Firestone-Callahan & Associates

Industry Partners for Patient Safety

Professional Healthcare Associations
Patient Safety Initiatives

Prepared
By

Firestone-Callahan & Associates

Firestone-Callahan & Associates

Healthcare Associations Patient Safety Initiatives
Table of Contents

Council on Surgical & Perioperative Safety (CSPS)	3
Association of Surgical Technologists (AST)	7
American College of Surgeons (ACS)	11
American Society for Anesthesiologists (ASA)	14
Association of periOperative Registered Nurses (AORN)	16
American Society of Peri-Anesthesiologists Nurses (ASPAN)	21
American Association of Surgical Physician Assistants (AASPA)	26
American Association of Nurse Anesthetists (AANA)	27
Centers for Medicare & Medicaid Services (CMS)	29
Joint Commission on the Accreditation of Hospital Organizations (JCAHO)	31
Institute for Health Improvement (IHI)	33
Association of Academic Health Centers (AAHC)	36
Det Norske Veritas (DNV)	38
Association for Professionals in Infection Control and Epidemiology (APIC)	41
The Leapfrog Group	44
American Society for Association for Healthcare Risk Managers (ASHRM)	47
American Association of Resource Materials Managers (AHRMM)	49

Firestone-Callahan & Associates

Council on Surgical & Perioperative Safety (CSPS)

633 N Saint Clair St.
Chicago, IL 60611
www.cspsteam.org

Phone: 312-202-5700
Fax: 312-202-5016
E-mail:info@cspsteam.org

Overview

The Council on Surgical and Perioperative Safety (CSPS) is an incorporated multidisciplinary coalition of seven professional organizations whose members are involved in the care of surgical patients. Each of these seven organizations has two voting members on the CSPS which constitutes the Board of Directors.

Member associations are the American Association of Nurse Anesthetists (AANA) American Association of Surgical Physician Assistants (AASPA) American College of Surgeons (ACS) American Society of Anesthesiologists (ASA) American Society of PeriAnesthesia Nurses (ASPAN) Association of PeriOperative Registered Nurses (AORN) Association of Surgical Technologists (AST).

The goals or CSPS are to:

1) Create opportunities for strategic, informed dialogue,
2) Identify areas of potential internal and external collaboration to improve surgical patient safety and PeriOperative workplace environments,
3) Share information and establish ongoing lines of communication between member organizations,
4) Raise awareness of surgical patient safety and perioperative workplace environment issues among the public, healthcare leaders, and members of the perioperative team,
5) Provide or facilitate joint educational opportunities for members of the perioperative/surgical team,
6) Coordinate advocacy efforts for surgical patient saftey and a caring workplace environment.

Mission

Promote a culture of patient safety and a caring perioperative workplace environment.

Top Patient Safety Initiatives

The SCPS has endorsed standards in order to:

- espouse and disseminate core principles in patient safety
- coordinate and sponsor educational programs and materials for the perioperative team
- address patient education needs related to safety issues
- network and collaborate with other patient safety groups and organizations

The following patient safety standards are endorsed by the CSPS.

Universal EMR Nomenclature

The CSPS endorses that a universal nomenclature must be used in the development of electronic medical records for documentation of perioperative care. (Adopted 02.03.07)

Monitoring of Patient Functions

The CSPS endorses that every reasonable effort be made to monitor critical physiologic functions of all patients based on patient needs, the type of procedure, and the anesthetic, including the perioperative team being able to hear audible physiologic alarms unobstructed by extraneous operating room noise. (Adopted 07.16.06; modified 07.15.07)

Standardized Scheduling Times

The CSPS endorses that the Standardized Glossary of Times be used for Scheduling and Monitoring Diagnostic and Therapeutic Procedures of the Association of Anesthesia Clinical Directors. (Adopted 07.16.06)

Transfer of Care

The CSPS endorses that the following Transfer of Care principles should be adhered to:

- patient care is individualized,
- transfer of care data elements need to be communicated to the next caregiver through documentation and/or verbally,
- implement patient briefing upon transfer of care to include patient's name, name of caregiver, essential data, identify concerns and/or potential that may occur and what can be done about it. (Adopted 07.16.06)

Correct Patient, Site, & Surgery

The CSPS endorses that all measures will be used to ensure correct patient, correct site, and correct procedure surgery, including implementation of the Universal Protocol of the Joint Commission is recommended and support of the Time-Out prior to surgery or initiation of an invasive procedure.

Consideration will be given to the use of the expanded Time-Out. (Adopted 07.15.07)

Prevention of Injuries

The CSPS endorses that all measures to prevent sharps injuries will be used, inclusive of: double-gloving, use of blunt suture needles, hands-free technique or neutral zone, and the universal adoption of all sharps safety measures in perioperative care is recommended. (Adopted 07.15.07)

Foreign Body Prevention

The CSPS endorses the implementation of all measures to prevent the retention of foreign bodies during surgical procedures which requires communication among all perioperative personnel and the consistent applications of reliable and standardized processes of care. (Adopted 07.15.07)

Prevention of Fire

The CSPS endorses the implementation of all measures to prevent fire in the operating room and during all phases of perioperative care, inclusive of the following: to control the fire triangle (air, heat, fuel, and electrical): control of oxygen sources, control of fuel or combustible material, appropriate drying of surgical prep solutions, and control of ignition or heat sources which includes electrosurgical devices and wires. (Adopted 07.15.07)

VTE Prevention

The CSPS endorses that all efforts to prevent venous thromboembolism (VTE) should be implemented perioperatively to include appropriate VTE pharmacologic and/or non-pharmacologic (pneumatic compression devices) prophylaxis based on risk factors (SCIP measure). (Adopted 07.15.07)

Healthcare Infection Prevention

The CSPS endorses the implementation of all measures to prevent healthcare- associated infections as follows:

- Pneumonia: Prevention of ventilator-associated pneumonia, ventilator bundle, head of bed elevated, daily wake up, sedation vacation, assessment for weaning, ventilator weaning protocol, and stress ulcer prophylaxis (SCIP measure).
- Bacteremia: Prevention of catheter-related bacteremia.
- Surgical Site Infection: Appropriate antibiotic selection, timing and duration, hair clipping instead of shaving, normothermia, normoglycemia, and oxygen supplementation. (Adopted 07.15.07)

Violence Protection

The CSPS has issued a Statement on Violence in the Workplace. It is the position of the CSPS that violence in the workplace must not be tolerated under any circumstances. (Adopted 10.09.07)

The CSPS endorses the development and implementation of evidence-based standards of practice. (Adopted 04.28.08)

Association of Surgical Technologists (AST)

6 West Dry Creek Circle, Suite 200
Littleton CO 80120
www.ast.org

Phone: (303) 694-9130
Fax: (303) 694-9169

Overview

The Association of Surgical Technologists was established in 1969 by members of the American College of Surgeons (ACS), the American Hospital Association (AHA), and the Association of periOperative Registered Nurses (AORN).

AST's primary purpose is to ensure that surgical technologists and surgical assistants have the knowledge and skills to administer patient care of the highest quality.

Mission

To enhance the profession to ensure quality patient care.

Top Patient Safety Initiatives

As a member society of the CSPS, AST follows the core principles outlined by the CSPS (discussed earlier). In addition to the core principles of CSPS, AST has several position/guideline statements related to patient safety. Key statements/guideline are outlined below.

Position Statement: Application of Aseptic Technique to all Patients

It is the position of the Association of Surgical Technologists that the surgical technologist is responsible for enforcing and practicing the uniform principles of aseptic technique for all patients, regardless of their gender, religion, handicap(s) or background; the principles of aseptic technique should be applied to all patients.

The three basic principles of asepsis, as stated in the Core Curriculum for Surgical Technology to be applied to all patients are:

Principle I: A sterile field is created for each surgical procedure;

Principle II: Sterile team members must be appropriately attired prior to entering the sterile field;

Principle III: Movement in and around the sterile field must not compromise the field.

