

	Yes	No
1. Bylaws in Manual and signed.		
2. Governing Body Minutes in Manual and signed.		
3. Mission Statement framed and displayed.		
4. Business Philosophy framed and displayed.		
5. Goals and Objectives written and in Governing Body Manual.		
6. Organizational Chart completed.		
7. Organizational Chart documented in minutes of Governing Body.		
8. Goals and Objectives reviewed with Staff and documented in Staff Meeting Minutes.		
9. Organizational Chart reviewed with Staff and documented in Staff Meeting Minutes.		
10. Policies and Procedures mentioned in Governing Body Minutes and approved.		
11. Policies and Procedures signed by the Chairman of the Board and the Medical Director.		
12. CQI Book and reporting system developed.		
13. CQI mentioned in the Governing Body Minutes and approved.		
14. Audit of financial matters in Policy and Procedure Manual.		
15. Patient Rights Policy developed.		
16. Patient Rights Policy framed and displayed for public view.		
17. Equipment and General Maintenance (Contracts) Book developed with Table of Contents.		
18. Written Hospital Transfer Agreement obtained.		

		Yes	No
19.	Transfer of Patient to Hospital Policy and Procedure.		
20.	Inservice documented of Staff reviewing transfer of a patient to the hospital.		
21.	Business Office Manual complete.		
22.	Business Office Staff inserviced on all business functions.		
23.	Transfer paperwork and forms completed for patient being transferred to the hospital.		
24.	Laboratory Contract signed and in Contract Book.		
25.	Procedure for Emergency Lab written.		
26.	Procedure for Emergency Radiology.		
27.	Procedure for Emergency Pharmaceutical Services.		
28.	Staff inservice for emergency lab, radiology, and obtaining of pharmaceuticals for patient.		
29.	Risk Management Form developed.		
30.	Risk Management reporting system developed.		
31.	Staff inserviced on Risk Management reporting.		
32.	Outcome Review developed.		
33.	Patient Satisfaction survey developed.		
34.	Patient Satisfaction policy and procedure developed.		
35.	Policy and procedure developed dealing with patient, vendor, and physician complaints.		
36.	Governing Body Meeting schedule developed.		
37.	Credentialing process developed.		
38.	Credentialing meeting held/documentation/minutes.		

		Yes	No
39.	Policy on continuing education requirements of the staff.		
40.	Personnel files complete.		
41.	Medical records Policy and Procedure Manual completed.		
42.	Medical Records release of information form developed.		
43.	Staff inservice on release of Medical Records/confidentiality.		
44.	List of services available developed / in Governing Body Manual.		
45.	Policy and procedure on treatment of minors developed.		
46.	Standards of patient conduct and responsibility developed.		
47.	Policy and Procedures for 23 hour care developed.		
48.	Fees for service policy developed.		
49.	Payment policy developed.		
50.	Plan for educating patient on insurance and payment policy.		
51.	Patient rights concerning experimental/research developed.		
52.	Display of policy on who to and how to complain about care and financial responsibility.		
53.	Marketing policy and procedure developed.		
54.	Policy and procedure concerning enforcement of policies and procedures of the facility and Governing Body developed.		
55.	Policy and procedure concerning maintenance of equipment.		
56.	Policy and procedure concerning maintenance of equipment.		
57.	Job descriptions of all staff members complete.		
58.	Policy and procedure concerning equipment care and storage.		
59.	Policy and procedure book complete with Table of Contents		

