated with other potentially infectious materials (OPIM)
- Pathological or biological waste containing blood or OPIM

Examples:
- Blood tubes and blood-soaked or dripping dressings
- Contaminated PPE and gloves
- Contaminated non-sharp plastic items
- Surgical sponges
- Suction canisters (after solidification)
- Body fluid containers (paracentesis, peritoneal, thoracentesis, pleural fluid) place directly into red transport tub in soiled utility room

IMPORTANT: Never place biohazard bags in regular trash.

All liquid infectious waste must be solidified prior to disposal.

SHARPS WASTE

Examples:
- Urine cup tops
- Needles with syringes
- Broken glass
- Broken RX vials
- Broken ampoules
- Blades, scalpels
- Pasteur pipettes
- Microscope slides
- Any item capable of puncturing the skin
- Orthopedic and OB instruments

HAZARDOUS WASTE

Common chemical hazardous waste items including:
- Xylene
- Formaldehyde/formalin
- Ethyl/methyl alcohol
- Methanol
- Stains

Hazardous combustible waste items:
- Aerosol canisters
- Gas cylinders

Amalgam and all mercury containing equipment

Contact the Hazardous Materials office for proper disposal guidelines.

Never pour chemicals down the drain or sewer.

Pathology/Microbiology

All pathology waste must be discarded into a black drum
- Tissue samples and tissue specimens.
- Sample body parts
  - Organs
  - Fetuses

PHARMACEUTICAL / CHEMOTHERAPY /CONTROLLED SUBSTANCE WASTE

PHARMACEUTICAL WASTE (Black container)

For **ALL non-controlled** hazardous (except chemo) and non-hazardous medications except aerosols (return aerosols and inhalers to pharmacy for destruction)

Examples:
- Unbroken vials
- Pills and tablets
- Medicinal liquids
- Antiseptics
- Allergens
- Transdermal patches
- Gums and lozenges
- Lotions/creams/gels
- Ointments and pastes

CHEMOTHERAPY WASTE (Yellow Container)

For All chemotherapy waste:
- Full/partial/empty syringes, vials, ampoules, IV bags
- PPE used to handle and administer chemo

CONTROLLED SUBSTANCE WASTE (Cactus)

- ALL controlled substances require a witness to waste into the Cactus Smart Sink or the Cactus PharmaLock per Harris Health Policy SB2 (Management and Accountability of Controlled Substance). The wasting of controlled medications shall be witnessed by two (2) licensed professionals (registered nurse, licensed vocational nurse, pharmacist, or physician). When at all possible, the documentation of the wastage shall be completed at the time the controlled substance is actually wasted.

RETURNING AND WASTING MEDICATION

- Nursing shall waste medication doses if the medication package is not intact per policy SB2 Management and Accountability of Controlled Substances.

NUCLEAR MEDICINE WASTE

Inpatient RadioPharmaceutical Therapy

Step 1: Radioactive waste generated during patient treatment shall be disposed of in designated **blue bags/liners.**

Step 2: Only the facility Radiation Safety Officer (RSO) can authorize removal of radioactive waste, after authorization is granted the material is placed in **red bio bag/liners** for disposal.

Nuclear medicine patient rooms should never be entered while signage is posted on patient room doors. All waste-linens should remain in patient rooms until cleared for removal by the RSO or designee.

Routine Imaging Studies:

Discard all contaminated biohazardous waste into red biohazardous waste bags. All red biohazardous waste bags should be passed through the radiation portal monitor located in the dock area to detect radioactive levels in biohazardous waste. Anytime the alarm sounds, the incident should be noted on the log sheet located near the portal monitor.

All BT & LBJ soiled linen and waste must pass through the radioactive waste portal monitors to exit facility.

SOLID MUNICIPAL NON-CONTAMINATED TRASH WASTE

Any items that are:
non-contaminated and non-hazardous

- Empty hazardous medication **bags that do NOT contain chemo therapy**
- Non-hazardous medication bags with tubing
- Non-contaminated glass items or containers
- Trash and wrappers
- Dry dressings
- Diapers and chux (non-contaminated)
- Gloves (non-contaminated)
- Empty foley bags
- Empty drainage bags
- Disposable patient items

Do not place any red biohazardous bags in municipal trash. This includes regulated medical waste, sharps waste, pharmaceutical waste, hazardous waste or any contaminated waste.