These principles form the basis for the development of surgical conscience as applied to the surgical

treatment of patients. Therefore, surgical technologists who have attended a CAAHEP-accredited surgical technology program are prepared to apply the principles of aseptic practice to all patients to aid in the reduction of postoperative surgical site infections. (Adopted October 2005)

Position Statement: Back Table and Mayo Stand Remaining Sterile until Patient is Transported from Operating Room

A routine practice in many health care facilities is to break down the sterile Mayo stand and back table, and remove instruments and supplies from the operating room prior to the patient being transported out of the room in order to decrease turnover time. However, this practice is questionable in relation to providing quality patient care in those emergency instances, when an incision may need to be quickly reopened or an emergency tracheotomy needs to be performed.

Therefore, it is the position of AST that the CST in the first scrub role should not remove the sterile gown and gloves, and at the minimum, maintain the sterility of the Mayo stand, including retaining a few sterile instruments, such as a knife handle with knife blade loaded, hemostats, scissors, retractor(s), and needle holder until the patient has been transported out of the operating room. (Adopted BOD April 2008).

Guideline Statement: Safe Medication Practices in the Perioperative Area

With the emphasis on patient safety initiatives, AST recognizes the life-threatening potentials of medication errors in the perioperative setting; therefore, AST developed the following guideline statement to provide support to health care facilities in the reinforcement of safe medication practices in the perioperative setting.

The purpose of this Guideline Statement is to provide an outline that health care workers (HCWs) in the perioperative setting can use to develop and implement policies and procedures for safe medication practices.

A Certified Surgical Technologist (CST) and a Certified First Assistant (CFA) are qualified to handle and administer medications in the O.R. under the direct supervision and order of the surgeon. The following protocol is presented with the realization that it is the responsibility of the health care facilities to develop, approve, and establish policies that are protocol specific.

CSTs/CFAs adhere to the following principles related to safe drug handling and medication practices:

AST Six Basic Rights of Drug Handling

- The right patient
- The right drug
- The right dose
- The right route of administration
- The right time and frequency
- The right documentation

Safe Medication Practices

- Transfer of a medication to the sterile field
- Labeling all medications
- Having the surgical technologist in the scrub role (STSR) confirm the medication as it is received.
- The STSR will announce the name of the medication and its strength as it is passed to the person who will administer it.
- Monitoring patients for adverse reactions
- Original medication container should be kept as a reference until the operating procedure is completed.

(Adopted May 2005)

**The full guideline statement can be read at
http://www.ast.org/pdf/Standards_of_Practice/Guideline_Safe_Medication_Practices.pdf

Guideline Statement: Maintenance of Normothermia in the Perioperative Patient

CSTs and CFAs are qualified to identify potential complications, associated with hypothermia and hyperthermia in the perioperative environment, and appropriate interventions for treatment.

The maintenance of normothermia in the perioperative patient is essential during all phases of the surgical procedure. Measures to monitor and maintain body temperature should begin in the preoperative phase and continue into the postoperative phase of the surgical procedure. The monitoring of patient temperature is the responsibility of all surgical team members and not just the anesthesia provider.

AST guideline Statement: Maintaining normothermia in the perioperative patient is a collaborative effort between the anesthesia provider, the surgeon, perioperative personnel, and perianesthesia personnel.

(Adopted October 2005)

**The full guideline statement can be read at
http://www.ast.org/pdf/Standards_of_Practice/Guideline_Normothermia_%20Perioperative_Patient.pdf

Recommended Standards of Practice for Correct-site Surgery

These Recommended Practices are guidelines for verification of correct site surgery and to prevent potential patient safety incidents. According to The Joint Commission, wrong site surgery is a term that encompasses wrong patient, wrong side of patient and wrong body part, and these errors can be prevented. The Recommended Practices contribute to ensuring effective, safe, quality care of the surgical patient by the surgical staff. Confirming the correct-site surgery, correct patient and correct procedure is the equal responsibility of all members of the surgical team and requires equal

participation. All surgical team members are advocates of the patient and share the burden of responsibility in protecting the patient from injury and forwarding the principles of patient safety.

- *Standard of Practice I*: Each member of the surgical team will properly identify the patient.
- *Standard of Practice II:* Each member of the surgical team will identify and confirm the correct surgical site.
- *Standard of Practice III*: The patient will identify the correct surgical site.
- *Standard of Practice IV*: The surgical team members will perform a "time-out" immediately prior to the start of all surgical procedures.

(Adopted October 2005)

**The full guideline statement can be read at
http://www.ast.org/pdf/Standards_of_Practice/RSOP_Correct_Site_Surgery.pdf

Firestone-Callahan & Associates

American College of Surgeons (ACS)

633 N. Saint Clair Street
Chicago, IL 60611-3211
www.facs.org

Phone: (312) 202-5000
Fax: (312) 202-5001
E-mail: postmaster@facs.org

Overview

The American College of Surgeons is a scientific and educational association of surgeons that was founded in 1913 to improve the quality of care for the surgical patient by setting high standards for surgical education and practice.

The College currently has over 74,000 members, including more than 4,000 Fellows in other countries, making it the largest organization of surgeons in the world. There are presently more than 2,600 Associate Fellows.

ACS has a special institute devoted to patient safety and quality improvement. The purpose of the Nora Institute is to provide a resource to the College in policy development concerning surgical care quality improvement and patient safety; provide educational information for the profession and public on the subjects of surgical care quality improvement and patient safety; and to help the College provide input to public and private sector entities that are involved in the development and implementation of performance- and cost-based incentive programs.

Mission

The American College of Surgeons has addressed patient safety as a top priority. More specifically, the College's perennial efforts to ensure surgeons and hospitals access to scientifically verifiable standards, availability of effective quality improvement tools, and a better understanding of errors in care.

Top Patient Safety Initiatives

As a member of CSPS, ACS follows the patient safety guidelines promoted by CSPS. In addition, ACS follows JCAHO universal protocol for preventing wrong site, wrong-procedure, wrong-person surgery.

In addition to CSPS and JCAHO standards for patient safety, ACS promotes the following patient safety initiatives.

Patient Safety Principles for Office-Based Surgery Utilizing Moderate Sedation/Analgesia, Deep Sedation/Analgesia, or General Anesthesia

There has been a noticeable increase in the number of invasive procedures being performed in the office setting. Recognizing that many states still haven't issued patient safety guidelines in this area, the

Firestone-Callahan & ASSOCIATES

American College of Surgeons (ACS) sponsored a resolution for the AMA to work with the ACS in identifying principles for patient safety in office-based procedures.

The following principles are promoted by the ACS for office-based surgery:

- *Core Principle #1* - Guidelines or regulations should be developed by states for office-based surgery according to levels of anesthesia defined by the American Society of Anesthesiologists' (ASA's) "Continuum of Depth of Sedation" statement dated October 13, 1999, excluding local anesthesia or minimal sedation.
- *Core Principle #2* - Physicians should select patients by criteria, including the ASA Patient Selection Physical Status Classification System, and so document.
- *Core Principle #3* - Physicians who perform office-based surgery should have their facilities accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), Accreditation Association for Ambulatory Health Care (AAAHC), American Association for Accreditation of Ambulatory Surgical Facilities (AAAASF), American Osteopathic Association (AOA), or by a state-recognized entity such as the Institute for Medical Quality (IMQ), or be state licensed and/or Medicare certified.
- *Core Principle #4* - Physicians performing office-based surgery must have admitting privileges at a nearby hospital, or a transfer agreement with another physician who has admitting privileges at a nearby hospital, or maintain an emergency transfer agreement with a nearby hospital.
- *Core Principle #5* - States should follow the guidelines outlined by the Federation of State Medical Boards regarding informed consent
- *Core Principle #6* - States should consider legally privileged adverse incident reporting requirements as recommended by the FSMB and accompanied by periodic peer review and a program of Continuous Quality Improvement.
- *Core Principle #7* - Physicians performing office-based surgery must obtain and maintain board certification by one of the boards recognized by the American Board of Medical Specialties, American Osteopathic Association, or a board with equivalent standards approved by the state medical board within five years of completing an approved residency training program. The procedure must be one that is generally recognized by that certifying board as falling within the scope of training and practice of the physician providing the care.
- *Core Principle #8* - Physicians performing office-based surgery may show competency by maintaining core privileges at an accredited or licensed hospital or ambulatory surgical center for the procedures they perform in the office setting. Alternatively, the governing body of the office facility is responsible for a peer review process for privileging physicians based on nationally recognized credentialing standards.
- *Core Principle #9* - At least one physician, who is credentialed or currently recognized as having successfully completed a course in advanced resuscitative techniques (ATLS®, ACLS, or PALS), must be present or immediately available with age and size-appropriate resuscitative equipment until the patient has met the criteria for discharge from the facility. In addition, other medical personnel with direct patient contact should at a minimum be trained in Basic Life Support (BLS).
- *Core Principle #10* - Physicians administering or supervising moderate sedation/analgesia, deep sedation/analgesia, or general anesthesia should have appropriate education and training.

