

Browse Responses

[Filter Responses](#) [Download Responses](#) [View Summary](#)

Displaying 12 of 12 respondents [« Prev](#) [Next »](#) **Jump To:** 12 [Go »](#)

Respondent Type: Normal Response

Collector: Outpatient Surgical Centers Rulemaking (Web Link)

Custom Value: *empty*

IP Address: 68 156 159 10

Response Started: Monday, February 4, 2013 3:37:36 PM

Response Modified: Monday, February 4, 2013 3:43:15 PM

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

No Response

2. How can the draft rules be improved?

Delete the requirement for physician progress notes to be included in the medical record.

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

Require that at least 1 fire drill occur in an oxygen enriched atmosphere and that a fire risk assessment should be performed for each patient having a surgical procedure

Browse Responses

[Filter Responses](#) [Download Responses](#) [View Summary](#)

Displaying 11 of 12 respondents [« Prev](#) [Next »](#) **Jump To:** [Go »](#)

Respondent Type: Normal Response

Collector: Outpatient Surgical Centers Rulemaking (Web Link)

Custom Value: *empty*

IP Address: 68 156 159 10

Response Started: Monday, February 4, 2013 3:31:19 PM

Response Modified: Monday, February 4, 2013 3:34:25 PM

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

No Response

2 How can the draft rules be improved?

Please provide clarification as to if the H&P can be performed the day of the procedure

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

No Response

Browse Responses

[Filter Responses](#)[Download Responses](#)[View Summary](#)

Displaying 10 of 12 respondents

[« Prev »](#)[Next »](#)

Jump To: 10

[Go »](#)**Respondent Type:** Normal Response**Collector:** Outpatient Surgical Centers Rulemaking (Web Link)**Custom Value:** *empty***IP Address:** 68 156 159 10**Response Started:** Monday, February 4, 2013 12:06:20 PM**Response Modified:** Monday, February 4, 2013 12:07:19 PM**1. What parts of the draft rules do you believe are effective?**

No Response

2. How can the draft rules be improved?

Clearly define what types of surgery/procedures require an RN circulator

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

No Response

Browse Responses

[Filter Responses](#)[Download Responses](#)[View Summary](#)

Displaying 9 of 12 respondents

[« Prev](#)[Next »](#)

Jump To: 9

[Go »](#)**Respondent Type:** Normal Response**Collector:** Outpatient Surgical Centers Rulemaking (Web Link)**Custom Value:** empty**IP Address:** 68 156 159 10**Response Started:** Wednesday, January 30 2013 5:48:55 PM**Response Modified:** Wednesday, January 30, 2013 5:57:29 PM**1. What parts of the draft rules do you believe are effective?****No Response**

2 How can the draft rules be improved?

Concerns regarding R9-10-101 2 -Definitions being deleted? "Circulating nurse" means a licensed nurse who is responsible for the functioning of the operating room during a surgical procedure and who does not directly assist the surgeon. Believe this would lower standard of care provided also R9-10-1076- Ensure that a licensed nurse who does not directly assist the surgeon (Following lined through: "shall function as a circulating nurse during each surgical procedure") is responsible for the functioning of an operating room in which a surgical procedure is performed?" Again, AORN standards of offering the vulnerable patient the highest level of care will be challenge?

3. Has anything been left out that should be in the rules?Refer to above comments please.

Browse Responses

[Filter Responses](#)
[Download Responses](#)
[View Summary](#)

 Displaying 8 of 12 respondents
 [« Prev](#)
[Next »](#)
 Jump To: 8
 [Go »](#)

Respondent Type: Normal Response

Collector: Outpatient Surgical Centers Rulemaking (Web Link)

Custom Value: empty

IP Address: 206 213 43 100

Response Started: Wednesday, January 9, 2013 3:47:43 PM

Response Modified: Wednesday, January 9, 2013 3:49:05 PM

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

Val, As promised, my comments to the rules follow. Always happy to connect, and am even willing to come to ADHS to meet with you on one of the two days you're working. Great seeing you.--Janice Dinner

