Health Care Organizations Risk Management - Rozovsky and Conley, § 14.03 , EXAMPLES FROM THE CONTINUUM OF CARE

[B] Ambulatory Surgical Care

The performance of surgery in nonhospital settings has grown and continues to grow rapidly. Dedicated Ambulatory Surgical Centers (ASCs) are performing a significant percentage of surgical procedures once performed only on an inpatient basis. These centers are the focus of much regulation on federal and state levels. All ASCs approved for Medicare undergo inspection by the federal government to determine their compliance with the Medicare Conditions for Coverage.

Conditions for Coverage (CfCs) are the minimum health and safety standards that providers and suppliers must meet in order to be Medicare and Medicaid certified. ASCs are not exempt from CMS regulation and are required to comply with established CMS CfCs. On November 18, 2008, CMS published an ASC final rule updating the existing CfCs to reflect contemporary standards of practice in the ASC community, as well as recommendations from the HHS Office of Inspector General. After the requisite public review and comment period, the Ambulatory Surgical Center Conditions for Coverage were further revised. New CfCs were added and more detailed guidance was provided for those CfCs that were not revised. The new and/or revised CfCs went into effect on December 30, 2009.

The new requirements were enacted to promote and protect patient access to quality services in ASCs. Significant changes were made, including the following:

- Revision of the definition of an ASC, adding language indicating that the expected duration of ASC services would not exceed 24 hours;

- Revisions to and reorganization of the Governing Body and Management CfC, including addition of explicit responsibilities for the quality assurance/performance improvement program and for a disaster preparedness plan;

- Revisions to the Surgical Services CfC concerning anesthetic risk and evaluation;

- Renaming of the Evaluation of Quality CfC as "Quality Assessment and Performance Improvement," and the addition of detailed regulatory standards;

- Reorganization of the Laboratory and Radiologic Services CfC, and addition of a requirement for Radiologic Services provided in the ASC to meet the Hospital Condition of Participation at 42 C.F.R. §482.26 ;

- Addition of a CfC on Patient Rights;

- Addition of a CfC on Infection Control; and

- Addition of a CfC on Patient Admission, Assessment and Discharge.

Of note in the revisions is the addition of a CfC on Infection Control and inclusion of a 16-page Infection Control Surveyor Worksheet for use by CMS's on-site survey teams. Obviously, infection control has been given increased importance in the ASC setting; therefore, ASCs should give increased scrutiny to their Infection Control Plan and be prepared for increased surveyor attention in this area. The Worksheet should be reviewed and identified deficiencies corrected to avoid citations for noncompliance.

Also of note are the changes to the Interpretive Guidelines for the three standards relevant to the administration of anesthesia in an ASC, specifically:
1. Anesthesia Risk and Evaluation §416.42(a)

2. Administration of Anesthesia §416.42(b)

3. State Exemption §416.42(c)\footnote{60.2}

These changes speak to preoperative and predischarge patient assessment; who may administer anesthesia—i.e., an anesthesiologist, a CRNA, or an anesthesia assistant—and the credentialing and privileges required; the anesthesia informed consent process; and more. A discussion of the changes to these standards, along with the concomitant changes to the CoPs for Anesthesia Services in the hospital setting can be found in §8.09.

Because of the extensive length of the ASC CfCs, it is neither possible nor appropriate to include them here. The complete CMS Ambulatory Surgical requirements\footnote{60.3} can be found online at <http://www.access.gpo.gov/nara/cfr/waisidx_04/42cf416_04.html>. Suffice it to say that ASC risk managers, patient safety officers, and compliance officers should be aware of the CfCs and their requirements and ensure that ASC policies and procedure meet or exceed those standards.

In addition, the majority of states require state licensure of ASCs and specify criteria for licensure. Both state and Medicare surveys are conducted regularly to assure that the ASCs are in compliance with standards and regulations.

There are four accreditation bodies that have set standards of care and performance for ASCs:

- the Accreditation Association for Ambulatory Health Care (AAAHC),
- the Joint Commission,
- the American Association for Accreditation for Ambulatory Surgery Facilities (AAAASF), and
- the American Osteopathic Association.