Statement on Ensuring Correct Patient, Correct Site, and Correct Procedure Surgery

The American College of Surgeons (ACS) recognizes patient safety as being an item of the highest priority and strongly urges individual hospitals and health organizations to develop guidelines to ensure correct patient, correct site, and correct procedure surgery. The ACS offers the following guidelines to eliminate wrong site surgery:

- Verify that the correct patient is being taken to the operating room. This verification can be made with the patient or the patient's designated representative if the patient is under age or unable to answer for him/herself.
- Verify that the correct procedure is on the operating room schedule.
- Verify with the patient or the patient's designated representative the procedure that is expected to be performed, as well as the location of the operation.
- Confirm the consent form with the patient or the patient's designated representative.
- In the case of a bilateral organ, limb, or anatomic site (for example, hernia), the surgeon and patient should agree and the operating surgeon should mark the site prior to giving the patient narcotics, sedation, or anesthesia.
- If the patient is scheduled for multiple procedures that will be performed by multiple surgeons, all the items on the checklist must be verified for each procedure that is planned to be performed.
- Conduct a final verification process with members of the surgical team to confirm the correct patient, procedure, and surgical site.
- Ensure that all relevant records and imaging studies are in the operating room.
- If any verification process fails to identify the correct site, all activities should be halted until verification is accurate.
- In the event of a life- or limb-threatening situation, not all of these steps may be followed.

American Society for Anesthesiologists (ASA)

520 N. Northwest Highway
Park Ridge, IL 60068-2573
www.asahq.org

Phone: (847) 825-5586
Fax: (847) 825-1692
E-mail: mail@asahq.org

Overview

The American Society of Anesthesiologists is an educational, research and scientific association of physicians organized to raise and maintain the standards of the medical practice of anesthesiology and improve the care of the patient.

Since its founding in 1905, the Society's achievements have made it an important voice in American Medicine and the foremost advocate for all patients who require anesthesia or relief from pain.

As physicians, anesthesiologists are responsible for administering anesthesia to relieve pain and for managing vital life functions, including breathing, heart rhythm and blood pressure, during surgery. After surgery, they maintain the patient in a comfortable state during the recovery, and are involved in the provision of critical care medicine in the intensive care unit.

Mission

The American Society of Anesthesiologists is dedicated to elevating the standards of the specialty by fostering and encouraging education, research and scientific progress in anesthesiology.

Top Patient Safety Initiatives

The ASA has long been a leader in patient safety initiatives, and has drastically reduced the number of anesthesia-related deaths through their initiatives such as the use of oxygen measurement.

One way that safety has been improved by these organizations is by establishing consistent high standards of practice, and guidelines to practice that are based on the best science available.

As a member of CSPS, ASA follows the patient safety guidelines promoted by CSPS. In addition, they advocate the following patient safety initiatives.

The Anesthesia Patient Safety Foundation

The Anesthesia Patient Safety Foundation (APSF) was created in 1984 by ASA to raise the level of consciousness and knowledge regarding patient safety issues by fostering investigation to provide a better understanding of preventable anesthetic injuries, encouraging programs that will reduce the number of anesthetic injuries and promoting national and international communication of information

and ideas about causes and prevention of anesthetic morbidity and mortality. ASA, as the original founding patron, continues to be the largest annual contributor to APSF, which has given more than $2 million in research grants in addition to its unparalleled communication efforts.

ASA has been a leader in the development of basic monitoring standards, guidelines and statements. To date, under the direction of the Committee on Standards and Practice Parameters, ASA has funded and issued 12 practice guidelines and five practice advisories through a rigorous and well-defined process of evidence review. In addition to these, there are approximately 40 other policy statements and policy guidelines approved by the House of Delegates, available both in print and on the ASA Web site.

Committee on Patient Safety and Education

Through ASA's Committee on Patient Safety, the Society provides education, training, applications of current and developing technologies and the acquisition of new knowledge about the causes and prevention of mishaps.

The following excerpt from ASA's bylaws describes the duties of the Committee on Patient Safety and Education.

Duties

1. To develop, initiate and evaluate studies designed to enhance the safety of anesthetized patients.
2. To serve as a source for distribution of information concerning patient safety and risk management to members of this Society.
3. To serve as liaison between this Society and those private organizations and government agencies that share the concerns of this Society with regard to the safety of the anesthetized patient.
4. To advise all concerned individuals and agencies on methods of minimizing risk in the event of an adverse reaction.

ASA Closed Claims Project

The ASA uses case analysis to identify liability risk areas, monitor trends in patient injury, and design strategies for prevention. The ASA Closed Claims Project is an ongoing analysis of claims, revealing patterns of patient injury from anesthesia and developing procedures to eliminate the errors.

This type of central reporting is important in providing an early warning about problems that might occur too infrequently for individual organizations to detect them. Such evaluations lead to changes in practice as do the development of better ways to measure how well patients are doing during operations. For example, 20 years ago, anesthesiologists began to use devices that continuously measure oxygen levels in the blood. As a result, dangerous decreases in oxygen level are detected rapidly and can be corrected quickly. This has greatly reduced the occurrence of brain damage due to lack of oxygen.

Firestone-Callahan & Associates

Association of periOperative Registered Nurses (AORN)

2170 South Parker Road, Suite 300
Denver, CO 80231
www.aorn.org

Phone: 800-755-2676

Overview

The Association of periOperative Registered Nurses (AORN) is the national association committed to improving patient safety in the surgical setting. AORN is the premier resource for perioperative nurses, advancing the profession and the professional with valuable guidance as well as networking and resource-sharing opportunities. AORN promotes safe patient care and is recognized as an authority for safe operating room practices and a definitive source for information and guiding principles that support day-to-day perioperative nursing practice.

Our Mission

The Association of periOperative Registered Nurses (AORN) mission is to promote safety and optimal outcomes for patients undergoing operative and other invasive procedures by providing practice support and professional development opportunities to perioperative nurses. AORN will collaborate with professional and regulatory organizations, industry leaders, and other healthcare partners who support the mission.

Top Patient Safety Initiatives

As a member of CSPS, AORN follows the patient safety guidelines promoted by CSPS. In addition, they advocate the following patient safety initiatives.

AORN position statements articulate the Association's official position or belief about certain perioperative nursing-related topics. Position statements are authored by a AORN Board of Directors appointees and are approved by the Board and the House of Delegates.

As patient advocates, perioperative registered nurses have a duty to the public to protect the patient from injury and to safeguard the patient's health, welfare, and safety. Although it is the surgeon's responsibility to diagnose a patient's need for surgery and to delineate the surgical site, verifying the correct surgical site at the time of surgery is the responsibility of perioperative registered nurses and every member of the health care team.

