MEDICAL ARTS SURGERY CENTERS **NATIONAL PATIENT SAFETY GOALS** **2009**

Note: Items in bold are new or revised Goals

GOAL/MEASURE(S)	MEASUREMENT(S) (Responsible Party for Reporting)	Who	What	When	Where	Why	How
1. Improve the accuracy in patient identification							
01.01.01 Use at least two patient identifiers whenever confirming patient identity for testing, administering medications/ blood products, or providing any other treatments or procedures, throughout the organization.	1. Random observation of practice (MASC) 2. Random audit of patient records for documentation (MASC & QM)	All staff with direct patient contact	Identify patient by name and birth date	Every time the patient's care is passed to another member of the staff	At all stages in the process; scheduling to post discharge follow-up	To ensure that the correct patient is having the correct procedure	Ask the patient/family member to say their name and confirm their DOB
01.03.01 Eliminate transfusion errors related to patient misidentification	1. Random observation of practice (MASC) 2. Random audit of patient records for documentation (MASC & QM)	All members of the surgical team	Verify that it is the correct patient	Prior to transfusion	At any stage in the perioperative process	To ensure that the correct patient is receiving the correct blood/ blood product	Perform verification process with another RN or an MD
2. Improve the effectiveness of communication among caregivers							
02.01.01 Adherence to verbal order/ telephone order policy.	Random audit of records to insure compliance with policy for "read-back" and sign off of these orders. (MASC & QM)	All staff will adhere to BOS Policy # 1005.07	Properly receive and relay verbal/ telephone orders	Each time a verbal/tele-phone order is necessary.	At any stage in the perioper-ative process	To ensure the accuracy and appropriate-ness of the orders	By performing a "read-back" at the time the order is taken/given, and, documenting it
02.02.01 Adherence to the standard-ized list of **do not use** abbreviations, acronyms and symbols throughout the organization	Random audit of patient records for documentation (MASC & QM)	All staff who enter informa-tion into the medical record	All staff will refrain from using items on the DNU list	Whenever documentation is entered	At any stage in the perioperative process	To ensure correct interpretation of documentation/ orders	By not using unapproved abbreviations
02.03.01 Measure, assess and, if appropriate, take action to improve the timeliness of reporting, and the timeliness of receipt by the responsible licensed caregiver, of critical test results and values.	1. Random audit of records to insure compliance with policy for reporting critical test results and values. (MASC) 2. Logging calls/ notification regarding critical test results with "read-back" verification. (MASC)	All staff who receive test results	Report all critical and/or abnormal results to appropriate physicians	Whenever critical and/or abnormal results are received	At any stage in the perioperative process	To ensure appropriate action and timely intervention occurs	By notifying the appropriate MD/staff of critical/abnormal values
02.05.01 Implement a standardized approach to "hand off" communi-cations, including an opportunity to ask and respond to questions. Use the SBAR template	1. Random observation of practice (MASC) 2. Random audit of patient records for documentation (MASC & QM)	All staff with direct patient contact	Identify patient per policy and give/receive complete report	Every time the patient's care is passed to another staff member	At all stages in the process; scheduling to post discharge	To ensure accuracy of information and prevent errors	Give/receive a **brief** and accu-rate report using the SBAR and document same
3. Improve the safety of using medications							
03.03.01 Identify and, at a minimum, annually review a list of look-alike/sound-alike drugs used in the organization, and take action to prevent errors involving the interchange of these drugs.	1. P&T Committee process for reviewing formulary (MASC P&T Committee) 2. Review of incident reports/ medication error reporting (Risk & QM)	BOS Pharmacy Services and designated staff	Review all medications and dosages kept in the department.	**At least annually**	In the peri-operative area	To ensure safe medication administration	Review and revise the Formulary and implement processes for med safety
03.04.01 Adherence to the standard of labeling all medications, or other solutions, that are placed in a syringe, cup, etc., on or off the sterile field in perioperative and other settings.	1. Random observation of practice (MASC) 2. Review of incident reports/ medication error reporting (Risk & QM)	All staff handling medications	Label **all** containers holding medications	Whenever medications are used	At any stage in the perioper-ative process	To ensure safe medication administration	By labeling **all** containers: syringes, cups, basins, aseptos, etc.

