GUAM MEMORIAL HOSPITAL AUTHORITY

REVIEW AND ENDORSEMENT CERTIFICATION

The signatories on this document acknowledge that they have reviewed and approved the following:

[ ] Bylaws Submitted by Department/Committee: Materials Management

[ ] Rules & Regulations: Policy No: A-LD1320

[X] Polices and Procedures Title: PRODUCT STANDARDIZATION EVALUATION COMMITTEE

Reviewed/Endorsed Title	Date 6/19/14	Signature Dolores F. Pangelinan Assistant Supply Management Administrator, Acting
Reviewed/Endorsed Title	Date 6/19/14	Signature Dolores F. Pangelinan Chairperson, Standardization Committee, Acting
Reviewed/Endorsed Title	Date 8/5/14	Signature Joseph P. Verga, MS, FACHE Chairman, Executive Management Council
Reviewed/Endorsed Title	Date ~~6.24.14~~ 8.1.2014	Signature Joygemma Villaruel Chairperson, Patient Safety Committee
Reviewed/Endorsed Title	Date 6/20/14	Signature Gordon T. Mizusawa Chairperson, Environment of Care
Reviewed/Endorsed Title	Date	Signature
Reviewed/Endorsed Title	Date	Signature

GUAM MEMORIAL HOSPITAL AUTHORITY
ADMINISTRATIVE MANUAL

APPROVED BY:	RESPONSIBILITY:	EFFECTIVEDATE	POLICY NO.	PAGE
Joseph P. Verga, Hospital Administrator, CEO	Materials Management	6/1/92	A-LD1320	1 of 14
TITLE: PRODUCT STANDARDIZATION EVALUATION COMMITTEE				
LAST REVIEWED/REVISED: 6/2009, 3/12, 6/14				
ENDORSED: SE&SC __/____,PSC__/____, EOC__/____, EMC ____				

PURPOSE:

To evaluate and standardize the use of supplies and equipment within the Hospital with emphasis on the quality of care and the containment of cost.

POLICY:

The Committee identifies and selects products and equipment for use in Guam Memorial Hospital Authority (GMHA).

The hospital has an established Product Standardization Evaluation Committee (PSEC) in an effort to reduce costs, standardize and improve materials used, and evaluate current products for quality and cost effectiveness.

COMMITTEE RESPONSIBILITIES:

I. STANDARDIZATION COMMITTEE

A. The Standardization Committee consists of:

1. Hospital Materials Management Administrator, Chairperson
2 Inventory Management Officer
3. Nursing Administrator
4. Operating Room, Unit Supervisor
5. Infection Control Practitioner
6. Medical Director
7. Facilities Maintenance Manager or Designee
8. Central Supply & Receiving Supervisor
9. Buyer Supervisor
10 Patient Safety Committee Chair
11. Guest members (as items pertain to their area)

B. The PSEC is chaired by the Hospital Materials Management Administrator. The committee will meet a minimum of four (4) times a year (quarterly) to review hospital products and equipment. The committee has the authority to approve or reject products. Actual distributor selection is the responsibility of the Hospital Materials Management Administrator based on negotiations.

C. The PSEC reviews products at each meeting. Generally the department or a staff member requesting evaluation of a product will present it to the committee. The committee will also do a follow-up on surveys of selected products and equipment to validate decisions.

D. COMMITTEE COMMUNICATIONS

a. The committee will communicate the following:

1. Decisions and/or actions of the committee to departments requesting an evaluation of a product.
2. Distribution of minutes to department directors will be available upon request.
3. Results of follow-up surveys validating committee decisions.

b. The Chairperson is responsible for preparing the agenda, chairing the meetings, disseminating minutes and publishing results that affect hospital departments and staff members.

c. Appeal - Any appeals regarding product selection will be addressed to the Hospital Administrator/CEO.

II. II. EVALUATION OF NEW PRODUCTS AND EQUIPMENT

A. All potential products (either for use or evaluation) must be submitted to the Materials Management Department by physicians, hospital personnel, patients, and others for evaluation and approval by the PSEC **prior to purchase**.

1. Submissions shall be in writing with clearance from the appropriate Department Head with any required recommendations from Medical Staff Committees or the Fixed Assets Office located at Materials Receiving Department. The "Equipment Request / Evaluation Form" ***(Attachment II)*** shall be completed for new equipment. The "Product Request / Evaluation Form" ***(Attachment III)*** shall be completed for new products.