AORN believes that it is the right of every patient to receive the highest quality of care in all surgical/procedural settings and that all health care providers must collaboratively strive to create an environment of patient safety. Every patient scheduled for a surgical or invasive procedure deserves to have a registered nurse throughout the continuum of perioperative care, including a registered nurse in the role of circulator.2,3 The perioperative registered nurse forms a professional bond with the patient through patient advocacy.4 The patient-nurse bond is further strengthened through nursing

interventions that promote optimal surgical and procedural outcomes. The patient's physical and emotional needs are entrusted to the perioperative registered nurse by the patient and his or her family members, who also believe that the care provided will be safely and effectively delivered by the entire health care team.

AORN is committed to promoting patient safety by advancing the profession through scholarly inquiry to identify, verify, and expand the body of perioperative nursing knowledge. AORN accepts the responsibility and accountability as a leader in patient safety dedicated to reducing error, educating health care providers and patients about safe practices, and creating innovative and collaborative strategies to strengthen the culture of safety.

As a member of CSPS, AORN follows the patient safety guidelines promoted by CSPS. In addition, they advocate the following patient safety initiatives. The following sections describe AORN's published position statements on patient safety.

Position Statement on Wrong Site, Wrong Procedure, Wrong Person Surgery

AORN is dedicated to patient safety. Using suggested risk-prevention strategies for identification and verification of correct patient, surgical site, and procedure will reduce the risk of error. AORN endorses the Joint Commission's Universal Protocol for Preventing Wrong Site, Wrong Procedure, Wrong Person Surgery.

Position Statement on Culture of Patient Safety

AORN believes that all health care organizations must strive to create a culture of safety. Such a culture will provide an atmosphere where perioperative team members can openly discuss errors, process improvements, or system issues without fear of reprisal. AORN further believes in the following precepts.

- A commitment to safety must be articulated at all levels of the organization.
- Most patient safety initiatives will fail in the absence of a viable safety culture.
- Safety should be valued as the top priority, even at the expense of productivity.
- Health care organizations should allocate an appropriate amount of resources and provide the necessary incentives or rewards to promote a healthy patient safety culture.
- Health care organizations must adopt a responsible and accountable environment to promote a culture that freely reports errors.
- Health care organizations should value learning and respond to a medical error with a focus on process improvement rather than individual blame.
- Errors and mistakes must be evaluated in a manner such that contributing factors are reviewed first, and then accountability is determined in relation to actions.
- Each perioperative team member has an ethical obligation to perform his or her role and responsibilities with appropriate competencies and with the highest level of personal integrity.
- A just culture is an environment where actions are analyzed to ensure that individual accountability is established and appropriate actions are taken. It is not a blame-free

environment.

- A learning culture is demonstrated by the organization's willingness and ability to draw the correct conclusion from safety data and the responsibility to implement the needed strategies for reform. Evidence-based practices and continued safety research contribute to an environment that fosters learning. Learning is enhanced by an open interdisciplinary discussion of untoward events by all members of the perioperative team.
- Patients and their family members are essential partners, and including them in appropriate aspects of care is necessary to develop a safe perioperative culture.
- Disciplinary policies must balance the benefits of a learning culture with the need to retain personal accountability and discipline. Tools should be created to assist perioperative leaders in investigating and determining accountability when an error has occurred. James Reason, professor of psychology at the University of Manchester, United Kingdom, has proposed a model of culpability that provides one example of a tool that can be used to determine when disciplinary actions should be taken.(p k1)
- Disruptive behavior is an impediment to communication and cannot be tolerated in any member of the perioperative team. All members of the team, including perioperative leaders, should immediately confront the individual and implement strategies to de-escalate the situation and manage behaviors.

Position Statement on Minimum Care for Surgical Patients

AORN is committed to the provision of safe perioperative nursing care by ensuring that every patient undergoing a surgical or other invasive procedure is at a minimum cared for by a registered nurse in the circulating role, regardless of the setting. To this end, AORN believes the following:

- At a minimum, one perioperative registered nurse circulator should be dedicated to each patient undergoing a surgical or other invasive procedure and present during that patient’s entire intraoperative experience.
- Patient care in the perioperative setting is dynamic in nature and depends on the clinical knowledge, judgment, and critical-thinking skills possessed by the perioperative registered nurse.
- The foundation of perioperative nursing practice is based on both the art and science of nursing, including evidence-based practice and patient advocacy.
- A practice environment that acknowledges the unique education of a registered nurse supports perioperative nurses to provide the highest quality of patient care in the surgical arena.
- Scientific research and the identification of nursing quality indicators, such as those found in the language of the PNDS, are the best means to monitor the relationship between appropriate nurse staffing and patient outcomes in the surgical setting.
- Having a practice environment with one perioperative registered nurse circulator dedicated to each patient undergoing a surgical or other invasive procedure will provide for safe, quality patient care in the surgical arena.
- Administrative and collegial support, as well as effective relationships with physicians and surgeons, contributes to the perioperative nurse’s ability to provide safe, quality patient care.

Furthermore, AORN affirms

- Support for ongoing research to determine proper nurse staffing to sustain safe quality patient outcomes,
- continued collaboration with all organizations endeavoring to reduce and eliminate health care errors,
- and adequate staffing as an essential element of error prevention.

Statement on Patient Safety

AORN believes that it is the right of every patient to receive the highest quality of care in all surgical/procedural settings and that all health care providers must collaboratively strive to create an environment of patient safety. Every patient scheduled for a surgical or invasive procedure deserves to have a registered nurse throughout the continuum of perioperative care, including a registered nurse in the role of circulator. The perioperative registered nurse forms a professional bond with the patient through patient advocacy. The patient-nurse bond is further strengthened through nursing interventions that promote optimal surgical and procedural outcomes. The patient's physical and emotional needs are entrusted to the perioperative registered nurse by the patient and his or her family members, who also believe that the care provided will be safely and effectively delivered by the entire health care team.

AORN is committed to promoting patient safety by advancing the profession through scholarly inquiry to identify, verify, and expand the body of perioperative nursing knowledge. AORN accepts the responsibility and accountability as a leader in patient safety dedicated to reducing error, educating health care providers and patients about safe practices, and creating innovative and collaborative strategies to strengthen the culture of safety.

Patient Safety First Initiative

The Patient Safety First initiative was launched in 2002 with the purpose of providing direction for AORN patient safety activities and assisting members in meeting The Joint Commission's National Patient Safety Goals.

Following are some of the ways AORN supports surgical patient safety:

- *National Time Out Day* - AORN sponsors National Time Out Day, in support of The Joint Commission's Universal Protocol, to raise awareness about the importance of requiring the entire surgical team to pause before all invasive procedures to help prevent errors.
- *Correct Site Surgery Tool Kit* - Provides a set of practical resources and hands-on tools that promote the effective implementation of the Universal Protocol.
- *Nurse Consultation* - AORN members may consult with AORN's perioperative nursing experts on matters of patient safety.
- *AORN Tool Kits* - In addition to the Correct Site Surgery Tool Kit, AORN offers other resource packages to address practical patient safety issues such as fire safety, safe medication, patient hand-off, human factors, and more.
- *Council on Surgical and Perioperative Safety* - AORN took the lead in creating a coalition of organizations whose members collaborate to improve the care of the patients they serve.

Member organizations include AORN, ACS, ASA, AANA, ASPAN, AASPA, and AST.

- *Executive Symposium on Surgical Patient Safety* - This annual event includes surgical teams from across the country who come together to discuss emerging issues in the surgical setting and imperative steps to improving surgical patient safety.
- *Public Policy* - The Government Affairs Department at AORN advocates for and promotes patient safety through public policy and legislative initiatives at the state and federal levels.
- *OR Protocol Course* - This education activity provides health care industry representatives with comprehensive information to be prepared in their various roles in the perioperative setting

Firestone-Callahan & Associates

American Society of Peri-Anesthesiologists Nurses (ASPAN)

10 Melrose Avenue, Suite 110
Cherry Hill, NJ 08003-3696
Website: http://aspan.enoah.com/

Phone: (877) 737-9696
Fax: (856) 616-9601
E-mail: aspan@aspan.org

Overview

The American Society of PeriAnesthesia Nurses (ASPAN) is the professional specialty nursing organization representing the interests of more than 55,000 nurses practicing in all phases of preanesthesia and postanesthesia care, ambulatory surgery, and pain management.