Contaminated linen must be placed in labeled laundry bags for transport –never in red biohazard bags or solid waste.

LBJ Nursing, EVS, and 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~~9662. 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.

~~5.~~6. The pest control provider will begin treatment based on their findings and guidelines.

~~6.~~7. The pest control provider will release room after treatment ends and instruct EVS to wait at least an hour before entering the room.

~~7.~~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.

~~8.~~ EVS Management will contact the ACS Infection Prevention (IP) Department at 346-426-0144 to inform the department of the completion of the terminal clean. ~~Upon speaking to the ACS IP Department, the EVS Management will send an email to the ACS IP Department to maintain documentation of the process.~~

9. ~~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).

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:

The Ambulatory Surgical Center (ASC) at LBJ

REVIEW/REVISION HISTORY:

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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 Monitoring at the ASC

A. 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

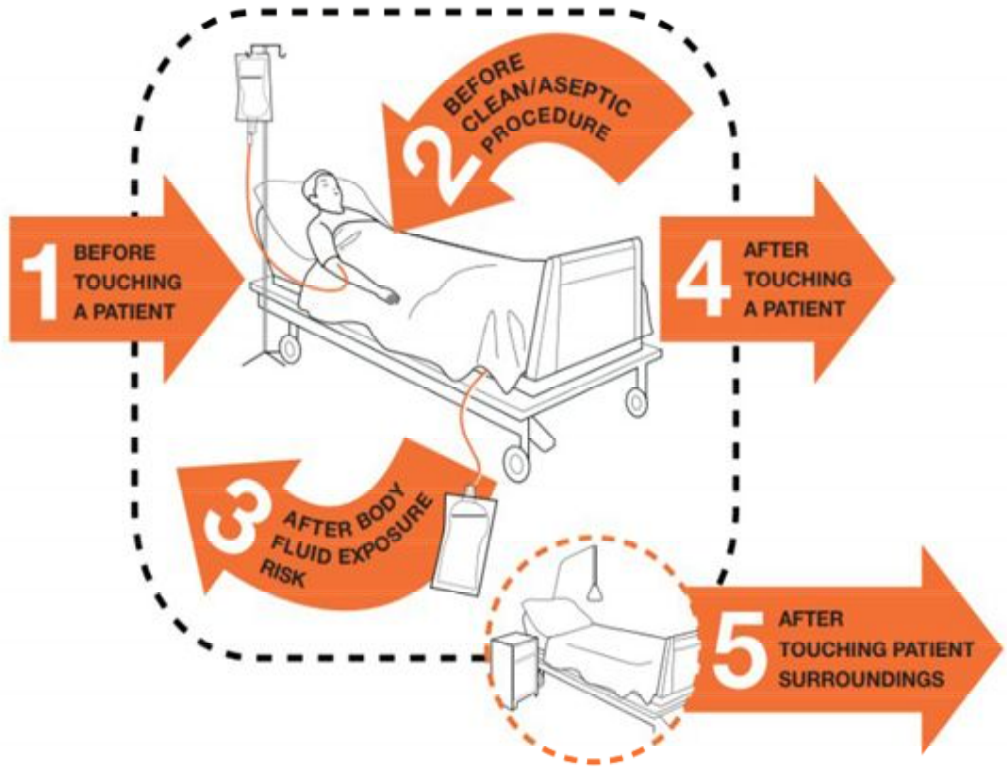
    2. Observations determine who practiced hand hygiene, verified when they practiced it, and if their technique was correct

    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




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:

AAAHC Version 43
42 Code of Federal Regulations (C.F.R.) §416.51.