All four bodies are approved and accepted by Medicare for ASC accreditation. ASCs must meet specific standards established by these entities, demonstrating compliance during onsite inspection and surveys. Generally speaking, the facilities providing outpatient surgical care are held to the same standard of care as those doing inpatient surgery. While there is some variation in the standards across the accrediting bodies, in general, they address the same areas. (See Exhibit 14–35, Bases for Evaluation of Ambulatory or In-Office Surgical Facilities.)

**EXHIBIT 14–35. BASES FOR EVALUATION OF AMBULATORY OR IN-OFFICE SURGICAL FACILITIES**

**General Environment**

- How does the facility look in terms of cleanliness, convenience, comfort?
- Is the lighting sufficient?
- Are there convenient restroom facilities?
- Is there adequate space for administrative activities?
- Is there adequate space for storage?

**Operating Room Environment**
- Is the operating room distinct and separate?
- Is it of sufficient size to accommodate all required equipment?
- Does it have all the necessary lighting?
- Does it have sources for emergency power?
- Does it have resuscitative equipment?
- Is proper aseptic technique followed?

**Recovery Room Environment**

- Are the appropriate policies and procedures in place to score the patients prior to discharge?
- Is there significant recovery monitoring equipment?
- Is there a means for communicating with other office personnel?

**General Safety**

- Are there fire exits, fire extinguishers?
- Is exit lighting in place?

* Although each accrediting organization covers generally the same standards, the titles may vary somewhat.

**Blood and Medications**

- Are appropriate intravenous fluids available?
- Are narcotics stored appropriately?
- Are there any outdated drugs?

**Medical Records**

- Are they secure?
- Are they legible?
- Is HIPAA being followed?
- Is there proper documentation?
- Are laboratory reports and operative reports present?

**Quality Assessment and Quality Improvement**

- Is there a type of peer review plan in effect to evaluate the performance of those individuals in this facility?

**Personnel**

- Are they properly trained?
- Are they certified for their various positions?
- Do they have their appropriate inoculations?
- Are they properly supervised?

**Governance**

- Who is responsible for the rules and regulations of the facility?
- Who is in charge of missions and goals?
- Who establishes policies and procedures?

**Anesthesia**

- Who is qualified to administer the anesthesia?
- Is there proper anesthetic equipment and medications available?
- Is the anesthesiologist available until full discharge of the patient from the facility?
- Has the anesthesiologist evaluated the patient preoperatively?


Standards of care with regard to delivery of anesthesia and the performance of surgery should be the same whether the procedure is performed in-hospital or in an ambulatory surgical center. Patients should receive the same quality of care at the hands of appropriately credentialed and experienced health care providers in appropriately equipped facilities. However, at present, these are not uniformly applied to the performance of surgery in physicians' offices; few states require the same standards and regulations in doctors' offices as they do in hospitals and surgical centers. However, comprehensive guidelines for office-based practices are available from the American Society of Anesthesiologists (ASA), and the American College of Surgeons, and the American Society of Plastic Surgeons (ASPS). These specialty societies and others are lobbying for nationwide adoption of these or similar guidelines by all states.

All of these standards and guidelines are intended to address the risks inherent in the performance of outpatient surgical procedures, whether in an accredited ambulatory surgical center or a physician's office. Many of these risks are not peculiar to any one venue where surgery is performed, but are, rather, known risks of surgery. However, patient perception and a nonhospital setting can affect both the potential risk of patient injury and the likelihood of subsequent malpractice litigation. Patients simply do not associate the same level of complexity, the same level of risk, or have the same level of anxiety about "same-day" or "walk-in/walk-out" surgery. These commonly used names may have led to that misperception—"How serious can it be? I don't have to be in the hospital, and I'll be back home in five hours!" When complications or unanticipated outcomes do occur, patients are quick to jump to the conclusion that someone had to have done something wrong—"How else could something like this happen during a ‘simple’ procedure?"

[1] **Patient Screening and Assessment**

Patient screening and assessment is a critical piece of the care of the patient—Is the performance of this surgery on this patient in this ambulatory setting appropriate? Not every patient is a suitable candidate for surgery in a nonhospital setting. Nor is every surgical procedure appropriate to perform in a nonhospital operating suite. Therefore, it is imperative that the patient selection process is carefully performed by the health care providers involved. There should be no less of a preoperative evaluation performed on an outpatient than an inpatient; in fact, additional questions and concerns have to be addressed. But a thorough patient assessment, medical clearance process, and
surgical and anesthesia evaluations should take place preoperatively, regardless of the surgical setting.