The American Society of PeriAnesthesia Nurses advances nursing practice through education, research and standards.

This is accomplished by:

- Providing education with respect to all phases of perianesthesia care through a variety of formats.
- Developing Standards of Perianesthesia Nursing Practice.
- Encouraging specialization and research in all phases of perianesthesia nursing.
- Promoting interest and professional growth of nurses engaged or interested in the care of patients in all phases of perianesthesia nursing.
- Facilitating cooperation among perianesthesia nurses and physicians and other members of the healthcare team concerned with the care of the perianesthesia patient.
- Exchanging professional knowledge.
- Promoting public awareness and understanding of the care required by the perianesthesia patient.
- Cooperating with universities, government agencies or any organization in matters affecting the purposes of the Society.

Mission

To advance the unique specialty of perianesthesia nursing.

Core Values

- Building Integrity
- Modeling Respect
- Honoring Diversity
- Promoting Stewardship
- Providing Mentorship

- Cultivating Passion
- Supporting Community

Value Discipline

ASPAN will be branded for having an identity and image of leading edge programs and services.

This brand will need to be supported by operational excellence, eminent influence and advocacy, and membership focus.

Top Patient Safety Initiatives

As a member of CSPS, ASPAN follows the patient safety guidelines promoted by CSPS. In addition, they advocate the following patient safety initiatives.

Safety Committee

The Safety Committee exists to promote a comprehensive safety culture for perianesthesia practice. Committee strategic initiatives include: identification of perianesthesia safety priorities; development of a perianesthesia safety resource manual; expansion of perianesthesia safety publications; promotion of a safety section on the ASPAN Web site; and creation of a confidential safety incident reporting database.

The environment of care is guided by research and evidence based practice. Within the environment of care, the nurse's foci are:

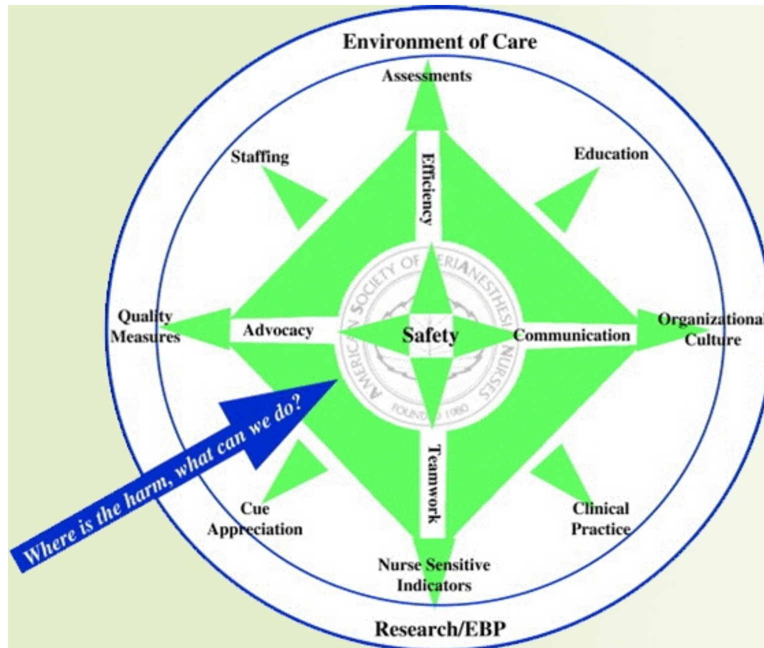
- clinical practice
- assessment
- education
- organizational structure
- cue appreciation
- quality measures
- staffing

Safety Committee Strategic Goals

The Safety Committee established organization-based strategies to direct and guide the team's efforts:

- ASPAN will be its member's indispensable resource for perianesthesia education and knowledge exchange worldwide.
- ASPAN will be the influential force for perianesthesia patient safety, public policy and practice standards.
- ASPAN will be the recognized voice and source of perianesthesia information to the public.
- The art and science of perianesthesia nursing will be advanced through ASPAN's evidence based practice and research activities.

ASPAN Safety Model



Perianesthesia Patient Safety Net with Related Event Types

I. Improve the accuracy of patient idenfification
  A. Identification Errors
  B. Final Verification Prior to Procedures

II. Improve the effectiveness of communication among caregivers
  C. Communication Errors

III. Improve the safety of using medications
  D. Medication Errors

IV. Eliminate Wrong-site, Wrong-patient, Wrong-procedure Surgery
  E. Wrong Site Surgery

V. Improve the Safety of using Infusion Pumps/Equipment
  F. Pumps/Equipment

VI. Improve the Effectiveness of Clinical Alarm Systems
  G. Monitor Alarm Error

VII. Reduce the Risk of Healthcare Associated Infections

Firestone-Callahan & Associates

H. Healthcare Associated Infections

VIII. Reduce the Risk of Patient Harm Resulting from Falls
I. Fall

IX. Reduce the Risk of Influenza and Pneumococcal Disease in Institutionalized Older Adults
J. Influenza

X. Reduce the Risk of Surgical Fires
K. Fires

XI. Implementation of Applicable National Patient Safety Goals and Associated Requirements by Components and Practitioner Sites
L. Application of Standards

XII. Encourage the Active Involvement of Patients and their Families in the Patient's Care as Patient by Components and Practitioner Sites Is this correct as written?
M. Lack of Family Involvement

XIII. Prevent Healthcare Associated Pressure Ulcers
N. Pressure Ulcer

XIV. The Organization Identifies Safety Risks Inherent in its Patient Population
O. Suicide risk

XV. Other
P. Laboratory Test Problems
Q. Radiology/Imaging Test Problem
R. Transfusion
S. Behavioral
T. Care Coordination
U. Staffing Related Problem:
a. Cause of harm to patient
b. Contributory causes to adverse outcomes

V. Physician Order Entry Related Problems
W. Other Adverse Events

Index for Categorizing Medication Errors

The Index for Categorizing Medication Errors was based on the National Coordinating Council for Medication Error Reporting and Prevention.

Category A: circumstances or events that have the capacity to cause error

Category B: an error that occurred but did not reach the patient

Category C: an error that occurred and did reach the patient but did not cause harm

Category D: an error that occurred, reached the patient, and required monitoring to confirm that it resulted in no harm to the patient and/or required intervention to preclude harm

Category E: an error that occurred which may have contributed to or resulted in temporary harm to the patient, and required intervention

Category F: an error that occurred which may have contributed to or resulted in temporary harm to the patient, and required initial or prolonged hospitalization

Category G: an error that occurred that may have contributed to or resulted in permanent patient harm

Category H: an error that occurred which required intervention necessary to sustain life

Category I: an error that occurred which may have contributed to or resulted in the patient's death

PMB 201 4267 NW Federal Highway
Jensen Beach, FL 34957
www.aaspa.com

Phone: (888) 882-2772
Fax: (772) 388-3457
E-Mail: aaspa@aaspa.com

Overview

AASPA is the organization that represents Physician Assistants (PAs) that work in the pre-operative, intra-operative, and post-operative settings. AASPA was formed for Surgical PAs, by Surgical Pas. AASPA also represent PAs in training, both students and PA residents in a wide variety of academic settings.

AASPA was formed in 1972 as the American Association of Surgeon Assistants. It is the oldest specialty Physician Assistant organization. The name was changed to the American Association of Surgical Physician Assistants (1996).

Mission

**Not defined

Top Patient Safety Initiatives

CSPS Membership

As a member of CSPS, AASPA follows the patient safety guidelines promoted by CSPS. In addition, they advocate the following patient safety initiatives.