OFFICE OF PRIMARY RESPONSIBILITY:

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		Revised / Approved 02/20/2025	The Ambulatory Surgical Center (ASC) at LBJ Governing Body

ATTACHMENT "C"

1. Gloves:

a. Disposable latex, nitrile, or vinyl gloves are available for use in the ASC. The gloves are not puncture-resistant; nor are the gloves one-hundred percent protective against infectious agents or organisms.
b. Gloves must be replaced as soon as practical when contaminated (at a minimum, after each patient). Torn or punctured gloves must be replaced as soon as feasible. Gloves must be removed prior to leaving the treatment area.
c. Gloves may not be washed for reuse.
d. Grossly contaminated gloves will be discarded appropriately.
e. Gloves must be used in the following circumstances:

i. During all surgical procedures;
ii. If a Workforce member's skin is cut, abraded or chapped;
iii. During an exam of a patient's mouth, oropharynx, gastrointestinal tract, or genitourinary tract;
iv. While examining abraded or non-intact skin or patients with active bleeding;
v. During invasive procedures;
vi. When performing phlebotomy, processing and/or testing blood, preparing pathology specimens, or other potentially infectious specimens; and
vii. During housekeeping and decontaminating procedures.

2. Eyewear:

a. Protective eyewear includes goggles, face shields, or glasses with solid side shields.
b. Protective eyewear must be worn when a procedure or surgery presents a danger of splashing or if a manufacturer recommends that protective eyewear be worn when using their product.
c. Protective eyewear must be removed prior to exiting the treatment area. Goggles and face shields will be cleaned and decontaminated after each use or disposed of properly, if disposable.

3. *Masks:*

a. Masks should be used when indicated and disposed of properly after use.
b. Contaminated masks will be replaced immediately or as soon as feasible. Contaminated masks must be disposed of properly.

4. Gowns, Aprons, Lab Coats:

a. Gowns are worn to protect clothing and the arm and neck areas of Workforce members from contamination.
b. Gowns may be worn until soiled, damaged, or made wet, at which time they must be immediately removed and replaced.
c. Protective laboratory coats, gowns, and aprons must be removed and replaced when they become visibly damaged or contaminated.

5. Donning and Removing Personal Protective Equipment:

a. ***Donning:*** The following order will be followed when donning PPE:

i. Gown;
ii. Mask;
iii. Goggles/face shield;
iv. Gloves

b. ***Removing:*** The following order will be followed when removing PPE:

i. Gloves;
ii. Goggles/face shield;
iii. Gown;
iv. Mask.

TITLE: STANDARD AND TRANSMISSION BASED PRECAUTIONS

PURPOSE: To prevent the transmission of healthcare associated or community acquired organisms and/or infections to patients, visitors, and members of the Ambulatory Surgical Center at LBJ's workforce.

POLICY STATEMENT:

It is the policy of the Ambulatory Surgical Center (ASC) at LBJ ("ASC") that every person is potentially infected or colonized with an organism that could be transmitted in the healthcare setting.

POLICY ELABORATIONS:

I. DEFINITIONS:

A. **AIRBORNE INFECTION ISOLATION ROOM (AIIR):** Formerly, negative pressure isolation room, an AIIR is a single-occupancy patient-care room used to isolate persons with a suspected or confirmed airborne infectious disease. AIIRs should provide negative pressure in the room so that air flows under the door gap into the room; and an air flow rate of 6-12 ACH and direct exhaust of the air from the room to the outside of the building or recirculation of air through a HEPA (high-efficiency particulate air) filter before returning to circulation.

B. **COHORTING**: Applies to the practice of grouping patients infected or colonized with the same infectious agent together to confine their care to one area and prevent contact with susceptible patients. Cohorting patients during outbreaks, Workforce members may be assigned to a cohort of patients to further limit opportunities for transmission to Cohorting staff.

C. **MULTI-DRUG RESISTANT ORGANISM (MDRO)**: In general, bacteria, excluding M. Tuberculosis, that are resistant to one or more classes of antimicrobial agents and usually are resistant to all but one or two commercially available antimicrobial agents e.g, MRSA, VRE, Extended Spectrum Beta-Lactamse (ESBL) producing or intrinsically resistant gram-negative bacilli, or Carbapenem Resistant Enterobacteriacae (CRE). In addition, organisms of clinical significance or that have special virulent properties such as *Clostridium difficile* will be considered in the same fashion.

