

Article 9 Outpatient Surgical Centers

1. 902A.4. Board to approve policies and procedures (Currently Administrator is responsible)
2. 902C 2.b. requires policies that cover the provision of medical and nursing services and health related services. What does that mean????
3. 902C.7 Give information within 2 hours Four for hospitals Why less?
4. 905A1a. and 2 Behavioral health services in outpatient surgery???
5. 905B2. NOT All employees must be certified in CPR (billing, front desk staff)
6. 907B. Need not be a med staff member who does H&P if med staff does update at time of admission. PCP would do H&P.
7. 907D3. No informed consent for care of the patient Just for surgical procedure.
8. 9082. Records are electronic Will not accompany patient
9. 909B 2. Must give consent to photograph. Why if for ID purposes?
10. 909C1. No discrimination based upon source of payment Really?
11. 910C13d Do surgery centers give psychotropic drugs?
12. 913 Behavioral health services?????
13. 914A 1.c. Procedures to ensure that medication regimen is reviewed by doc and meets patient's needs. The surgeon will not review the entire medication regimen.

# CHAPTER 10 – ARTICLE 9

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1. What parts of the draft rules do you believe are effective?

No Response

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2. How can the draft rules be improved?

Clarify who is included as being a personnel member Is this not an employees? Are the physicians, anesthesiologists, managers considered Personnel? Clarify education and in-service requirements for Personnel Is this educational events they attend on their own or must it be provided by the surgery center? CPR should be extended to at least the first 3 months of employment as long as there are other employees who are CPR certified For medication storage- The rules state that medication must be locked in a closet or separate room Can we store them in a locked cabinet within a room? Evacuation Drills- Must we evacuate patients or can this be done after hours? Pain medication administration-if we are administering a pain medication as part of conscious sedation for pain prevention, must a before and after pain assessment be performed? When the physician performs a patient assessment prior to the procedure, must it be a full physical assessment or can it just include verbal questioning of the patient for any changes since the 30 H&P?

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3. Has anything been left out that should be in the rules?

No Response

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Response Started: Thursday, April 18, 2013 12:41:45 PM