	Yes	No
identifying each section and each policy.		
60. All staff inserviced on Policy and Procedure Manual with minutes to document.		
61. Personnel file contains signed Job Description for each employee.		
62. Orientation Program developed.		
63. Orientation documentation form developed.		
64. Orientation form completed and in every employee personnel file.		
65. Competencies developed for all professional staff.		
66. Competencies completed by all professional staff and in personnel files.		
67. Minimum staffing policy developed for each area of ASC.		
68. Policy on how and who is to contact patient for any problem. (e.g. abnormal lab, radiologic findings, pathology findings)		
69. Specialty consultation service list developed.		
70. CPR Class / documentation of CPR in every personnel file.		
71. Infection Control policy and procedures developed.		
72. Personnel forms developed for Infection Control: TB skin test, Chest X-ray, Hepatitis, employment history and physical.		
73. Inservice Manual developed.		
74. Annual inservice requirements listed and in front of Inservice Manual.		
75. CQI Committee has been chosen to include different specialties: Recovery Room Nurse, OR Nurse, Admission Nurse, MD (Anesthesiologist and surgeon), and an Administrative representative.		
76. CQI Committee has met to approve plan and forms. Minutes document the meeting.		

	Yes	No
77. Developed a log system to document all: fires, patient deaths, emergency and non-emergency transfers from ASC to hospital.		
78. CQI activities shall encompass, but not be limited to the following: 1) clinical performance of health care practioners 2) standards for medical records 3) quality controls for radiology, pathology, and laboratory 4) other services provided (professional and technical) 5) patient satisfaction surveys		
79. Policy and procedure concerning the evaluation of the patient prior to discharge by a physician developed.		
80. Policy and procedure concerning discharging the patient to a responsible adult unless an order is written by a physician to dismiss not requiring an adult to accompany patient.		
81. Fire Safety Policy completed. (To include how often to review)		
82. Inservice on Fire Safety completed and documented.		
83. Infection Control Coordinator chosen.		
84. An internal Emergency Plan developed.		
85. All evacuation signs in place.		
86. All Exit signs in place.		
87. An external Emergency Plan developed.		
88. Internal Emergency Plan inservice with documentation.		
89. External Emergency Plan inservice with documentation.		
90. Safety Committee developed. (This committee needs a member from every area of the center to include housekeeping and a physician.)		
91. Safety Committee Policy and procedures developed. (To include tracking forms for documentation of various safety issues. e.g. floors, exit signs, walls, emergency carts, emergency equipment check lists, etc.)		

		Yes	No
92.	Policies and procedures on cleaning the surgery center.		
93.	Biohazard waste policy and procedure developed.		
94.	Staff inservice on biohazard waste and proper disposal with documentation.		
95.	Biohazard Contact obtained and in contract book.		
96.	Laboratory space identified and has a sink, electrical services, storage cabinet(s) or closet for storage.		
97.	Proper changing area along with restroom available with easy access for patient.		
98.	Anesthesia services approved by the Governing Body and is documented in minutes.		
99.	Policy on who can administer anesthesia developed.		
100.	Anesthesia policies and procedures developed to include but limited to: 1. education 2. training 3. supervision of personnel 4. responsibilities for nonphysician anesthetists 5. responsibilities of supervising physicians 6. use and degree of supplemental local anesthesia.		
101.	Policy and procedure of anesthesia evaluation of a patient prior to a patient going to the OR.		
102.	Policy and procedure developed concerning history and physical prior to surgery being completed.		
103.	Policy and procedure development defining Informed Consent and who is responsible for obtaining Informed Consent.		
104.	List developed of tissue that does not have to be sent to Pathology.		
105.	List of tissue that does not have to be sent to Pathology must be approved by the Governing Body and documented in the minutes.		
106.	Policy and procedure on handling tissue for pathology is developed.		

		Yes	No
107.	Staff inservice on handling tissue is documented.		
108.	Policy and procedure on Op Report dictation developed.		
109.	Physician staff informed of policy and procedure for dictation.		
110.	Policy and procedure on isolation and transfer of a patient identified with a communicable disease after admission.		
111.	Dress code policy and procedure developed for all areas of the ASC.		
112.	Staff inserviced on dress code with documentation.		
113.	Policies and procedures developed concerning sterilization of equipment, supplies, and CQI on sterilization.		
114.	Policy and procedure on use of medications (one time use vials, multi-use vials) IV admixture and pre-filled syringes developed and approved by Governing Body.		
115.	Staff inservice and documentation on use of medication.		
116.	Policy and procedure developed for obtaining blood and blood products.		
117.	Contract with a hospital or a blood bank for obtaining blood and blood products in contract book.		
118.	Staff inservice with documentation on obtaining blood and blood products.		
119.	Emergency power policy and procedure.		
120.	Logs developed for documenting generator test.		
121.	Equipment repair book developed.		
122.	Biomed contract obtained and in Contract Book.		
123.	Biomed certification of equipment in a book.		
124.	Policy and procedure developed describing the care a patient will		