2. All product samples shall be in the form of actual products or product literature.

B. Materials Management will initially screen all items before submitting them to the PSEC.

This screening will include a review of items currently being used, existing stock on hand, and utilization rates.

C. Materials Management personnel will contact the concerned department for their recommendations and comments before the item is brought to the PSEC for review.

D. A product standardization profile is prepared for each item to be reviewed. The profile of each item is distributed to each committee member prior to the meeting. ***(Attachment I)***

E. An agenda is prepared and distributed at least one week prior to the next committee meeting.

F. The PSEC shall meet at least quarterly.

G. If the requesting department is not represented on the committee, then it may send a representative to present the item. This representative may not vote.

H. Possible committee actions are:

1. Acceptance of the product
2. Non-acceptance of the product
3. A 30-day evaluation
4. A 60-day evaluation
5. A 90-day evaluation

Actions are recorded on the "Product Standardization Committee Action Form" ***(Attachment I)***, as well as on the appropriate Request / Evaluation Form.

I. Once an item has been reviewed and rejected, the product will not be evaluated by the Committee for at least a year.

J. The end-users will be responsible to include the required utilization quantities and the required training or orientation procedure to the Committee for review. If the new product or supply is accepted for purchased, the end-user department supervisor or designee must ensure the proper training or orientation are completed prior to use. (See Section 7 & 8 on ***Attachment II & III*** forms).

K. All approved items shall be submitted to the Chief Financial Officer for a charge code and fee approval by the Guam Administrative Adjudication Act if required. This will be done before the item is received or used by the GMHA.

Fees shall be established in accordance with the Hospital's rate setting model.

L. The minutes of all Committee meetings must be sent to the Hospital Administrator/CEO or his/her designee before any actions is taken. The "Product Standardization Evaluation Committee Action Form" ***(Attachment I)***, is to be submitted to the Hospital Administrator/CEO for approval before a product is ordered. If Administration does not approve the stated action(s), this is communicated back to the Committee and the item(s) are not purchased.

Exceptions: All items must undergo the above procedure with one exception. If the product is requested on an emergency basis and is not the qualified product, it may be purchased or borrowed in limited quantities that will be determined by the end users department supervisor or designee. The department supervisor will be responsible to advise if any training or other information is required before use. However, this item and action will be reviewed at the next Committee meeting.

New items to be purchased as replacement items will be put into use only after existing stock inventories have been depleted so as to minimize any wasted supplies and losses.

III. SUPPLY OR EQUIPMENT EVALUATION

The following criteria will be used by the Committee to determine the acceptance of a supply:

a. These criteria measure the service-related aspects of product vendors:

i. Availability – The product is readily available and does not require back order.
ii. Waiting time for delivery – The length of time required for delivery from the date of purchase.
iii. In-service/training support - The availability of quality in-service support from the manufacturer.
iv. Servicing and repair – The availability of adequate service and repair for reasonable maintenance.

b. COMPARISON GUIDELINES– The following provide the basis for comparison:

i. Hospital user reviews – Information from other hospital who use the product, are made available for reference.
ii. Competitive product comparison – The product is competitive in the market.
iii. Independent / company studies – Independent studies are available to support the products on the market.
iv. Impact of recommendations and approval – Preferences from end users of the product are indicated.

v. Special considerations - for special product are warranted.
vi. At the end of the trial evaluation period, a written report summarizing the results of the questionnaire is submitted to the Chairperson of the Committee.

IV. DELETIONS TO SLOW MOVING ITEMS

A list will be established by the Inventory Management Officer (IMO) and shall be submitted to the Hospital Materials Management Administrator for review and for distribution to the departments, units and wards for their review. Departments will confirm that the items are no longer required and can be deleted from the stock inventory.

A final list is then presented to the PSEC for review, approval or disapproval.