D. **OTHER POTENTIAL INFECTIOUS ORGANISMS**: Human body fluids shall be treated as if they are known to be infectious for blood borne pathogens. These fluids include, but are not limited to:

a. Amniotic Fluid;
b. Pleural Fluid;
c. Blood;
d. Saliva (in dental procedures);
e. Cerebrospinal Fluid;
f. Semen;
g. Pericardial Fluid;
h. Synovial Fluid;
i. Peritoneal Fluid; and
j. Vaginal Secretions.

E. **PERSONAL PROTECTIVE EQUIPMENT (PPE)**: A variety of barriers used alone or in combination to protect mucous membranes, skin, and clothing from contact with infectious agents. PPE includes gloves, masks, respirators, goggles, face shields, and gowns.

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

G. **REGULATED MEDICAL WASTE**:

a. A liquid or semi-liquid blood or Other Potentially Infectious Material (OPIM); contaminated items that would release blood in a liquid or semi-liquid state if compressed;
b. Items that are caked with dried blood or OPIM and are capable of releasing these materials during handling; contaminated sharps; and pathological and microbial wastes containing blood or other potentially infectious materials.

H. **RESPIRATORY HYGIENE/COUGH ETIQUETTE**: A combination of measures designed to minimize the transmission of respiratory pathogens via droplet or airborne routes in healthcare settings.

I. **STANDARD PRECAUTIONS**: A group of infection prevention practices that apply to all patients, regardless of suspected or confirmed diagnosis or presumed infection status. Standard Precautions are based on the principle that all blood, body fluids, secretions, excretions except sweat, non-intact skin, and mucous membranes may contain transmissible infectious agents. Standard Precautions includes hand hygiene, and depending on anticipated exposure, the use of gloves, gowns, masks, eye protection, or face shields.

J. **TRANSMISSION-BASED PRECAUTIONS**:

a. Transmission-Based Precautions are used when the routes of transmission are not completely interrupted using Standard Precautions alone. There are three categories of Transmission-Based Precautions:
   i. Contact Precautions;
   ii. Droplet Precautions; and
   iii. Airborne Precautions.

b. They may be combined together for diseases that have multiple routes of transmission. When used either singularly or in combination, they are to be used in addition to Standard Precautions.

K. **WORKFORCE:** Employees, Medical Staff, trainees, contractors, volunteers, and vendors.

II. GENERAL PROVISIONS:

A. It is safer to "Over-Isolate" than to "Under-Isolate." If there is a question regarding isolation, then the more stringent Isolation Precaution should be used in until a definitive diagnosis is confirmed.

B. All QLPs, nurses, students, etc., are responsible for complying with Isolation Precautions.

C. Education and training on preventing transmission of infectious agents associated with healthcare will be provided during orientation to the ASC and thereafter, annually.

D. Identification of MDROs:

1. The ASC's pre-procedure screening clinic will aid in the coordination of patient care by identifying patients with MDROs so that those patients receive the appropriate level of care, i.e., care at either Lyndon B. Johnson Hospital or Ben Taub General Hospital.

2. Harris Health's Laboratory will alert infection prevention and the nursing of a MDRO laboratory result pursuant to the Letter of Agreement between Harris Health System and the ASC.

3. Nursing will initiate the appropriate isolation immediately.

4. The patient will be placed in the isolation room. The appropriate signage must be placed on the isolation room door and the isolation type should be entered into the patient's medical record.

E. Categories of Standard and Transmission-Based Precautions:

1. Standard Precautions: This presumes that all body substances may carry infectious agents. PPE appropriate to the potential exposure should be worn. PPE may not be worn in hallways, nursing stations, other areas outside of the ASC, or in isolation rooms, when applicable.

2. Contact Transmission Precautions: These precautions are based on direct contact with an infected patient or contact with a contaminated environment. Gowns and gloves should be worn by ASC QLP or other personnel to protect against contact with body fluids or contaminated surfaces.

3. Droplet: Droplet Transmission Precautions are based on an infectious agent being transmitted from droplets that can reach the respiratory tract of a susceptible host; and

i. Surgical face masks must be worn within 3-6 feet of an individual with a respiratory infection;
ii. Gowns and gloves should be worn if Workforce members or QLPs are touching surfaces where droplets may have landed.