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03.05.01 Reduce the risk of patient harm with anticoagulation therapy. This does not include patients given short term DVT prophylaxis, only patients on long term therapy where there is risk for adverse outcome.	1. Random audit of patient records for documentation (MASC & QM) 2. Review of incident reports(Risk & QM)	Physicians and staff along the continuum of the visit from Pre-Assessment thru Intra-Op	Confirm that patients have been instructed to discontinue anticoagulants as appropriate to the procedure scheduled	**Every patient will be screened for these meds during Pre-Assessment, Pre-Op, Anesthesia, and Intra-Op Medication Reconciliation Process**	Documentation of these meds will be done on the appropriate forms, with information re: instructions from ordering MD, and last dose taken	To prevent or mitigate adverse events such as excessive bleeding and other complications of the procedure, or, to prevent the unnecessary stoppage of long term therapy	Confirm and document that patients have been given the appropriate instructions re: anticoagulants and the scheduled procedure.
7. Reduce the risk of health care-associated infections.							
07.01.01 Comply with current **World Health Organization (WHO) Hand Hygiene Guidelines** Centers for Disease Control and Prevention (CDC) hand hygiene guidelines.	Random observation of practice (MASC) and observation during Surveillance Rounds (Inf Cntrl)	All staff, LIPs	Wash and/or disinfect hands for 15 seconds.	Between each patient contact	Sinks or handwashing stations in the clinical area	To prevent HCAIs	Per policy
07.02.01 Manage as sentinel events all identified cases of unanticipated death or major permanent loss of function associated with a health care-associated infection.	Sentinel Events will be handled per organization-wide policy # 130.01	Staff involved in the incident, Manager, Risk and PI	Perform Root Cause Analysis	Within 45 days of occurrence	In the Center	To determine causal effects and improve practice	Per BHSF policies
07.04.01 Implement best practices/evidence-based guidelines to prevent central line-associated infections. **Educate staff re: same** **Education of patients/families** **(Full implementation 1/1/10)**	1. Random audit of patient records for documentation (MASC & QM) 2. Review of MD Infection Control Surveillance reports (Inf Ctrl)	Staff caring for any patient who has a central line (in-dwelling or being placed at MASC)	Appropriately care for the line. Educate patient/ family re: proper care of the site	Every time we have a patient with a central line	At all stages of the peri-operative process	To prevent adverse outcome/ infection	Adhere to all policies/protocols related to central lines/ infection control
07.05.01 Implement best practices for preventing surgical site infection. **Educate staff re: same** **Education of patients/families** **(Full implementation 1/1/10)**	1. Random observation of practice (MASC) 2. Random audit of patient records for documentation (MASC & QM)	All Staff, LIPs	All Staff adhere to Infection Control policies Educate patient/ family re: proper care of wound/ dressing	At all times	At all stages of the peri-operative process	To prevent adverse outcome/ infection	Adhere to all policies/protocols related to infection control
8. Accurately and completely reconcile medications across the continuum of care							
08.01.01 Implement a process for obtaining and documenting a complete list of the patient's current meds upon the patient's entry to the organization and with the involvement of the patient. This process includes a comparison of the meds the organization provides to those on the list.	Random audit of patient records for documentation (MASC and QM)	All staff assessing and documenting care in the patient's record	Document medications the patient is on pre-surgery, meds given during the visit, and those prescribed at discharge	During pre-surgery and pre-op assessment, when meds are administered and at discharge	At all stages of the peri-operative process	To prevent errors in medication administration and to avoid adverse drug interactions	By compiling an accurate list and updating it as appropriate