RESCISSION(S):

Policy 4.35 – *PRODUCTSTANDARDIZATION COMMITTEE,* GMHA Materials Management Policy and Procedure Manual, Effective 09/2001, last reviewed/revised 06/2009

Policy 4:36 – *PRODUCTS REVIEW COMMITTEE,* GMHA Materials Management Policy and Procedure Manual Effective 9/01, last reviewed/revised 06/2009

ATTACHMENT(S):

I. **PRODUCT STANDARDIZATION COMMITTEE ACTION FORM**
II. **EQUIPMENT REQUEST / EVALUATION FORM**
III. **SUPPLY REQUEST / EVALUATION FORM**

ATTACHMENT I

Product Standardization Evaluation Committee Action Form

PRODUCT STANDARDIZATION EVALUATION PROFILE

Date: _____ Hospital Product Number: _____

Request Product: _____

Manufacturer: _____

Supplied By: _____

Requested By: _____

Requested Item will:

[ ] Be an additional item

[ ] Replaces: _____

[ ] Reduces use of another item: _____

[ ] Other: _____

Product Comparisons:

Characteristics	Present Item	Request Item
Manufacturer		
Supplier		
Annual Use		
Use and / or Evaluation Results		
Availability		
Patient Charge		
Package Data		
Hospital Stock Item		
Minimum Order Quantity		
Advantages		
Disadvantages		
Quantity of Hand		
Cost Per Unit		
Net Savings or Loss		
Other		

Standardization Committee Action:

[ ] Accepted

[ ] Not Approved

[ ] Approved for 30 Days Evaluation

[ ] Approved for 60 Days Evaluation

[ ] Approved for 90 Days Evaluation

[ ] Tabled Pending Further Information

[ ] Other: _____

Additional Comments:

_____

_____

_____

_____

Date: _____

Signature of Chairperson: _____

Administration:

[ ] Approved

[ ] Not Approved

_____ _____

Hospital Administrator/CEO Date

ATTACHMENT II

Guam Memorial Hospital Authority
Tamuning, Guam 96931

EQUIPMENT REQUEST / EVALUATION FORM

Committee's Use Only		
Complete	Incomplete	N/A

PART I (To be completed by the Requesting Department)

1. Is the requested item a Planned Purchase? ☐ Yes ☐ No

2. The item is a: ☐ REPLACEMENT ☐ NEW/ADDITION

If a replacement:

a. What are you replacing? _____

_____

(Be specific include: Name, Model, Manufacturer)

b. Please give reasons for replacement:

☐ life Expectancy ☐ Efficiency of Repairs:
Cost of Labor: _____ Cost of Parts: _____

☐ Other: _____
(Be specific)

If New/Addition:

a. Does this equipment involve a new service? ☐ Yes ☐ No
If yes, please specify: _____

b. Has this new service been approved by the Board of Trustees? ☐ Yes ☐ No

c. Specify the space identified for the new/addition. _____

d. Specify the cost for the new item. $_____

e. Does this purchase change any existing fees? ☐ Yes ☐ No
If yes, please specify the service code fee(s) _____

f . Does this purchase introduce a new fee? ☐ Yes ☐ No
If yes, please advise the Comptroller's Office. A copy of this form will be routed to the Comptroller's Office if the purchase is approved.

g. What is the lead time for the equipment delivery?

_____ days/weeks/months (Indicate quantity and Circle one unit of time)

h. Please give reasons for new / additional item.

☐ Increase in services
☐ Improved efficiency and/or capabilities of new item
☐ Increases compliance with safety standards
☐ Other (Be specific): _____

Please discuss any special requirements or needs of your department that would be addressed by this item.

_____

_____

Page 2 of 3 (PART I)

EQUIPMENT REQUEST / EVALUATION FORM

	Committees Use Only		
	Complete	Incomplete	N/A

3. Nomenclature:
   Type of Equipment: _____
   Model: _____
   Manufacturer: _____
   Please attach a copy of the equipment specifications.

4. Life expectancy of the equipment: _____

5. a. Is the item UL listed? ☐ Yes ☐ No
   b. If no, then explain why the equipment is not UL listed:
   _____
   _____
   Please note that ifthere is no explanation as to why equipment is not UL listed, then the equipment is disapproved.

6. Is the item ☐ Fixed or ☐ Portable

7. What is the frequency of usage? ☐ Monthly ☐ Weekly ☐ Daily

8. Please specify training requirements:
   a. For User: ☐ On-site by ☐ Vendor ☐ GMHA personnel
   ☐ Off-Island
   # to be trained _____ # of training hours _____
   ☐ Please check if training will provide for clinical competence
   b. For Maintenance: ☐ On-site by ☐ Vendor ☐ GMHA personnel
   ☐ Off-Island
   # to be trained _____ # of training hours _____
   c. Trainer's certification and experience in the field will be provided by: _____
   _____