AASPA Endorsement of Anesthesia Patient Safety Foundation's (APSF's) PCA Safety Position

AASPA also endorses APSF's position on safety during patient controlled anesthesia (PCA). APSF endorses a goal that “no patient shall be harmed by opioid-induced ventilatory depression in the postoperative period.” To address this goal, APSF urges healthcare professionals to give consideration to the potential safety value of continuous monitoring of oxygenation (pulse oximetry) and ventilation in patients receiving PCA or neuraxial opioids in the postoperative period.

American Association of Nurse Anesthetists (AANA)

222 South Prospect Avenue

Firestone-Callahan & Associates

Park Ridge, Illinois 60068-4001
www.aana.com

Phone: (847) 692-7050
Fax: (847) 692-6968
Email: info@aana.com

Overview

Founded in 1931 and located in Park Ridge, Ill., the AANA is the professional organization for more than 90 percent of the nation's CRNAs.

Founded in 1931, the American Association of Nurse Anesthetists (AANA) is the professional association representing more than 37,000 Certified Registered Nurse Anesthetists (CRNAs) nationwide. The AANA promulgates education, and practice standards and guidelines, and affords consultation to both private and governmental entities regarding nurse anesthetists and their practice. The AANA Foundation supports the profession by awarding education and research grants to students, faculty and practicing CRNAs.

The AANA developed and implemented a certification program in 1945 and instituted a recertification program in 1978. It established a mechanism for accreditation of nurse anesthesia educational programs in 1952, which has been recognized by the U.S. Department of Education since 1955. In 1975, the AANA was a leader among professional organizations in the United States by forming autonomous multidisciplinary councils with public representation for performing the profession's certification, accreditation, and public interest functions. Today, the CRNA credential is well recognized as an indicator of quality and competence.

Mission

*Vision Statement- "*Recognized leaders in anesthesia care."

*Mission Statement- "*Advancing patient safety and excellence in anesthesia."

Core Values- "Integrity, professionalism, advocacy and quality."

*AANA Motto- "*Supporting our members ~ Protecting our patients."

Top Patient Safety Initiatives

As a member of CSPS, AANA follows the patient safety guidelines promoted by CSPS. The AANA also endorses JCAHO's universal protocol to prevent wrong site, wrong procedure, and wrong person surgeries.

In addition, they advocate the following patient safety initiatives.

Anesthesia Patient Safety Website

AnesthesiaPatientSafety.com is a website that promotes safe anesthesia patient care through public education. This sister website to AANA.com explains the intricacies of undergoing anesthesia, and what patients can expect from their surgical experience. Important information about what patients can do to make their surgical experience better is also included.

Standards of Practice for Office-Based Sedation

The American Association of Nurse Anesthetists has adopted strict new standards for the administration of anesthesia in office settings.

These standards are designed to mitigate the risk of anesthesia-related injuries during office-based surgeries.

**The entire document of standards can be viewed at
http://www.aana.com/uploadedFiles/Resources/Practice_Documents/stds_officebasedanesth.pdf.

Quality of Care in Anesthesia

Quality of Care in Anesthesia is a synopsis of published information comparing certified registered nurse anesthetists and anesthesiologist patient outcomes.

The entire document can be read at the AANA website.

"Culture of Safety" Focus

The AANA, along with AORN, ACS, and ASAhosted the fifth Executive Symposium on Surgical Patient Safety in 2007. The focus of the symposium discuss patient safety with the theme "Creating a Culture of Safety."

Centers for Medicare & Medicaid Services (CMS)

http://cms.hss.gov

Overview

The Centers for Medicare and Medicaid Services (CMS), previously known as the Health Care Financing Administration (HCFA), is a federal agency within the United States Department of Health and Human Services (DHHS) that administers the Medicare program and works in partnership with state governments to administer Medicaid, the State Children's Health Insurance Program (SCHIP), and health insurance portability standards.

In addition to these programs, CMS has other responsibilities, including the administrative simplification standards from the Health Insurance Portability and Accountability Act of 1996 (HIPAA), quality standards in long-term care facilities (more commonly referred to as nursing homes) through its survey and certification process, and clinical laboratory quality standards under the Clinical Laboratory Improvement Amendments.

Medicare has various initiatives to encourage improved quality of care in all health care settings where Medicare beneficiaries receive their health care services, including physicians' offices and ambulatory care facilities, hospitals, nursing homes, home health care agencies and dialysis facilities.

Top Patient Safety Initiatives

Six Primary Topics of CMS Patient Safety Theme

- Improving inpatient surgical safety and heart failure treatment in hospitals
- Reducing rates of health care–associated MRSA infections
- Reducing rates of pressure ulcers in nursing homes and hospitals
- Reducing rates of use of physical restraints in nursing homes
- Improving drug safety
- Providing quality improvement technical assistance to nursing homes

Medicare Pay for Performance Initiatives

The foundation of effective pay-for-performance initiatives is collaboration with providers and other stakeholders, to ensure that valid quality measures are used, that providers aren't being pulled in conflicting directions, and that providers have support for achieving actual improvement.

Consequently, to develop and implement these initiatives, CMS is collaborating with a wide range of other public agencies and private organizations who have a common goal of improving quality and avoiding unnecessary health care costs, including the National Quality Forum (NQF), the Joint Commission of the Accreditation of Health Care Organizations (JCAHO), the National Committee for Quality Assurance (NCQA), the Agency for Health Care Research and Quality (AHRQ), the American Medical Association (AMA), and many other organizations. CMS is also providing technical assistance to a wide range of health care providers through its Quality Improvement Organizations (QIOs). Through these collaborative efforts, CMS is developing and implementing a set of pay-for-performance initiatives to support quality improvement in the care of Medicare beneficiaries. In addition to the initiatives for hospitals, physicians, and physician groups described below, CMS is also exploring

opportunities in nursing home care – building on the progress of the Nursing Home Quality Initiative – and is considering approaches for home health and dialysis providers as well. Finally, recognizing that many of the best opportunities for quality improvement are patient-focused and cut across settings of care, CMS is pursuing pay-for-performance initiatives to support better care coordination for patients with chronic illnesses.

Improving Patient Safety for Medicare and Medicaid by Addressing Never Events

CMS has announced the initiation of three Medicare National Coverage Determinations (NCD) proceedings for "wrong surgery," a category of "never events" included in the National Quality Forum's (NQF's) list of Serious Reportable Adverse Events. Further, the Agency has issued a State Medicaid Director (SMD) letter outlining the authority of State Medicaid Agencies to deny payment for selected hospital-acquired conditions.

These patient safety policies are part of CMS' efforts to promote higher quality, more efficient health care through value-based purchasing (VBP). VBP initiatives use performance-based financial incentives and public reporting of quality information to encourage improvement in all aspects of quality, including patient safety.

Addressing Wrong Surgery through Medicare National Coverage Policy

The Social Security Act requires CMS to deny payment for a particular item or service that is not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body part.

CMS will use its NCD process to establish coverage policies for surgery on the wrong body part, surgery on the wrong patient, and wrong surgery performed on a patient. After a 30-day comment period on the proposed decision, if CMS decides that any of the above surgeries are not reasonable and necessary, CMS will no longer pay for hospital and physician services that correspond to these surgeries.

Part D Data Available for Patient-Safety Efforts

CMS has issued final regulations that will make Medicare Part D claims data available to the FDA and other agencies, as well as academic researchers, for use in patient-safety initiatives. The FDA has said that it will use the data to pilot-test its Sentinel Initiative, a new electronic system that will let the agency query a large number of health information databases in an effort to more effectively detect post-market adverse events resulting from use of approved drugs and medical devices. This program won't only detect the events, it will allow the agency to monitor the performance of drugs and devices in real time, said FDA and CMS officials. The Sentinel program links claims data from 25 million beneficiaries with prescription drug coverage to other Medicare claims information, including diagnoses, treatments, hospitalizations and physician services

Joint Commission on the Accreditation of Hospital Organizations (JCAHO)

Firestone-Callahan & Associates

The Joint Commission Announces 2009 National Patient Safety Goals

The Joint Commission has announced the 2009 National Patient Safety Goals and related requirements for each of its accreditation programs and its Disease-Specific Care Certification Program. The National Patient Safety Goals promote specific improvements in patient safety by providing healthcare organizations with proven solutions to persistent patient safety problems. These Goals apply to the more than 15,000 Joint Commission-accredited and -certified healthcare organizations and programs.