	Yes	No
receive in pre-operatively.		
125. Policy and procedure developed describing the care a patient will receive post-operatively.		
126. Protocols developed for post-operative instructions for patient and family.		
127. License obtained by the State Board of Pharmacy.		
128. Contract for pharmacy consultant and in Contract Book.		
129. Pharmacy Committee developed. Committee to include but not limited to: Administrator, Nurse Manager, Pharmacy Consultant, Anesthesiologist, and a surgeon.		
130. Locked area provided for all drugs.		
131. Narcotic handling policy and procedure developed.		
132. Narcotic forms developed.		
133. CQI developed for all lab equipment calibration and monitoring.		
134. Minimum lab requirements developed.		
135. Minimum lab requirements approved by the Governing Body and documented in minutes.		
136. CLIA certificate obtained and displayed.		
137. Lab contract obtained with a Medicare approved lab.		
138. Policies and procedures for lab obtained at ASC site developed to include but limited to: 1. identifying specimen 2. collections 3. labeling 4. storage 5. transporting of specimen 6. preventive maintenance of equipment used in processing and storing 7. log book (include: patient name, identification number, date of specimen drawn, obtained and sent to lab, lab test ordered, date of final report, condition of specimen.)		
139. Written time criteria developed for lab test prior to surgery. (e.g. test can be no older than 14 days for a local and 7 days for a general)		

		Yes	No
140.	Blood administration policy and procedure developed.		
141.	Policy and procedure developed for handling of frozen sections.		
142.	Policy and procedure on when a path report has to have an original signature or a stamp has been developed.		
143.	Policies and procedures for radiology have been developed. to include but not limited to: 1. procedures for exams performed 2. infection control 3. dress code 4. cleaning of equipment 5. written order for x-ray (order must have consent statement for reason of exam) 6. regulation of use 7. storage of radioactive devices, equipment, 8. precautions against electrical, mechanical, and radiation hazards 9. proper shielding 10. monitoring devices 11. reports for x-rays.		
144.	Governing Body has granted privileges to certain physicians to read and report on their x-rays.		
145.	List of physician specialties that can read their own x-ray.		
146.	Policy and procedure on storage of x-rays taken at the facility.		
147.	Contract with outside x-ray company (if applicable). Must be Medicare certified.		
148.	Laser equipment has been licensed with the state.		
149.	Policies and procedures concerning education to include criteria for publishing material used in ASC.		
150.	Policy and procedure addressing research in the facility.		
151.	A statement to hand to all patients or patient's guardians at admission concerning whom to file a complaint with has been developed and printed for use.		
152.	Developed a process for reporting to the Department of Health the following problems within thirty (30) days of the incident: 1. complications that result in death 2. complications that result in an emergency transfer to a hospital 3. fire or other damage to the ASC.		
153.	Medical Records release of record form developed and approved.		