9. a. Are equipment accessories available? ☐ Yes ☐ No
   b. Are accessories included as part of the equipment purchase? ☐ Yes ☐ No
   If yes, please attach list of accessories.
   c. Please specify if accessories are: ☐ Reusable ☐ Disposable
   d. Is the vendor / manufacturer's representative on island? ☐ Yes ☐ No
   e. Is the item currently in use by any other healthcare provider on island? ☐ Yes ☐ No
   If yes, please list the organization and a contact person with experience in using the item.
   _____
   _____
   _____

10. Please indicate if technical expertise is available for
   ☐ User
   ☐ GMHA Personnel
   ☐ Vendor
   Please list Name(s), Department / Company
   _____
   _____

   ☐ Maintenance
   ☐ GMHA Personnel
   ☐ Vendor
   Please list Name(s), Department / Company
   _____
   _____

Submitted By: _____ _____
NAME / JOB TITLE DATE

Page 3 of 3 (Part II)

EQUIPMENT REQUEST / EVALUATION FORM

PART II (To be completed by the Product & Equipment Standardization Committee)

1. If the requested equipment is a Replacement,
   a. Who will remove the existing item? ☐ GMHA Personnel ☐ Contractor ☐ Other: _____
   b. Who will install replacement item? ☐ GMHA Personnel ☐ Contractor ☐ Other: _____
   c. Are site preparation / modification required? ☐ Yes ☐ No
      If yes, who will perform site preparation / Modification?
      ☐ GMHA Personnel ☐ Contractor ☐ Other: _____
   d. Who will provide as-built drawings? ☐ GMHA Personnel ☐ Contractor ☐ Other: _____

2. If the requested equipment in New / Addition,
   a. Specify the space for ☐ new / addition. GMHA ☐ Personnel ☐ Contractor Other
   b. Who will install new / addition ☐ GMHA Personnel ☐ Contractor ☐ Other
   c. Is site preparation / modification required? ☐ Yes ☐ No
      If yes, who will perform site preparation / modification? ☐ GMHA Personnel ☐ Contractor ☐ Other

3. Nomenclature:
   Voltage _____
   (Acceptable Range: 110 – 480)

   Hertz _____
   (Acceptable Range: 50 / 60 cycles)

   Steam Requirements_____
   Hot Water Required?_____
   Cold Water Required?_____
   Medical Gas Required?_____
   (Please specify)

4. Please indicate if the item is in compliance with any of the following:
   ☐ GEPA (Permit required)
      ☐ Installation
      ☐ Storage
      ☐ Disposal of Waste
   ☐ Guam OSHA (MSDS required)
   ☐ The Joint Commission (TJC)
   ☐ Life Safety Code
   ☐ The Food and Drug Administration (FDA)

REVIEWED BY:

_____ _____
NAME DATE

COMMITTEE ACTION:

☐ Recommended for APPROVAL
☐ Recommended for APPROVAL with QUALIFCATION
_____
_____
Recommended for DISAPPROVAL

_____ _____
Chairperson, DATE
Product / Equipment Standardization Committee

☐ APPROVED ☐ DISAPPROVED BY:

\

_____
HOSPITAL ADMINISTRATOR

_____
DATE

ATTACHMENT III

Guam Memorial Hospital Authority
Tamuning, Guam 96931

SUPPLIESREQUEST / EVALUATION FORM

	Committee's Use Only		
	Complete	Incomplete	N/A
PART I (To be completed by the Requesting Department)			
1. GENERAL DATE: Please attach a copy of the product specification, materials safety data sheet, brochures / descriptive literatures and any other special instructions regarding shipping, handling and storage for this item.			
a. Item Name:			
b. Catalog / Model #:			
c. Manufacturer:			
d. Vendor(s):			
e. Basic Use:			
f. Disposable? ☐ Yes ☐ No			
g. Autoclavable? ☐ Yes ☐ No If yes, which method? ☐ Steam ☐ Gas ☐ Cold			
2. Is the requested item a Planned Purchase? ☐ Yes ☐ No			
3. Is the item: ☐ REPLACEMENT ☐ NEW / ADDITION			
a. <u>If a REPLACEMENT</u>: 1) What are you replacing? _____ _____ _____ (Provide Stock Number, Nomenclature, Catalog Number, Manufacturer, etc.)			
2) Please give reasons for replacement: ☐ Product Recall, unsafe to use ☐ Product incompatible to new equipment ☐ Product no longer manufactured ☐ Other: _____ (Be Specific) ☐ Product complaint Product Name: _____ Product Manufacturer: _____ Problem: _____ _____			
b. <u>If NEW / ADDITION</u>: 1) Does this product involve a new charge / fee? ☐ Yes ☐ No If yes, please specify: _____ _____			