Major changes for 2009 include three new hospital and critical access hospital requirements related to preventing deadly healthcare-associated infections due to multiple drug-resistant organisms (MDROs), central line-associated bloodstream infections, and surgical site infections. These additions build on an existing National Patient Safety Goal to reduce the risk of healthcare-associated infections, and recognize that patients continue to acquire preventable infections at an alarming rate within hospitals. The new requirements related to central line-associated bloodstream infections also will take effect for ambulatory care facilities and office-based surgery practices, home care organizations, and long term care organizations. In addition, prevention of surgical site infections will be a new requirement for ambulatory care facilities and office-based surgery practices. These new infection-related requirements have a one-year phase-in period that includes defined milestones, with full implementation expected by January 1, 2010.

"The 2009 National Patient Safety Goals represent ongoing opportunities for improvement that can immediately benefit patients," says Mark R. Chassin, MD, MPP, MPH, president, The Joint Commission. "By taking action to consistently meet the Goals, healthcare organizations can substantially improve patient safety in America."

A revision of the requirements for the existing medication reconciliation Goal is based on feedback obtained from a Medication Reconciliation Summit convened in late 2007 and is included in the 2009 update. Other changes to the National Patient Safety Goals include a requirement to eliminate transfusion errors related to patient misidentification in hospitals, critical access hospitals, ambulatory care facilities and office-based surgery practices. New requirements for several programs focus on engaging patients in their care regarding infection control, prevention of surgical adverse events, and the patient identification process.

The requirements associated with the existing Universal Protocol, initiated to help prevent errors in surgical and non-invasive surgical procedures, were also improved for 2009. These changes, which address the topics of procedure verification, marking the procedure site, and conducting a "time out" immediately prior to starting procedures, were based on feedback received at the Wrong Site Surgery Summit in 2007. The Universal Protocol is used by hospitals, critical access hospitals, disease-specific care organizations, ambulatory care facilities and office-based surgery practices.

The development, annual review and modification of the National Patient Safety Goals, first introduced in 2003, is overseen by the Sentinel Event Advisory Group, a panel that includes widely recognized patient safety experts, nurses, physicians, pharmacists, risk managers and other professionals who have hands-on experience in addressing patient safety issues in hospitals and other healthcare settings. Each year, this panel works with The Joint Commission to undertake a systematic review of the literature and available databases to identify potential new Goals and requirements. The Joint Commission also

conducts an extensive field review of candidate new Goals and seeks input from practitioners, provider organizations, purchasers, and consumer groups among others. The Joint Commission's Board of Commissioners approves the Goals and requirements each year. Compliance with the requirements is a condition of continuing accreditation or certification for Joint Commission-accredited and -certified organizations.

Firestone-Callahan & Associates

Institute for Health Improvement (IHI)

20 University Road, 7th Floor
Cambridge, MA 02138
www.ihi.org

Phone: (617) 301-4800
Fax: (617) 301-4848

Overview

The Institute for Healthcare Improvement (IHI) is an independent not-for-profit organization helping to lead the improvement of health care throughout the world. Founded in 1991 and based in Cambridge, Massachusetts, IHI works to accelerate improvement by building the will for change, cultivating promising concepts for improving patient care, and helping health care systems put those ideas into action.

IHI works with health professionals throughout the world to accelerate the measurable and continual progress of health care systems toward these bold objectives, leading to breakthrough improvements that are truly meaningful in the lives of patients.

Mission

IHI is a catalyst for change, cultivating innovative concepts for improving patient care and implementing programs for putting those ideas into action.

Top Patient Safety Initiatives

IHI aims to improve the lives of patients, the health of communities, and the joy of the health care workforce by focusing on an ambitious set of goals adapted from the Institute of Medicine's six improvement aims for the health care system: Safety, Effectiveness, Patient-Centeredness, Timeliness, Efficiency, and Equity. The following are goals IHI strives for:

- No needless deaths
- No needless pain or suffering
- No helplessness in those served or serving
- No unwanted waiting
- No waste
- No one left out

The following are the IHI patient safety projects:

- Reducing Healthcare-Associated MRSA Infections on a Surgical Unit [Dec 08]
- Reducing Surgical Complications for Elective Surgery Inpatients [Oct 08]
- Reducing Hospital-Acquired Infections in a Long-Term Acute Care Hospital [Sep 08]
- Reducing Hospital-Acquired Infections in a Skilled Care Unit [Aug 08]

- Highly Reliable Surgical Teams (HRST): Improving Teamwork and Surgical Outcomes with
- Structured Briefings in a Large HMO [Apr 08]
- Medication Reconciliation Across the Continuum [Sept 06]
- Preventing Falls in the GI Surgical Unit [Mar 06]
- Reducing Surgical Site Infections [Mar 06]

Adverse Events Prevented Calculator

The Adverse Events (AEs) Prevented Calculator allows one to track the change in rate of any one type of adverse event over time and, when appropriate additional data are added, the consequent change in unnecessary deaths ("lives saved"), real and additional potential cost savings ("dark green dollar" savings and "light green dollar" savings, respectively), and the return on investment of quality improvement work targeting those adverse events.

Patient Safety Officer Program

To meet this challenge, and to comply with standards established by JCAHO and other agencies, hospitals identify a Patient Safety Officer to oversee the organization's strategy for keeping patients safe.

While these individuals usually have extensive clinical, quality or risk management experience, they are often under-prepared to effectively meet the daunting challenges of their new role and do not have ready access to the knowledge or tools needed to make the patient safety position robust and successful.

IHI's eight-day Patient Safety Officer Executive Development Program will cover topics critical to successful patient safety programs, including:

- Reliability Science: Using proven principles that pick up where vigilance leaves off
- Human Factors: Creating systems that compensate for the limits of human ability
- Accountability: Moving away from blame and shame
- Rules and Regulations: A guide to ensuring compliance with private, state, and federal standards

5 Million Lives Campaign

The 5 Million Lives Campaign was a voluntary initiative to protect patients from five million incidents of medical harm from December 2006 – December 2008.

The 5 Million Lives Campaign will ask hospitals to improve more rapidly than before the care they provide in order to protect patients from five million incidents of medical harm over a 24-month period, ending December 9, 2008. This represents a continuation of the largest improvement effort undertaken in recent history by the health care industry.

America's Blue Cross and Blue Shield health plans, the American Hospital Association (AHA), the

American Nurses Association (ANA), the Centers for Disease Control and Prevention (CDC), the Centers for Medicare & Medicaid Services (CMS) and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) will act as national champions and clinical advisors for the campaign.

The 5 Million Lives Campaign will promote the adoption of 12 improvements in care that can save lives and reduce patient injuries, and it aims to enroll even more hospitals than participated in the previous Campaign.

The 5 Million Lives Campaign aims to enlist 4,000 hospitals, challenging all to adopt up to 12 of the following interventions – six of which were included in the 100,000 Lives Campaign and six of which are new:

- Prevent Methicillin-Resistant Staphylococcus aureus (MRSA) infection...by reliably implementing scientifically proven infection control practices throughout the hospital.
- Reduce harm from high-alert medications...starting with a focus on anticoagulants, sedatives, narcotics, and insulin.
- Reduce surgical complications...by reliably implementing the changes in care recommended by the Surgical Care Improvement Project (SCIP).
- Prevent pressure ulcers...by reliably using science-based guidelines for prevention of this serious and common complication.
- Deliver reliable, evidence-based care for congestive heart failure…to reduce readmissions.
- Get boards on board…by defining and spreading new and leveraged processes for hospital boards of directors, so they can become far more effective in accelerating the improvement of care.