Detailed in-take information and a complete medical history are especially important to the process so that the appropriate patients may be "ruled in" for ambulatory surgery and others who would be better off having surgery as an inpatient, "ruled out." Preoperative patient history should include personal health, family, and social history; comorbid conditions, especially diabetes mellitus, cardiac diseases, and respiratory conditions; medications taken (both prescription and nonprescription); alternative/herbal products and dietary supplements taken; any known allergies (drug, latex, tape) and reaction; and a general review of body systems. Results of a complete blood count, ECG, and any additional diagnostic tests appropriate to the patient's condition should also be included in the preoperative assessment. This information must be current; ACS policy may vary in this regard, but in most cases, history and physical condition assessment must have been performed within 30 days of surgery, but physical examination must be performed within 7 days prior to the procedure to confirm that the history and physical condition is still current, and an update note is present to this effect on the patient's chart the day of surgery.

Sample preoperative assessment tools can be found in Chapter 13, Exhibit 13–5.1, Health History, and Exhibit 13–5.2, Nursing Preoperative Screening, on pages 13-36.4 to 13-36.9.

Once the necessary medical information has been collected, the American Society of Anesthesiology (ASA) Physical Status Classification, 64 routinely used in the inpatient surgical setting, should be used to assess patients being considered for ambulatory surgery or in-office surgery. The six levels of ASA classification are:

P1—A normal healthy patient
P2—A patient with mild systemic disease
P3—A patient with severe systemic disease
P4—A patient with severe systemic disease that is a constant threat to life
P5—A moribund patient who is not expected to survive without the operation
P6—A declared brain-dead patient whose organs are being removed for donor purposes

As is always the case, it is up to the surgeon to select the appropriate surgical facility on a patient-by-patient assessment. The ASPS guidelines for office-based surgery, 65 for example, offer plastic surgeons the following guidance with regard to facility selection, based on the ASA Classification:

- ASA class P1 and P2 patients are generally considered the best candidates for ambulatory surgery and reasonable candidates for the office-based surgery setting.
- ASA class P3 patients may also be reasonable candidates for office-based surgery facilities when local anesthesia, with or without sedation, is planned and the facility is accredited.
- ASA class P4 patients are appropriate candidates for the office-based surgery setting only when local anesthesia without sedation is planned.

The American Association of Orthopedic Surgeons has developed pre- and postoperative checklists to be completed by its member-surgeons performing surgery in either an ambulatory surgical center or in their own offices. These are found in Exhibits 14–36 through 14–38.

If there is any doubt that the patient might not be an appropriate candidate for ambulatory surgery because of being at a higher risk of complication, then inpatient surgery would be in the best interests of all concerned.

[2] HIPAA
Ambulatory surgical centers and physician offices where surgical procedures are performed both qualify as "covered entities" under the HIPAA Privacy Rule. As such, they are both required to comply with the regulations of that rule, demonstrating evidence of written privacy policies and procedures that are consistent with the Privacy Rule. These would include:

- Notice of Privacy Practices (NPP)

- Patient Receipt/Acknowledgment of NPP Form

- Access to Protected Health Information (PHI) Policy that addresses who may and may not have access to PHI of the facility's patients and under what circumstances. The policy should include the following permitted uses or disclosures of PHI by the ASC, as defined by the HIPAA Act, when patient authorization is not needed:

  — for its own treatment, payment, and health care operations activities (e.g., a physician may disclose protected health information about an individual as part of a claim for payment to a health plan);

  — for the treatment activities of any health care provider (including providers not covered by the Privacy Rule) (e.g., a primary care physician may send a copy of an individual's medical record to a specialist who needs the information to treat the individual);

  — to another covered entity or a health care provider (including providers not covered by the Privacy Rule) for the payment activities of the entity that receives the information (e.g., A physician may send an individual's health plan coverage information to a laboratory that needs the information to bill for services it provided to the physician with respect to the individual);

  — to another covered entity for certain health care operation activities of the entity that receives the information if: (1) each entity either has or had a relationship with the individual who is the subject of the information, and the protected health information pertains to the relationship; and (2) the disclosure is for a quality-related health care operations activity or for the purpose of health care fraud and abuse detection or compliance; and

  — a covered entity participating in an organized health care arrangement (OHCA) may disclose PHI about an individual to another covered entity who participates in the same OHCA for any health care operations activities of the OHCA (e.g., physicians with staff privileges at a hospital may participate in the hospital's training of medical students). 66

EXHIBIT 14–36. AAOS AMBULATORY SURGERY, PATIENT SAFETY CHECKLIST, PREOPERATIVE

Click to Launch

EXHIBIT 14–37. AAOS DIETARY SUPPLEMENT IN-TAKE FORM

Click to Launch

EXHIBIT 14–38. AAOS AMBULATORY SURGERY, PATIENT SAFETY CHECKLIST, POSTOPERATIVE

Click to Launch

In addition, the policy should speak to the issue of the release of PHI to someone other than the patient, that is, a legally recognized representative.