4. Airborne Precautions: Airborne transmission occurs by the dissemination of small particles that can remain suspended in the air for considerable time. N95 Respirators are required to be worn by Workforce members and QLPs as an Airborne Precaution.

F. Workforce members will instruct visitors about precautions to be taken while visiting patients in the isolation room. PPE must be worn by all visitors in the isolation room.

Patients having the same pathogen may be cohorted in the absence of private rooms.

III. GUIDELINES FOR ISOLATION OF PATIENTS WITH MULTI-DRUG RESISTANT ORGANISMS:

A. Patients colonized or infected with any identified MDRO must be initially placed in the ASC isolation room. Appropriate signage must be placed on the door of the isolation room to alert Workforce members.

B. After the MDRO has been identified, the following steps will be followed:

1. TB Infection:
   i. If a patient has TB, that patient will remain in the ASC isolation room. The patient's surgery/procedure at the ASC will be cancelled.
2. Other MDROs:
   i. If a patient has another MDRO (e.g., MRSA, VRE, VIRE), the ASC Medical Director and Administrator and Infection Prevention Manager in consultation with the surgeon will make a determination as to whether that patient's scheduled surgery/procedure may continue as scheduled and what precautions, if any, need to be taken.

IV. MANAGEMENT OF THE ENVIRONMENT:

A. Environmental Services: All trash, linen, and cleaning of rooms in the ASC are the same for all patients regardless of whether that patient has been in the isolation room. Privacy curtains must be changed at the patient's discharge.

B. Patient Care Equipment: When possible, equipment should be dedicated. If common equipment is unavoidable, then that equipment must be cleaned and disinfected after each use with an ASC approved product.

C. Patient Supplies: Supplies that are kept in the isolation room should be kept to a minimum and any leftover supplies from the isolation room should be discarded when the patient is discharged.

V. SPECIAL CONSIDERATIONS:

A. Surgery and Procedure Rooms: In the event that patients with a communicable disease are scheduled for surgery at the ASC and who are placed in the ASC isolation room, those patient's surgeries and/or procedures should be done as the last case of the day with a terminal clean being completed after the procedure concludes. If it is not possible to perform this surgery as the last case of the day, then a terminal clean must be performed on the operating room before the next surgery is performed.

B. Guest Transportation: Patients transported outside of the ASC must be transported with appropriate barriers in place, such as surgical masks on patients with a respiratory illness. Workforce members must wear appropriate PPE during the transport.

REFERENCES/BIBLIOGRAPHY:

APIC Text On-Line, Chapter 29 Isolation Precautions-Recommendations.

Siegel JD, Rhinehart E, Jackson M, Chiarello L, and the Healthcare Infection Control Practices Advisory Committee, 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings.

42 Code of Federal Regulations (C.F.R.) § 416.51.

OFFICE OF PRIMARY RESPONSIBILITY:

The Ambulatory Surgical Center (ASC) at LBJ

REVIEW/REVISION HISTORY:

Effective Date	Version # (If Applicable)	Review/ Revision Date (Indicate Reviewed or Revised)	Approved by:
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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 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 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 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 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 Paid Time Off (PTO) Policy 6.03.

REFERENCES/BIBLIOGRAPHY:

42 Code of Federal Regulations (C.F.R.) §416.51(b).

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:

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 and the ASC, Harris Health's Employee Health Services is available for consultation when needed.

III. PROCEDURES:

A. Any Workforce members with a fever should stay home until he or she has no fever for twenty-four (24) hours without medication. See the table below for guidelines regarding when to stay home in the setting of an acute respiratory viral illness.