Response Modified: Thursday, April 18, 2013 1:53:16 PM

## 1. What parts of the draft rules do you believe are effective?

No Response

## 2. How can the draft rules be improved?

R9-10-902 A 8 a. & b. - These two statements say the same thing R9-10-902 A 9. - What is the time frame in which an ASC has to notify the department of a change in Administrator? I could not find this information in the given referenced statute R9 - 10-902 B 1. Replace the words "treatment center" with surgical center R9 - 10-902 B 2 Replace the word "hospital" with outpatient surgical center (I don't think the ASC administrator has the authority and responsibility to manage the hospital as indicated in the regulation) R9 - 10-902 C 1 e. Replace the word ro with or. R9 - 10-902 C. 1 g Recommend adding the words "if applicable" after electronic records R9 - 10-902 C 2 b Please clarify what "health-related services" means R9 - 10-902 C. 2 d. Complete the sentence. It currently states "Cover dispensing, administering and disposing of medical and biological" (WHAT???) R9 -10-903 1 c Please provide examples or clarify what "delivery of services" is or what it means R9 - 10-905 1. & 2 Personnel: States in several locations "physical health services or behavioral health services" SHOULD state: "outpatient surgical services" R9 - 10-905 6 Replace behavioral health services or physical health services with "outpatient surgical services" R9 - 10-905 7 & 9 could be combined to state: "An individual's orientation and SUBSEQUENT IN-SERVICE education is documented to include: R9 -10-908 2 b. i. Patients in an outpatient surgical center do not receive behavioral health services This should be deleted R9-10-908 3. a If a patient needed to be transferred after the procedure they would not be able to sign a consent for transfer since they would be under the influence of anesthesia/narcotics A patient's representative may not be available to sign the consent for transfer R9-10-909 B 1 f & g - Combine to say sexual abuse according to A R S 13-1404 AND 1406 R9-10-909 B. 2 c Patients in an outpatient surgical center are not given psychotropic medication - this needs to be deleted. R9-10-909 C 5. Physical Health Services should be replaced with "outpatient surgical services" R9-10-910 C 8. I recommend adding "if applicable" after progress notes Most patients stay a short amount of time in an ASC and would not have separate "progress notes". R9-10-910 C 13. d i ii Delete: Psychotropic medications are not applicable to the ASC R9-10-911 B Please clarify: Why does a physician performing procedures at the ASC need to know (or care to know) what clinical privileges all of the other physicians at the center can and cannot perform? R9-10-912 A Please clarify if the Administrator and DON can be the same person In smaller centers these roles would be held by the same person This could be a cost burden to small centers to pay for both an Administrator and DON R9-10-913 - Delete this section Behavioral Health Services does not meet the definition of Outpatient Surgical Center R9-10-914 A. 1 C Please clarify "patient's medication regimen" does this refer to home medications or medications given at the outpatient surgical center? R9-10-914-B 3 A. States " A medication administered to a patient: Is administered in compliance with an order. ....An order written by whom????? R9-10-914 B. 4 a b. This is already covered on page 12 under R9-10-910 C 13 c i & ii R9 -10-917 A 1. 6 States' Heating and cooling systems maintain the outpatient treatment center at a temperature between 70 degrees and 85 degrees at all times This is in direct disagreement with AORN guidelines which states " Temperature should be maintained between 68 - 73 degrees within the operating suite and general work areas in sterile processing The decontamination area temperature should be maintained between 60 -65 degrees" R9-10-918 C 1 -3 - If existing centers do not meet these requirements will they be grandfathered in? Some existing facilities, if not meeting the correct number of stretchers per OR currently, may not have physical space to meet this requirement