- Patient Access to PHI Policy and Procedures allowing patients to access and amend their own medical records.
• Patient Authorization to Release Individual PHI.

• A mechanism for tracking all disclosures of a patient's PHI so that, upon request, the patient may be given an accounting of exactly who has received his or her PHI.

• Develop a Business Associates Policy, Procedure, and Agreement after identifying all potential business associates. In addition, consider if the ASC or its professional staff will, in turn, be business associates of other covered entities.

• A procedure to report/document all nonauthorized disclosure of PHI (excluding disclosure for treatment, payment purposes, and health operations) by any member of the professional or clerical staff. Policies should also address the consequences of willful unauthorized disclosure of PHI by a member of the staff, and corrective measures put in place to prevent reoccurrence of such unauthorized disclosure.

■ Privacy Personnel. The facility must designate a privacy officer whose responsibilities will include:

  • keeping informed and up to date on HIPAA regulations;
  • developing and implementing the facility's privacy policies and procedures;
  • providing individuals with information on the covered entity's privacy practices;
  • serving as a contact person responsible for receipt, investigation, and disposition of individual privacy-related complaints against the facility;
  • developing or overseeing staff education programs on HIPAA requirements and impact on the ASC and its staff; and
  • overseeing the facility's compliance to the HIPAA Act.

■ Workforce training and management. Workforce members include employees, volunteers, trainees, and may also include other persons whose conduct is under the direct control of the entity (whether or not they are paid by the entity). A covered entity must train all workforce members on its privacy policies and procedures, as necessary and appropriate for them to carry out their functions. A covered entity must have and apply appropriate sanctions against workforce members who violate its privacy policies and procedures or the Privacy Rule. While not specifically required by HIPAA, the facility should have all employees sign a confidentiality agreement upon hiring.

■ Mitigation. A covered entity must mitigate, to the extent practicable, any harmful effect it learns was caused by use or disclosure of protected health information by its workforce or its business associates in violation of its privacy policies and procedures or the Privacy Rule.

■ Data safeguards. The facility must maintain reasonable and appropriate administrative, technical, and physical safeguards to prevent intentional or unintentional use or disclosure of protected health information in violation of the Privacy Rule and to limit its incidental use and disclosure pursuant to otherwise permitted or required use or disclosure. For example, such safeguards might include shredding documents containing PHI before discarding them, securing medical records with lock and key or pass code, and limiting access to keys or pass codes.

Security measures to protect PHI can be both technical and nontechnical. Technical measures are part of information systems hardware and software, and include access controls, identification, authentication, encryption methods, automatic logoff, and audit controls. Nontechnical measures are management and operational controls, such as policies, procedures, standards, guidelines, accountability and responsibility, and physical and environmental security measures.
Once appropriate security measures have been identified to address PHI disclosure risks specific to the facility, they should be documented and, once implemented, reviewed regularly to assure continued protection.

- **Complaints.** An ASC or physician office, as covered entities, must have procedures for individuals to complain about its compliance with its privacy policies and procedures and the Privacy Rule. These procedures must be explained in the facility's Privacy Practices Notice. Among other things, the ASC must identify to whom individuals can submit complaints (usually the designated privacy officer) and advise that complaints also can be submitted to the Secretary of HHS.

- **Retaliation and waiver.** A covered entity may not retaliate against a person for exercising rights provided by the Privacy Rule, for assisting in an investigation by HHS or another appropriate authority, or for opposing an act or practice that the person believes in good faith violates the Privacy Rule. A covered entity may not require an individual to waive any right under the Privacy Rule as a condition for obtaining treatment, payment, and enrollment or benefits eligibility.