Symptoms	Stay At Home	Return to Work
FEVER • Fever (T38C or 100.4)	• T >38C or 100.4	• No fever for 24 hours(!)
RESPIRATORY SYMPTOMS WITHOUT FEVER • Cough • Sore throat • Nasal congestion / runny nose • Myalgia (body aches)	One or more symptoms on high risk units Two or more symptoms on all other units	• 24 hours after onset of symptoms AND • No fever AND • Symptoms have significantly improved
RESPIRATORY SYMPTOMS WITH FEVER (presumed Influenza) • Fever (T38C or 100.4F) • Cough • Sore throat • Nasal congestion/runny nose • Myalgia (body aches)	T> 38C or 100.4 and at least one symptom	No fever for 24 hours and symptoms have significantly improved

B. A Workforce member who provides patient care and who suspects or knows that he or she is infected with a potential communicable disease shall not engage in any activity that is known to be a risk to others in the ASC.

C. Workforce members who are linked epidemiologically to an increase in bacterial or viral infections caused by a pathogen associated with a carrier state may be advised to provide samples for microbiology testing, and, if positive, be excluded from patient contact until carriage is eradicated or the risk of disease transmission is eliminated.

D. Workforce members who are infected with a potential communicable pathogen should report their condition to their supervisor. Work restrictions are determined on a case-by-case basis.

E. For selected conditions, medical clearance by Harris Health Employee Health Services is required prior to return to work. These conditions are set out in Attachment D.

REFERENCES/BIBLIOGRAPHY:

42 Code of Federal Regulations (C.F.R.) §416.51(b).

Bolyard, E.A., et al. The Hospital Infection Control Practices Advisory Committee (1998). *Guidelines for Infection Control in Health Care Personnel,* 1998. American Journal of Infection Control, 26(3), 289-354.

Infectious Disease Guidelines by Type of Infection (2003). Occupational Exposure and Health.

CDC Recommendations for the Amount of Time Persons with Influenza-Like Illness Should be Away from Others. (Oct. 23, 2009).

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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 Team will be responsible for notifying 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 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 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 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.

Mayhall, Glen C., Hospital Epidemiology and Infection Control, 4th Edition, 2012.

APICTEXT 12. Outbreak Investigations | Epidemiology, Surveillance, Performance, and Patient Safety Measures | Table of Contents | APIC~~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~~

~~0. 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 ~~2025~~2026

PURPOSE:

The purpose of the Harris Health 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.*

BOARD OF TRUSTEES

Ambulatory Surgical Center at LBJ Governing Body

HARRISHEALTH

Thursday, August 20, 2026

Consideration of Approval of the ASC 2026-2027 Quality Assessment and Improvement Program

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As part of the regulatory requirements of the Ambulatory Surgical Center (ASC), the Governing Body is to review and approve the ASC Quality Assessment and Improvement Program annually.

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

- Minor changes in formatting and context
- Updated references

ASC at LBJ

Quality Assessment and Improvement Program

202654-202675

- # 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.

The ASC Quality Improvement Program is designed to integrate quality improvement activities, peer review, risk management, and infection prevention and control programs. The Quality Review Committee (QRC) includes multidisciplinary representation from each of these areas and meets quarterly to review and analyze data, performance improvement, and program effectiveness for quality and patient safety.

- **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 PDCA 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 developedment 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 and Harris Health Strategic Plan 2026- 2030.
- 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.

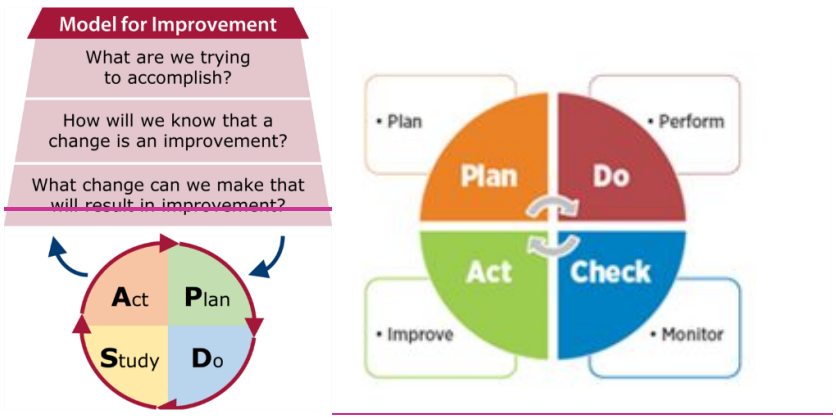

Figure 2.1: Plan-Do-Check-Act Cycle~~Model for Improvement~~

B. The "Plan-Do-Check~~Study~~-Act" (PDC~~S~~A)

The PDCA cycle tests and implements a change in a real-work setting. The PDCA~~DSA~~ 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. Check~~Study~~ – In the Check~~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 PDC~~S~~A 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)	
	Reviewed 08/21/2025	The Ambulatory Surgical Center (ASC) at LBJ Governing Body
	1/20/2026 Revision	