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08.02.01 A complete list of the patient's medications is communi-cated to the next provider of service when it refers or transfers a patient to another setting, service, practitioner or level of care within or outside the organization.	Random audit of patient records for documentation (MASC and QM)	All staff assessing and documenting care in the patient's record	Document and report meds the patient is on pre-surgery, meds given during the visit, and those pre-scribed at discharge	At each "hand-off" of the patient to the next caregiver	At all stages of the peri-operative process	To prevent errors in medication administration and to avoid adverse drug interactions	By compiling an accurate list, updating it as appropriate, and accurately reporting during "hand-off"
08.03.01 A complete list of the medications is also provided to the patient on discharge from the facility. **Patient/family is reminded to discard old/outdated lists.**	Random audit of patient records for documentation (MASC and QM)	Staff discharging the patient	Supply the patient with a copy of their home meds and those new medications prescribed by the physician.	At discharge from MASC	In PACU	To reconcile medications across the continuum and assist the patient in adhering to postop instructions	By providing the patient with the proper document
08.04.01 In settings where medications are used minimally, or prescribed for short duration, modified medication reconciliation processes are performed.	Random audit of patient records for documentation (MASC and QM)	Staff/LIPs	Reconcile medications	Throughout the visit	At all stages of the peri-operative process	To prevent med errors and adverse drug reactions	By reviewing and documenting on the Medication Record/ MD Progress Note
11. Reduce the risk of surgical fires							
11.01.01 Educate staff, including operating licensed independent practitioners and anesthesia providers, on how to control heat sources and manage fuels, and establish guidelines to minimize oxygen concentration under drapes.	In-service of all staff and L.I.P.'s working in the Center, as well as orientation to the department of all volunteers, vendors, and individuals performing equipment repair and/or maintenance, will be done per departmental and organizational policies.	Everyone	Learns and incorporates the rules of fire safety into their daily routines	Whenever they are at the Center	Anywhere in the facility	To prevent fires, especially in the perioperative setting	By following the rules of fire safety into their daily routines
13. Encourage patients' active involvement in their own care as a patient safety strategy.							
13.01.01 Define and communicate the means for patients and their families to report concerns about safety and encourage them to do so. **Patient/family education re: safety (e.g. site marking, verification process, time-out), infection prevention, etc.**	Random audit of patient records for documentation that the information was relayed to the patient/family. (MASC and QM)	Everyone	Educate and support the patient/family in voicing and reporting concerns about the patient's care and safety.	Whenever they are at the Center and to know there are ways to report this after they have left the Center	Anywhere in the facility that the question may be posed.	To provide the patient/family with access to a reporting mech-anism and to assure the patient/family that quality care and safety are a priority.	By providing the information to patients/ families, and by assisting them in the reporting process.

See Next Page for Universal Protocol

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Universal Protocol: The organization meets the expectations of the Universal Protocol.							
UP.01.01.01 Conduct a pre-procedural verification process	1. Random observation of practice (MASC) 2. Random audit of patient records for documentation (MASC & QM)	Everyone	Adhere to verification policy prior to any intervention Documentation of verification	Prior to any intervention (Block, Prep, Medications, etc.)	At all stages of the peri-operative process	To ensure that the correct patient is having the correct procedure at the correct site	Stop and verbally confirm that the site, the consent, and the patient are correct.
UP.01.02.01 Mark the procedure site	1. Random observation of practice (MASC) 2. Random audit of patient records for documentation (MASC & QM)	Physician performing the procedure	Physician marks site RN documents marking on Pre-Op Assessment	Prior to the procedure	In the Pre-Op Suite	To ensure that the correct patient is having the correct procedure at the correct site	Stop and verbally confirm that the site being marked, the consent, and the patient are correct.
UP.01.03.01 A time-out is performed immediately prior to starting procedures. To include: • **Correct patient,** • **Correct side,** • **Correct site, with marking visible,** • **Consent is correct,** • **Position of the patient is appropriate,** • **Films, implants, equipment are available and not expired** • **Antibiotic prophylaxis has been given according to standards** • **Medication reconciliation** • **All are in agreement before the procedure begins**	1. Random observation of practice 1 case/day (MASC) 2. Random audit of patient records for documentation (MASC & QM)	All members of the team	Stop and verify all requirements of the Time Out process Document on the OR Record	Just prior to incision/start of procedure	In the OR	To ensure that the correct patient is having the correct procedure at the correct site	Stop and verbally confirm that the site marked, the consent, and the patient are correct.

Source: Medical Arts Surgery Centers, Miami.