- **Documentation and record retention.** A covered entity must maintain, until six years after the later of the date of their creation or last effective date, its privacy policies and procedures, its privacy practices notices, disposition of complaints, and other actions, activities, and designations that the Privacy Rule requires to be documented.67

[3] **Consent Issues**

The issue of informed consent has already been covered in detail in Chapter 6, and readers are referred there for a detailed discussion. However, from a risk management perspective, because of the importance of this concept some caveats to keep in mind with regard to the performance of surgery in an ASC or a physician-office setting include the following:

- Informed consent is not a form! It is a process—the process of a physician communicating to his or her patient the necessary information to allow the patient to make a truly informed decision about whether or not to undergo a recommended procedure or therapy. In regard to the performance of surgical or invasive procedures in an ASC or physician-office setting, this would include providing the patient with adequate information about the nature of the procedure, the risks and possible complications, including any potential increase in risks or complications that could be directly attributed to the selection of the facility where the procedure will be performed, if any (outpatient versus in-hospital). The discussion should include the possible need for hospital admission from the ASC if there are complications in the intra- or postoperative period. In addition, inpatient surgery must be included as an alternative to having the procedure performed in an outpatient setting. The patient has to have the opportunity to consider that as an option and make his or her decision accordingly. As discussed earlier, patient perceptions about the seriousness of procedures performed as walk-in/walk-out surgery can be misleading. Making sure the patient and family members are appropriately informed during the consent process can help correct misperceptions and unrealistic patient expectations.

- Most ACS policies require a separate informed consent discussion and form for the procedure to be performed and the specific type of anesthesia to be delivered.

- While state laws on informed consent may vary to some degree, it is generally accepted that it is the physician's responsibility to obtain a patient's informed consent—this is not a task for the physician to delegate to office staff.

- Physicians should choose their words cautiously. Physician-patient communication should be in words the patient can understand, so physicians should tailor their discussions to each patient's level of understanding. Also, care should be taken to avoid statements that could be misinterpreted as guaranteeing a positive outcome or in any way downplaying the seriousness of having any surgical procedure.
Physicians should document all aspects of an informed consent discussion carefully. This should include questions asked by the patient and the physician's responses. In addition, documentation of any prepared patient education materials—informational brochures, audio- or videotapes, or any other form of media—used to inform the patient about a recommended procedure or treatment can be very important should allegations of lack of informed consent later arise.

Ideally, patient informed consent should be obtained prior to the day of surgery. The patient should be given information well in advance and be allowed time to consider options, if desired. In addition, patient consent should not be solicited after any preoperative medication or sedation has been administered. This, in and of itself, will render the consent invalid.


It is important that patients scheduled for ambulatory surgery or any invasive procedure involving anesthesia and/or sedation are informed preoperatively that they will not be permitted to drive themselves home and, usually, will not be permitted to drive for 24 hours after the operation. Most ASCs include this information in preoperative patient instructions; in addition, it should be mentioned and reinforced in preoperative discussions with the patient by surgeon and anesthesiologist; and reiterated in written discharge instructions sent home with the patient.

Because there can be no exceptions to this rule, many ASC facilities go beyond issuing the customary warning not to drive a car, operate machinery, sign legal documents, drink alcohol or take recreational drugs for 24 hours after operation, and have made it a written policy that surgery will be canceled or rescheduled if the patient arrives for surgery unaccompanied by an adult friend or relative to drive the patient home after discharge. Statements to that effect are now commonly included in the preoperative patient information. An example of such a statement follows.

Prior to the day of surgery, please make arrangements for an adult friend or relative to accompany you to (Name of ASC or office) on the day of surgery, be present when you receive your discharge instructions, and be able to drive you home when you are discharged. You will not be allowed to leave the Ambulatory Surgical Center alone after surgery. This is for your own safety and protection. Failure to follow these instructions may result in your surgery being cancelled or rescheduled for another date and time.

[5] Discharge Instructions

Discharge criteria and patient instructions are especially important in an ASC or nonhospital setting. The patient will be going home—to a nonmedical facility without skilled care. For that reason, there should be stringent, specific clinical criteria and procedures in place to follow prior to declaring a patient ready to be released—usually developed jointly by the surgical and anesthesia staff. The final decision to discharge will be based on these established criteria. A physician is usually required to review and sign off on any postop tests or x-rays prior to the patient's discharge, and ideally, a physician has the ultimate responsibility of discharging the patient.