BOARD OF TRUSTEES

Ambulatory Surgical Center at LBJ Governing Body

HARRISHEALTH

Thursday, August 20, 2026

Consideration of Approval of the ASC 2026-2027 Infection Control Program

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As part of the regulatory requirements of the Ambulatory Surgical Center (ASC), the Governing Body is to review and approve the ASC Infection Control Program annually.

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

- Minor changes in formatting and context
- Updated references

ASC at LBJ
Infection Control Program
20265642-20277653

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

BOARD OF TRUSTEES

Ambulatory Surgical Center at LBJ Governing Body

HARRISHEALTH

Thursday, August 20, 2026

Consideration of Approval of the ASC 2026 Workplace Safety and Violence Reduction Plan

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As part of the regulatory requirements of the Ambulatory Surgical Center (ASC), the Governing Body is to review and approve the ASC Workplace Safety and Violence Reduction Plan annually.

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

- Minor changes in formatting and context
- Updated references

HARRISHEALTH
AMBULATORY SURGICAL CENTER AT LBJ

The Ambulatory Surgical Center at LBJ

WORKPLACE SAFETY AND VIOLENCE REDUCTION PLAN

June 2026~~5~~

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 Plan conforms to requirements set forth in Section 331.004 of the Texas Health and Safety Code.

II. PURPOSE:

A. The purpose of the Plan is to mitigate obstacles impacting the ability of the organization to provide a safe environment for the ASC's patients, visitors, and workforce.

B. This occurs through:
   1. Annual workplace violence prevention education;
   2. Standardized system for responding to and investigating violent or potentially violent incidents;
   3. Environmental Assessment; and
   4. Review and evaluation of current workplace safety processes.

III. WORKPLACE VIOLENCE:

A. The definition of Workplace Violence utilized within the ASC is in alignment with Texas Health and Safety Code §331.004 and includes the following:

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

2. 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.

B. **Crisis Intervention**

1. 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.

2. Workforce members can call a Crisis Intervention by depressing the panic button on the unit or calling extension 37800.

~~B.~~C. Training/Education

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 behavioral issues are required to take an additional course related to workplace violence prevention techniques.

2. The ASC 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.

3. ~~Satori Alternatives to Managing Aggression (SAMA) training is provided to all nursing who are at an increased risk of caring for aggressive patients.~~ SAMA training is provided to nursing personnel and other staff identified as being at increased risk of exposure to aggressive behaviors.

~~C.~~D. Incident Reporting and Investigations

1. Facility health care providers and employees who witnesses or experience 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.

2. All incidents of workplace violence shall be documented in the Electronic Incident Reporting System (eIRS) or documented using downtime forms when the eIRS is not available.

3. ~~Incidents of workplace violence shall be investigated timely by the ASC.~~Incidents of workplace violence shall be investigated timely by ASC leadership in collaboration with Harris Health Security as appropriate.

~~D.~~E. Post-Incident Responsibilities

1. It is the responsibility of the ASC to consider adjusting patient care assignments following an occurrence of workplace violence. This may prevent a health care provider or employee of the ASC from treating or providing services to a patient whom has physically abused or threatened them.

2. ASC 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 supervisors 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.

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

4. Patients identified as disruptive will be flagged in Epic according to applicable policies.

~~E.~~F. Environmental Safety

1. Patients who are at increased risk of harming themselves or others have their environment assessed routinely for environmental hazards including ligature risks.

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

~~F.~~G. Management of Disruptive Patients and Visitor Behavior

1. The ASC has a zero-tolerance stance against workplace violence including verbal and physical acts of violence. The ASC takes threats seriously and shall take action as appropriate to assure the safety of facility health care providers, employees and patients.