		Yes	No
154.	Smoking Policy developed and displayed.		
155.	No smoking signs displayed in OR, PACU, other areas with inhalation therapy and storage area of flammable liquids.		
156.	Contract for service and testing of all fire and safety equipment.		
157.	Written fire evacuation plan for patients and staff.		
158.	Fire evacuation floor plan posted in conspicuous places for staff and patients.		
159.	Fire annual training program developed.		
160.	All storage space is 18 inches lower than ceiling or fire sprinkler.		
161.	Combustible liquids are stored in metal cabinet.		
162.	Call system in place and staff inserviced with documentation.		
163.	Waste disposal contract obtained and in Contract Book.		
164.	Watertight and rodent proof garbage containers obtained.		
165.	Access to drinking water for patient family members waiting.		
166.	Linen contract obtained and in Contract Book.		
167.	Policy and procedure for internal laundry of scrubs.		
168.	Proof on file that the cubicle curtains are noncombustible or rendered flame retardant and shows they will pass the large and small scale test of NFPA Standard 701.		
169.	Contract for testing of trace gases in OR obtained and in book.		
170.	Manometer installed across each filter bed.		
171.	Remote monitors for filters located in occupied space.		
172.	Fire Marshall approval letter on file.		
173.	Building Inspection Department approval on file.		

		Yes	No
174.	Fire Alarm Certificate on file.		
175.	Fire Spread documentation for wall coverings, curtains, and drapes on file.		
176.	Radiant Flux Test documentation on file.		
177.	Test certification for medical gas system on file.		
178.	Test/inspection/certification of sprinkler system on file.		
179.	X-ray containment/shielding report on file.		
180.	Complete and notarized TDH Form on file.		
181.	Air filter change log / follow manufacturer recommendation developed.		
182.	Pharmacy contract for consultant obtained and in Contract Book.		
183.	Formulary developed.		
184.	Formulary approved by the Governing Body and documented in minutes.		
185.	CQI program developed to include utilization of drugs and effectiveness of drugs used.		
186.	Forms developed for maintaining records for the pharmacy for both narcotic and non-narcotic drugs.		
187.	Inservice conducted by Pharmacy Consultant with staff and written documentation obtained.		
188.	Fire proof area for all drug records to be kept.		
189.	Pharmacy policies and procedures developed. Shall include but not be limited to the following: 1. controlled substances 2. investigational drugs 3. prepackaging and manufacturing 4. medication errors 5. orders of physician or other practitioner 6. floor stock 7. adverse drug reactions 8. drugs brought into the facility by the patient 9. self-administration 10. emergency drug cart 11. formulary 12. drug storage areas 13. drug samples 14. drug product defect 15. drug		

		Yes	No
	recalls 16. outdated drugs 17. preparation and distribution of IV Admixtures 18. procedures of supplying drugs for post-operative use 19. automatic drug dispensing 20. data processing systems.		
190.	Pharmacy license obtained and displayed.		
191.	Pharmacy is organized and labeled for easy location of drug(s).		
192.	Pharmacy contains a special locked area for schedule II drugs.		
193.	Pharmacy has a special area for poisons and external drugs away from regular drugs.		
194.	Pharmacy library shall include the following: 1. Texas Pharmacy Act and Rules 2. Texas Dangerous Drug Act and Rules 3. Texas Controlled Substance Act and Rules 4. Federal Controlled Substances Act and Rules or official publication describing the requirements of the Federal Controlled Substances Act and Rules 5. American Hospital Formulary Services with current supplements or Facts and Comparisons with Current supplements 6. Handbook on Injectable Drugs 7. basic antidote information 8. telephone numbers of the nearest regional poison control center (posted at key phone areas).		
195.	Formulary developed.		
196.	Formulary approved by the Governing Body of the ASC and documented in minutes.		
197.	Record form developed documenting removal of drug(s) from the pharmacy. Record to include: 1. name of drug 2. quantity removed 3. location drug is being removed to 4. date and time of removal 5. signature of person removing drug 6. all drug withdrawal will be verified by consulting pharmacist within seven days of withdrawal.		
198.	Anaphylactic Shock box developed.		
199.	Malignant Hyperthermia cart developed.		
200.	Inservice for Anaphylactic Shock box completed and documented.		
201.	Inservice for Malignant Hyperthermia Cart completed and documented.		

		Yes	No
202.	Inservice for Crash Cart and defibulator completed and documented.		
203.	Initial inventory of drugs completed by pharmacist and on file.		