The patient should be given appropriate discharge instructions based on the specific procedure and specific patient needs. Instructions should be given verbally to the patient in the presence of the adult who has accompanied the patient and will take the patient home, with written instructions provided for the patient to take with him or her. Generally, these instructions should address:

- Postoperative restrictions (for example, diet, bathing, activity, motor vehicle operation, back-to-work timing)
- Information about prescribed medications, if any, including possible side effects, food-drug interactions, etc.
- Instructions for follow-up care (for example, dressing change, suture removal, follow-up appointment)
- Instructions regarding those conditions that require contacting the physician (for example, excessive drainage
• Instructions for reaching a physician for postoperative or postprocedure problems, including a specific phone number

The staff member who gives the discharge instructions to the patient should document this process in the patient's chart. Some facilities require the patient and/or the person accompanying the patient to initial the chart to acknowledge that the discharge instructions were received.

Most facilities require the discharged patient to be taken to the vehicle of the person taking the patient home in a wheelchair, by a member of the facility staff.

[6] Follow-Up

Most ASCs have included a next-day follow-up call to the patient as part of their discharge procedures, usually by an RN or other member of the clinical staff. The patient should be advised that this follow-up will occur and that it is important (a good practice is to include this fact in the patient's verbal and written discharge instructions). The patient should be asked to provide specific contact information as to where he or she will be and the appropriate phone number for the ASC staff member to call. This is an excellent policy for several reasons. This call provides the clinical staff with an opportunity to make sure the patient's recovery is going as expected; to identify any specific problems or issues that need to be brought to the physician's attention or that need immediate medical attention; and to answer any questions or concerns on the part of the patient or his/her family. In addition, from a patient-relations perspective, it can be extremely reassuring to the patient and family to know someone will be calling the next day—that someone from the ASC or physician office "cares" enough to call to see how the patient is doing. The call and the information provided and discussed and any action(s) that were taken as a result of the call should be documented in the patient's chart.

[7] Emergency Transfer

One last issue that should be mentioned is the need to have policies and procedures in place to address transfer of a patient in an ASC or physician office because of a medical, surgical, or anesthesia emergency. For ASCs, this is an accreditation requirement, but it is something a physician office doing surgical procedures should also address. Should a patient suddenly "crash"—whether before, during, or after the procedure—the facility should have the necessary resources to respond promptly to provide initial management and stabilization of the patient.

This includes the availability of staff who are appropriately trained and certified in CPR and advanced cardiac life support and recovery, and the necessary emergency resuscitative equipment and medications—whether in a crash cart or an emergency kit—to either manage the emergency or maintain the patient until emergency services arrive. In addition, the facility should have an arrangement in place with a nearby acute care hospital to accept emergency transfer of patients. This arrangement should also include transfer of nonemergency patients who do not meet the facility's criteria for discharge to home.

See also Chapter 13, § 13.01, Office-Based Surgery.

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EXHIBIT 14–35. BASES FOR EVALUATION OF AMBULATORY OR IN-OFFICE SURGICAL FACILITIES

General Environment

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Is the lighting sufficient?

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Is there adequate space for administrative activities?

Is there adequate space for storage?

Operating Room Environment

Is the operating room distinct and separate?

Is it of sufficient size to accommodate all required equipment?

Does it have all the necessary lighting?

Does it have sources for emergency power?

Does it have resuscitative equipment?

Is proper aseptic technique followed?

Recovery Room Environment

Are the appropriate policies and procedures in place to score the patients prior to discharge?

Is there significant recovery monitoring equipment?

Is there a means for communicating with other office personnel?

General Safety

Are there fire exits, fire extinguishers?

Is exit lighting in place?

Although each accrediting organization covers generally the same standards, the titles may vary somewhat.

Blood and Medications

Are appropriate intravenous fluids available?
Are narcotics stored appropriately?
Are there any outdated drugs?

**Medical Records**
Are they secure?
Are they legible?
Is HIPAA being followed?
Is there proper documentation?
Are laboratory reports and operative reports present?

**Quality Assessment and Quality Improvement**
Is there a type of peer review plan in effect to evaluate the performance of those individuals in this facility?

**Personnel**
Are they properly trained?
Are they certified for their various positions?
Do they have their appropriate inoculations?
Are they properly supervised?

**Governance**
Who is responsible for the rules and regulations of the facility?
Who is in charge of missions and goals?
Who establishes policies and procedures?