## 3 Has anything been left out that should be in the rules?

No Response



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IP Address: 68 14 252 70

Response Started: Wednesday April 17 2013 4:54:15 PM

Response Modified: Wednesday, April 17 2013 4:54:25 PM

## 1. What parts of the draft rules do you believe are effective?

No Response

## 2 How can the draft rules be improved?

1 Pg 3 R9-10-803.A.5 We are opposed to adopting a Quality Management Program There is currently no rule requiring the adoption of a Quality Management Program for Assisted Living and this would be highly labor intensive as well as costly, which would force the facility to pass this cost down to the residents and families This would go against the Legislature's Directive in HB 2634 which is to "reduce monetary or regulatory costs on persons or individuals" 2 Pg 4 R9-10-803.C 1 a We are opposed to job descriptions, duties and qualifications including required education, experience, skills & knowledge for volunteers who do not provide hands on care It would be costly and labor intensive and go against HB 2634, to implement this and not necessary We are fine with requiring an orientation for volunteers 3 Pg 4 R9-10-803 C 1 d i, ii & iii We are opposed to the requirement of a demonstration of the employee's ability to perform cardiopulmonary resuscitation at the time of orientation We do not have staff that are trained to teach nor critique or assess someone's ability to perform cardiopulmonary resuscitation It should be sufficient that a new employee is providing proof of their ability to do so, by giving their employer a copy of their issued CPR card. We are opposed to requiring us to have a policy on method and content of CPR training and the qualifications to provide CPR training. We are not in this business Other organizations do this line of business of certifying individuals for CPR & F A. This would be very costly and goes against HB 2634 4 Pg 7 R9-10-803 G 1 & 3 We are opposed to contacting the Department within one working day of a resident's death We are in a business where people dying is a regular and most times expected occurrence To notify the Department after each death would be highly labor intensive and unnecessary We do understand and agree with why the Department would want to be notified for situations regarding suicide attempts and self injury We are also highly opposed to notifying the Department within 3 working days after a resident has an accident or emergency This is not specific enough and would be extremely labor intensive and costly Accident is not defined and your definition of emergency is way too broad Does the department want to be notified every time someone acquires a serious health condition? We do understand and are ok with notifying the Department in situations of the resident resulting in a serious injury due to an emergency or accident This goes against HB 2634 5 Pg 7 R9-10-804 We are opposed to the idea of forming a quality management program for Assisted Living It is our understanding that the Legislature's Directive is to "reduce monetary or regulatory costs on persons or individuals" Forming a quality management program would be costly and would force the facility to pass this cost down to the residents and their families This goes against HB 2634 6 Pg 17 R9-10-810 A 3 g This does not relate at all to your definition of "service plan" and is not consistent with your definition We are opposed to this because it is impractical to require it to be in the service plan and is already required elsewhere in the chart 7 Pg 19 R9-10-812 A 2 What about a home health agency? 8 Pg 23 R9-10-814 A 2 We are opposed to specifying a process for review of medication administration through the Quality Management program, because there is no current requirement for a Quality Management Program in Assisted Living and it would be highly labor intensive, as well as costly to implement such a program This would be going against the Legislature's Directive in HB 2634 to "reduce monetary or regulatory costs on persons or individuals" because this cost would be passed down to the residents and families 9 Pg 23 R9-10-814 B 1 a We are opposed to a medical practitioner being required to review and approve any Policies and Procedures for medication administration In the previous drafts this wording said "registered nurse, pharmacist or medical practitioner" which is acceptable to us. To insist on a medical practitioner approving all Policies and Procedures would be very costly to the facility, which would then be passed down to the residents and families This goes against HB 2634 10 Pg 24 R9-10-814.C 4 We are opposed to the training for a personnel member in the self administration of medications being provided by a medical practitioner or registered nurse Once a caregiver has gone through the required training to be certified as a caregiver they have already had the component for medication passes taught to them by an individual licensed to train the course This should be sufficient When they are hired, the facility orients them on their process usually by a Lead Caregiver as well as the nurse on staff The wording "nurse" would be acceptable for us, but not the words "registered nurse" The cost would be high to the facility and would be passed on to the residents and families 11 Pg 25 R9-10-815.A & C We are opposed to the Administrator being responsible to ensure the Resident Records have all required documents in them In the previous Draft it said the "Manager" was responsible and this is acceptable to us It would be difficult and burdensome for the Administrator to be responsible for such 12 Pg 20 R9-10-812 E 1 Sometimes a resident who is receiving personal care services is not receiving services that allow caregivers to observe skin status Sometimes its very difficult to prevent a bruise or injury Residents sometimes do not notify staff of bruises 13 Pg 8 R9-10-805 Contract Services We are opposed to this as our resident's contract for outside services Sun Valley Lodge Assisted Living Center does not do this for our residents 14 Pg 9 R9-10-806 Personnel C 1 a We are opposed to requiring volunteers supplying us with D O B information Volunteers are reluctant to give this information. 15 Pg. 10 R9-10-807 Residency Agreements B 2 a b d Need clarification as on Pg 11 most of this is prohibited 16 Pg 12 R9-10-808 Transport, Transfer We are opposed to this entire section as its very costly and labor intensive and goes against HB 2634 17 Pg 16 R9-10-810 Service Plans A 3 a We are opposed to the emotional wording 18 Pg 18 R9-10-810 C 1 f We are opposed to this requirement as caregivers may not be qualified to detect deficits

and also this would be very costly to the resident and the facility to reinforce remaining cognitive awareness 19 Pg 27 R9-10-815 Resident Records B 19 c & d We are opposed to these requirements for an Assisted Living setting 20 Pg 29 R9-10-817 A 2 , 3 , 4 , 5 & 6 We are opposed to all of this Very labor intensive This will add to cost for residents and providers The current requirements in rule applying to drills and documentation are acceptable Respectfully Submitted by Sun Valley Lodge Assisted Living Center 4/17/13

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**3 Has anything been left out that should be in the rules?**

No Response

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