2 How can the draft rules be improved?

R9-10-1001(2) This is broad enough to include billing services, etc. Revise to add "to address the patient's medical or behavioral health issue." R9-10-1001(4) Delete "immediate." Is a return call within 5 minutes "immediate"? There will be survey issues around this term. Even in the ED, the physician is given 20 minutes or longer to return a call. R9-10-1001(8) and (23) Still don't understand why there is a difference between crisis services and observation/stabilization services. What will OTCs do differently? R9-10-1001(16) See comments to R9-10-1008 (C)(1) A general consent covers much "proposed treatment," including an aspirin for a headache. Mammograms are diagnostic procedures, and a general consent is sufficient. The definition of "informed consent" should be rewritten to delete proposed treatment and add "invasive" diagnostic procedures. R9-10-1001(27) Can we accept a patient representative if the delegation of authority doesn't comply with the requirements for a HCPOA? R9-10-1001(38) Definition of volunteer is too broad. Doctors, PAs, NPs, certain vendors, are not volunteers. How about: "without compensation" from the outpatient treatment center or directly or indirectly from the patient." See R9-10-1008(2): We are not going to verify the skills and knowledge of these individuals every 12 months. There are other requirements as well. R9-10-1003 (B)(3) If the Board will simply rubber stamp policies, why should policies go to the Board at all? How about requiring a Board policy to review and approve policies? The Board can determine who is authorized to review and approve them. R9-10-1003 (E) Why is this expanded beyond children and vulnerable adults? This would require an OTC to report to ADHS if the patient is hit by another patient at the OTC. This is written so broadly that any time a patient made an allegation of abuse, neglect or exploitation to the OTC (while the patient is on premises), an argument could be made that we have to report. We are already required to report certain abuse, neglect, exploitation to the police or CPS/APS. Will the OTC be subject to three investigations for the same allegations? Second R9-10-1009(b)(1)(b) Specify individuals "other than medical practitioners" who may. Second R9-10-1009(b)(1)(c) and that a patient's "known" refusal to take... Second R9-10-1009(b)(4)(b) Add "if known." The patient may leave the OTC before feeling full effects. R9-10-1010(A)(2)(c) OTC staff must walk through waiting area checking hands of all individuals, whether or not a patient???

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

No Response

Browse Responses

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2. How can the draft rules be improved?

The rule regarding physician presence in a surgery center until the patient leaves needs to be reinterpreted to its real intent which "medically discharged". I have seen no instances where a patient was deemed ready for discharge and then required intervention while waiting for a ride. This creates an unnecessary burden for medical professionals and offers no real benefit

3. Has anything been left out that should be in the rules?**No Response**

Browse Responses

Filter Responses

Download Responses

Displaying 6 of 12 respondents

« Prev

Next »

Jump To: 6

Go »

Respondent Type: Normal Response**Collector:** Outpatient Surgical Centers Rulemaking (Web Link)**Custom Value:** empty**IP Address:** 68 231 89 49**Response Started:** Saturday, October 20, 2012 9:01:18 AM**Response Modified:** Saturday, October 20, 2012 9:17:57 AM**1. What parts of the draft rules do you believe are effective?**

The draft rules for R9-10-1709 Surgical Services Requirement part D states": A physician remains on the premises until all patients are discharged from the recovery room." This statement is ambiguous and ineffective.

2. How can the draft rules be improved?

First of all, we as physicians feel that after the required post op evaluation and clearance of the surgical patient that has met the criteria for discharge, the licensed RN is more than able to discharge the patient from the facility without continued presence of the physician. At the very least, the physician is NOT required to remain on premises if the patient is DISCHARGED from the recovery room and is for example waiting for a ride home in the waiting room.

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

I suggest rewording the rules to state "After a physician evaluates the patient post operatively and has determined that the patient is ready for discharge, the physician may leave the facility and the licensed nurse can discharge the patient." At the very least the amended draft rule can stand as written with the added statement of clarification "If a patient is discharged from the recovery room he/she does not need physician supervision if the patient remains on the premises for any other reason (ie. waiting for a ride)

Browse Responses

[Filter Responses](#)[Download Responses](#)[View Summary](#)

Displaying 5 of 12 respondents

[« Prev](#)[Next »](#)

Jump To: 5

[Go »](#)**Respondent Type:** Normal Response**Collector:** Outpatient Surgical Centers Rulemaking (Web Link)**Custom Value:** empty**IP Address:** 70 176 49 36**Response Started:** Monday, September 24, 2012 7:51:31 AM**Response Modified:** Monday, September 24, 2012 8:01:22 AM**1 What parts of the draft rules do you believe are effective?**

Broaden interpretation of the rule that requires a physician must stay within the licensed space once a patient meets discharge criteria and is waiting for a ride.

2 How can the draft rules be improved?

remove the expanded interpretation. If the patient is ready to be discharged to responsible person, they are stables Having an anesthesiologist or physician stay at the facility while a patient is waiting for their ride is not meaningful in providing quality patient care.

3. Has anything been left out that should be in the rules?**No Response**

Browse Responses

[Filter Responses](#) [Download Responses](#) [View Summary](#)Displaying 4 of 12 respondents [« Prev](#) [Next »](#) Jump To: 4 [Go »](#)

Respondent Type: Normal Response

Collector: Outpatient Surgical Centers Rulemaking (Web Link)

Custom Value: *empty*

IP Address: 67 40 81 33

Response Started: Thursday, September 6, 2012 11:27:11 AM

Response Modified: Thursday, September 6, 2012 11:33:03 AM

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

Arizona Administrative Code R9-10-1709 Surgical Services Requirement section D states "A physician shall remain on the premises until all patients are discharged from the recovery room " Interpretation consistent with CMS - a physician must stay until the patient meets discharge criteria and is assessed for proper recovery from anesthesia and the operating surgeon signs a discharge order.