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

3. Security shall be contacted for any anticipated disruptive behavior.

IV. WORKPLACE SAFETY AND VIOLENCE PREVENTION COMMITTEE:

A. The ASC will partner with the Harris Health 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:

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

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

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

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

V. REFERENCES/BIBLIOGRAPHY:

Harris Health System Policies and Procedures 6.27 Workplace Violence Prevention

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 Code of Conduct

Texas Health and Safety Code § 331.004.

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	The Ambulatory Surgical Center (ASC) at LBJ Governing Body
		Revised / Approved August 21, 2025	The Ambulatory Surgical Center (ASC) at LBJ Governing Body

BOARD OF TRUSTEES

Ambulatory Surgical Center at LBJ Governing Body

HARRISHEALTH

Thursday, August 20, 2026

Report Regarding ASC Medical Staff Operations, Clinical Operations, Statistical Analysis of Services Performed and Operational Opportunities

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The Ambulatory Surgical Center at LBJ Earns National Recognition for Surgical Safety: Smoke Evacuation

HOUSTON, Texas – The Ambulatory Surgical Center at LBJ, part of Harris Health System, has been recognized by the Association of periOperative Registered Nurses (AORN) as a **Center of Excellence in Surgical Safety: Smoke Evacuation**, earning the prestigious **Go Clear™ Award**. This national recognition underscores The Ambulatory Surgical Center at LBJ's unwavering commitment to providing a safe and healthy environment for both patients and surgical staff by effectively eliminating the hazards of surgical smoke.

The AORN Go Clear™ Award signifies that The Ambulatory Surgical Center at LBJ's surgical teams have successfully completed AORN's comprehensive, evidence-based program and implemented advanced technologies to ensure a smoke-free environment wherever surgical smoke is generated. This achievement demonstrates the facility's proactive approach to protecting the health and well-being of everyone in the operating room.

"We are honored to receive the AORN Go Clear™ Award and be recognized as a Center of Excellence in Surgical Safety," said **Randy Nelson Polanco Rodriguez, Director of Nursing, The ASC at LBJ, Harris Health System**. *"This achievement reflects our team's unwavering commitment to patient and staff safety and our dedication to maintaining the highest standards of surgical care. By eliminating surgical smoke and creating a safer operating room environment, we are strengthening our mission to provide exceptional, high-quality care to the communities we serve."*

Surgical smoke, a hazardous byproduct of laser and electrosurgical procedures, poses significant health risks to those exposed. The Ambulatory Surgical Center at LBJ recognizes the importance of eliminating this risk and has taken proactive steps to ensure a smoke-free surgical environment.

"Surgical smoke occurs every day in operating rooms and poses health risks to those exposed to it. AORN created this program so that every facility can understand the urgency and take steps to protect the health and safety of patients, nurses, physicians, and support staff," said David Wyatt, PhD, RN, NEA-BC, CNOR, FAORN, FAAN, AORN CEO & Executive Director. *"This Center of Excellence for Surgical Safety designation shows the community that the surgical teams at The Ambulatory Surgical Center at LBJ are committed to providing high-quality care."*

About The Ambulatory Surgical Center at LBJ

The Ambulatory Surgical Center at LBJ is part of Harris Health System, the public healthcare safety-net system serving Harris County, Texas. Located on the campus of Lyndon B. Johnson Hospital in Houston, the center provides high-quality outpatient surgical services through a multidisciplinary team committed to excellence, innovation, and compassionate care. The facility is dedicated to advancing patient safety, improving clinical outcomes, and ensuring equitable access to healthcare services for the diverse communities it serves.

About AORN

Founded in 1949, AORN is the leading professional organization for perioperative nurses, supporting the practice of more than 200,000 perioperative nurses by providing evidence-based research, nursing education, standards and practice resources to enable optimal outcomes for patients undergoing operative and other invasive procedures. AORN unites and empowers perioperative nurses, healthcare organizations, and industry partners to support safe surgery for every patient, every time.

For more information about AORN and its initiatives, visit **www.aorn.org**.

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