Page 2 of 5 (Part I) **SUPPLIES REQUEST / EVALUATION FORM**	Committees Use Only		
	Complete	Incomplete	N/A
2) Specify the space, storage, refrigeration needs for the new / additional product. _____ _____ _____			
3) Specify the cost for the new item. $_____			
4) What is the lead time for the product delivery? _____ days / weeks / months (indicate quantity and circle one unit of time).			
5) Please give reasons for new / additional item. ☐ Increase in service as result of new equipment purchase ☐ Improved efficiency and / or capabilities of new item ☐ Increased compliance with safety standards ☐ Other (be specific) _____			
6) Please discuss any special requirement or needs of your department that would be addressed by this item. _____ _____ _____			
7) A. What is the unit of measure? , i.e. each, case, box, bundle, pieces, etc. Case of 10 ea. Box of 25 ea., etc: :_____ B. What is the frequency of usage? Annual, Monthly, Semi-Annual, Weekly ,_____			
8) Please specify training requirement. a. <u>For Operations</u>: Training will be provide by: _____ ☐ On-Site by: _____ ☐ Vendor ☐ GMHA Personnel ☐ Off-Island (as a result of new equipment purchase)			

Page 3 of 5 (Part I) **SUPPLIESREQUEST / EVALUATION FORM**	**Committee's Use Only**		
	Complete	Incomplete	N/A
b. For Maintenance: Training will be provide by: _____ ☐ On-Site by: _____ ☐ Vendor ☐ GMHA Personnel ☐ Off-Island (as a result of new equipment purchase)			
9) Is the vendor / manufacturer's representative on-island? ☐ Yes ☐ No			
10) Is the item currently is use by any other healthcare provider on island? ☐ Yes ☐ No If yes, please list the organization and contact person with experience in using the item. _____ _____ _____			
4. Submitted By: _____ _____ NAME / POSITION TITLE DATE			

SUPPLIES REQUEST / EVALUATION FORM

PART II (To be completed by the Supplies& Equipment Standardization Committee)

1. STORAGE AND CONTROL DATA:

Shipping unit _____ Dispensing unit _____

(for stock only)

☐ Replacing currently used ☐ New item

☐ Stock item ☐ Direct

☐ Single department use
Name of department: _____

☐ Multi-department use
Name of departments: _____

a. If the requested product is a Replacement,

1) Disposability of new product:

☐ Incineration ☐ Ordinary Trash

☐ Other: _____
(Specify)

2) What is the disposition of the old product?

☐ Destroy / Discard ☐ Use until exhausted

☐ Survey / Donate ☐ Keep as back up

2. ELECTRICAL / MECHANICAL DATA:

a. Does this item meet OSHA and UL requirements? ☐ Yes ☐ No

Problems: _____

b. Is this item compatible with current institutional systems? ☐ Yes ☐ No

Modifications necessary: _____

_____

c. Is the item FDA approved? ☐ Yes ☐ No

If no, then explain why the item is not FDA approved.

_____

_____

Please note that if there is no explanation as to why item is not FDA approved, the product is disapproved.

Page 5 of 5 (Part II)

SUPPLIESREQUEST / EVALUATION FORM

3. FINANCIAL DATA:

a) What is the item's unit cost? $_____

b) What is the support supply cost(s)?

Labor costs _____
(reprocessing)
Hours @ x _____

Total $_____ per unit of use

c) Is this item chargeable? ☐ Yes ☐ No

If yes, Patient Charge will be $ _____

REVIEWED BY RISK MANAGER:

_____ _____
Signature Date

COMMENTS: _____

_____

COMMITTEE ACTION:

☐ Recommended for APPROVAL

☐ Stock Item Stock Number Assigned _____

☐ Recommended for APPROVAL with QUALIFICATIONS

_____

_____

☐ Recommended for DISAPPROVAL

_____ _____
Chairperson, Date
Supplies/ Equipment Standardization Committee

☐ APPROVED ☐ DISAPROVED

_____ _____
HOSPITAL ADMINISTRATOR/CEO Date