2. How can the draft rules be improved?

The Rule interpretation has been broadened by the AZDHS to state that physician must stay until the patient has left the premises. We have situations in which the patient meets discharge criteria and properly assessed for anesthesia recovery and discharge and the patient's ride is not available. As a result of this Rule interpretation, a physician is required to wait until the ride arrives to pick up the patient. When a patient is ready for discharge based on the criteria and ready for discharge to the care of a responsible person, it does not make sense for a physician to wait at the facility until the ride comes. Furthermore, in most cases 2 PACU RN's are tending to the patient until their ride comes as well. In the event of a medical emergency or complication, the RN's are ACLS certified and able to respond. Physicians are not required to maintain ACLS certification. Of most significance, if the patient is ready to be handed off to a responsible person to continue care, then why would a physician need to stay while waiting for a ride? The broadened interpretation of this Rule has questionable foundation for providing quality patient care. Also, this interpretation of the Rule meets a higher standard than the majority of States and CMS.

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

The Rule is fine as it exist; it's the broadened interpretation that is excessive.

Browse Responses

[Filter Responses](#)[Download Responses](#)

Displaying 3 of 12 respondents

[« Prev](#)[Next »](#)

Jump To: 3

[Go »](#)**Respondent Type:** Normal Response**Collector:** Outpatient Surgical Centers Rulemaking (Web Link)**Custom Value:** empty**IP Address:** 70 190 237 236**Response Started:** Thursday, August 16, 2012 5:05:00 AM**Response Modified:** Thursday, August 16, 2012 5:26:50 AM**1. What parts of the draft rules do you believe are effective?**

The Department of Health Services - Arizona Administrative Code R9-10-1709 Surgical Services Requirement section D states "A physician shall remain on the premises until all patients are discharged from the recovery room " I feel that the interpretation of this rule, specifically that a physician must stay "in house" until a patient is actually leaving the facility, as apposed to remaining until they have clinically recovered from anesthesia places an excessive burden on the facility and the attending anesthesiologist. There are times when a patient's ride is unavailable and therefore the anesthesiologist must stay in the facility until their ride is available. This may be for any number of hours, and to what end? They have recovered from anesthesia and they are simply waiting for a ride home. Their iv is out, they are fully dressed and most likely watching television, passing time until their ride home can finally make it to the facility. And what must the anesthesiologist do? He or she also must wait... and wait... for no real clinical reason at all. If the patient were in fact home already they wouldn't warrant an anesthesiologist to sit with them at home, but in the facility they do. Why? It's simply burdensome and offers no real clinical effect. Bruce Cahill MD

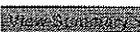
2. How can the draft rules be improved?

This rule's interpretation could be improved simply and effectively, by stating that when a patient is fully recovered and ready to leave the facility that the attending anesthesiologist can then leave the this same facility. Bruce Cahill MD

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

I do not feel so at this time, rather, the interpretation of this rule over reaches, and to no real effect. Bruce Cahill MD

Browse Responses

[Filter Responses](#) [Download Responses](#) Displaying 2 of 12 respondents [« Prev](#) [Next »](#) Jump To: 2 [Go »](#)

Respondent Type: Normal Response

Collector: Outpatient Surgical Centers Rulemaking (Web Link)

Custom Value: *empty*

IP Address: 72.222.183.210

Response Started: Saturday August 11, 2012 10:43:16 AM

Response Modified: Saturday, August 11, 2012 11:14:27 AM

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

As a Medical Director of an ASC, I believe the need to have a physician present during the patient's recovery is important. However, once the patient is eligible for discharge, there is no need to have a physician present. This creates problems when the patient's transportation home is delayed and the physician is needed elsewhere.

2. How can the draft rules be improved?

There should be language that describes when a physician's presence due to medical necessity is no longer needed. The current wording can be interpreted too broadly. It could read: "An administrator shall ensure that a physician remains on the premises until all patients are ELIGIBLE FOR DISCHARGE from the recovery room." This allows the physician to leave the premises when there is no longer a medical indication to be there.

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

The above comment would resolve my concerns and the concerns of most ASC directors. It appears that there should be a reinterpretation of AZ Administrative Code R9-10-1709 Section D, until the moratorium is lifted.

Browse Responses

[Filter Responses](#) [Download Responses](#) 

Displaying 1 of 12 respondents [« Prev](#) [Next »](#) Jump To: 1 [Go »](#)

Respondent Type: Normal Response

Collector: Outpatient Surgical Centers Rulemaking (Web Link)

Custom Value: *empty*

IP Address: 159.36.0.199

Response Started: Tuesday, May 29, 2012 10:57:17 AM

Response Modified: Tuesday, May 29, 2012 10:57:28 AM

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

test

2. How can the draft rules be improved?

No Response

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

No Response