**Anesthesia**
Who is qualified to administer the anesthesia?
Is there proper anesthetic equipment and medications available?
Is the anesthesiologist available until full discharge of the patient from the facility?
Has the anesthesiologist evaluated the patient preoperatively?

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EXHIBIT 14-36: AAOS AMBULATORY SURGERY, PATIENT SAFETY CHECKLIST, PREOPERATIVE

Clip this checklist to the patient chart and upon completion, insert in file.
Prior to bringing the patient into the OR, the orthopaedic surgeon is to complete and sign the patient safety checklist.

Patient’s Name: ______________________ Date: __/__/____

Scheduled Procedure: ______________________

I have considered the following as they relate to the safety of my patient undergoing this procedure:

- History and Physical Examination Performed
- Labs and EKG Attached
- Medications:
  - Prescription
  - Over the Counter (OTC) Drugs
  - Herbals or Other Products
- Patient Risk Factors/Co-Morbidities
- Prior Anesthetic Complications

The following processes have been performed:

- Patient Identifier Checked
- Surgeon Signed the Site
- Appropriate ASA Classification Assigned
- Equipment Checked – Present and Functioning Properly
- Primary Care Physician Notified of Procedure
- Time-Out Prior to Procedure

Orthopaedic Surgeon’s Signature: ______________________

EXHIBIT 14–37. AAOS DIETARY SUPPLEMENT IN-TAKE FORM

Your orthopaedic surgeon needs the following information about your usual dietary supplement usage. Please complete all sections completely and accurately. Many supplements may cause negative drug interaction effects. The patient and physician should carefully review checked items in light of prescribed medications and/or planned procedures.

NAME: ________________________ AGE: _______ DATE: ________________

What specific supplement(s) do you take, amount you take, how often and the primary reason for taking it?

<table>
<thead>
<tr>
<th>Supplement</th>
<th>Amount/Dose</th>
<th>Number of Doses (per day or week)</th>
<th>Primary Reason for Taking</th>
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<tbody>
<tr>
<td>Aloe</td>
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<td>Amino acid(s)</td>
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<td>Black cohosh</td>
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<td>Bee pollen</td>
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<td>Calcium</td>
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<td>Cat’s claw</td>
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<td>Chondroitin</td>
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<td>Chromium</td>
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<td>Coenzyme Q10</td>
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<td>Creatine</td>
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<td>Echinacea</td>
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<td>Evening primrose oil</td>
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<td>Feverfew</td>
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<td>Fiber</td>
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<td>Fish oil/DHA</td>
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<td>Folic acid</td>
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<td>Garlic 1</td>
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<td>Ginger 1, 2, 4</td>
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</tr>
<tr>
<td>Ginkgo biloba 1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ginseng 1, 2, 3, 4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Goldenseal 4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grapeseed extract</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Iron</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kava kava 2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Licorice 3, 4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Milk thistle</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Multiple vitamin/mineral</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peppermint</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pyruvate</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>St. John’s wort 1, 2, 4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Saw palmetto</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>SAM-e</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Valerian 2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vitamin B complex</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vitamin C</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vitamin D</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Vitamin E</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1: possible interactions with anticoagulants  
2: possible interactions with barbiturates  
3: possible interactions with corticosteroids  
4: possible interactions with anti-hypertensives  
5: contraindicated for organ transplant recipients, antiviral therapy

EXHIBIT 14-38. AAOS AMBULATORY SURGERY, PATIENT SAFETY CHECKLIST, POSTOPERATIVE

Clip this checklist to the patient chart and upon completion, insert in file. The orthopaedic surgeon is responsible for the completion of the checklist prior to discharge.

Patient’s Name: __________________________ Date: __ / __ / __

Being discharged to: __________________________

In care of: __________________________

Follow-up appointment: _______ Date: _______ Time: _________

I have attended to the following issues as they relate to my patient’s safe discharge:

<table>
<thead>
<tr>
<th>Patient was provided with and reviewed written discharge instructions.</th>
<th>ASC Rep</th>
<th>Patient/Rep</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient was provided with and reviewed written medication instructions.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient follow-up has been arranged for a specific date and time.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient is determined safe to go home.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient will be accompanied by a responsible adult.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient has been given emergency contact phone number(s).</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Orthopaedic Surgeon’s Signature: __________________________