The six interventions from the 100,000 Lives Campaign

- Deploy Rapid Response Teams… at the first sign of patient decline – and before a catastrophic cardiac or respiratory event.
- Deliver reliable, evidence-based care for acute myocardial infarction…to prevent deaths from heart attack.
- Prevent adverse drug events…by reconciling patient medications at every transition point in care.
- Prevent central line infections…by implementing a series of interdependent, scientifically grounded steps.
- Prevent surgical site infections…by following a series of steps, including reliable, timely administration of correct perioperative antibiotics.
- Prevent ventilator-associated pneumonia…by implementing a series of interdependent, scientifically grounded steps.
- There is no cost for hospitals to join the 5 Million Lives Campaign though there is an obligation to adopt at least one intervention and an expectation of regularly reporting hospital profile and mortality data throughout the Campaign.

Firestone-Callahan & Associates

Association of Academic Health Centers (AAHC)

1400 Sixteenth Street, NW, Suite 720
Washington, DC 20036
www.aahcdc.org

Phone: (202) 265.9600
Fax: (202) 265-7514

Overview

As the national organization for academic health centers, the Association of Academic Health Centers seeks to improve the nation's health and well-being by strengthening, advocating, and leading on behalf of its member institutions, which are at the forefront of health professions education, patient care, and biomedical and health services research. This requires vigorous leadership that enhances and mobilizes the intellectual capital, influence, and resources of academic health centers towards the overarching goal of improving health care system.

Core Values

These are the core values of that guide the work of the Association of Academic Health Centers:

- Social Responsibility
- Leadership
- Innovation
- Collaboration
- Trust and Integrity

Three Imperatives

For the next three years, the Association of Academic Health Centers has recognized the following imperatives towards achieving its vision and mission:

1. Strengthen: We must strengthen the association and increase its capacity to serve its members.
2. Advocate: We must position the association as a vital voice regarding the nation's health, science, higher education, and economic infrastructure.
3. Lead: We must enhance the role of the association as a national leader on issues concerning the academic health center enterprise and the nation's health and well-being.

Mission

To improve the nation's health care system by mobilizing and enhancing the strengths and resources of the academic health center enterprise in health professions, education, patient care, and research

Top Patient Safety Initiatives

Although patient safety is at the forefront of AAHC's initiatives, they do not have any specific patient safety initiatives. Much of AAHC's work is in workforce management and clinical trials administration.

Det Norske Veritas (DNV)

<u>Overview</u>

DNV (Det Norske Veritas) was established in 1864 and is an independent foundation with a purpose to safeguard life, property and the environment. Increasing patient safety and reducing errors in healthcare is an important part of that purpose.

On 27 July, 2007, DNV acquired TUV Healthcare Specialists which was actively developing NIAHOSM. DNV's experience in hospital evaluations and rating spans the globe. DNV has been awarded by UK's NHSLA (National Health services Litigation Authority) a five year program to evaluate and rate the hundreds of hospitals it controls in England.

Furthermore, DNV has issued 1,200 ISO certificates to healthcare facilities worldwide, including hospitals, outpatient clinics, diagnostic centers, laboratories, nursing homes and homecare centers.

Headquarters for DNV Healthcare Inc. is Houston, Texas, with offices in Cincinnati, Ohio and we maintain survey staff throughout the United States

<u>Mission</u>

To Safeguard Life, Property, and the Environment.

<u>Top Patient Safety Initiatives</u>

Patient safety is at the core of DNV's risk management services for the healthcare sector. DNV delivers the risk management tools that hospitals and healthcare institutions need to reduce the risk of malpractice in particular and improve management in general.

DNV has been involved in improving quality and patient safety in hospitals and healthcare institutions through various means:

- Hospital accreditation
- Hospital evaluation and rating
- Hospital management system certification in accordance with national voluntary schemes
- Hospital management system certification to international standards
- Risk management tools/methodology
- Corporate Responsibility/sustainability/fraud prevention profiles

Hospital Accreditation Program

NIAHOSM is the first new CMS-approved accreditation program in more than 40 years, and is the first ever to integrate hospital accreditation with ISO 9001. NIAHOSM is designed from the ground up to drive quality transformation into the core processes of running a hospital.

With NIAHOSM, healthcare organizations meet their national accreditation obligations and achieve ISO 9001 compliance.

The goal is to offer healthcare organizations and companies a new alternative to hospital accreditation. DNV has already accredited 27 hospitals in 22 states participating in the NIAHOSM program.

Hospital Accreditation Program Comparison:

	DNV NIAHO℠	TJC
Deeming authority for Medicare CoPs	Yes	Yes
Accountable to CMS	Yes	No
Accreditation requirements	Fully consistent with CMS; stable	Determined by accreditor; change frequently
Survey process	Outcomes based	Inspection focused
Quantity of findings determine accreditation status	No	Yes
Approach to patient safety	Encourages innovation	Narrow path to compliance
Life safety survey	Comprehensive	Basic
Integrates ISO 9001 Quality Management System	Yes	No

**TJC = JCAHO

Partnership/Contract with England's NHS

In an effort to further develop its risk management programme, NHSLA has awarded DNV a contract to deliver risk assessment, standard development, training and helpdesk services to over 400 National Health Service (NHS) Trusts and more than 150 NHS maternity services in England.

The scope of work focuses on improving the safety of NHS patients and staff and thereby reducing the potential for litigation claims. An important aim of the NHSLA is to contribute to a reduction in the number of negligent, or preventable, incidents occurring within the country. It is essential, therefore, that there is an efficient process to reduce the potential for litigation claims and improve patient and staff safety.

According to a NHSLA spokesperson, the main aim of the partnership is to contribute to an improvement in risk management practices in the NHS and thereby support patient safety and the well-being of NHS staff.

Association for Professionals in Infection Control and Epidemiology (APIC)

1275 K St., NW, Suite 1000
Washington, DC, 20005-4006
www.apic.org

Phone: (202) 789-1890
Fax: (202) 789-1899
E-mail: apicinfo@apic.org

Overview

APIC has more than 12,000 members with primary responsibility for infection prevention, control and hospital epidemiology in healthcare settings around the globe. APIC's members include nurses, epidemiologists, physicians, quality and patient safety professionals, healthcare executives, microbiologists, clinical pathologists, laboratory technologists, and public health practitioners. APIC advances its mission through education, research, consultation, collaboration, public policy, practice guidance and credentialing.

The organization, which is based in Washington, DC, is led by an elected board of members who volunteer their time and expertise.

Vision 2012

By 2012, APIC will be recognized as the leader in infection prevention and control by practitioners, policy makers, healthcare executives, and consumers. In order to do so, APIC is working toward achieving the following goals:

- APIC will emphasize prevention and promote zero tolerance for healthcare-associated infections and other adverse events.
- APIC will ensure that appropriate standards and measures are set by which infection prevention and control programs are evaluated by regulatory agencies, healthcare executives, payers and consumers.
- Infection prevention and control will be recognized as a separate and distinct profession, whose members are positioned for leadership roles in healthcare.
- APIC will serve as a catalyst for leading edge research for the prevention of infection and associated adverse outcomes.
- APIC will play a leadership role in emergency preparedness related to infection prevention and control, including emerging and reemerging diseases, bioterrorism, natural disasters and other issues.

Mission

APIC's mission is to improve health and patient safety by reducing risks of infection and other adverse outcomes.

Top Patient Safety Initiatives

In addition to offering training and education for members, APIC has employed the following strategies related to patient safety.

Developing Standards for Public Reporting

APIC considers the need for standards and measures so important that the Association made a clear commitment in Vision 2012 to ensure that appropriate standards are set by which infection prevention and control programs are developed, managed and evaluated. This means playing an integral role at all levels of the health care system—from the crafting of voluntary consensus standards to the development of state and federal legislation.

For example, APIC was one of the primary drivers behind the groundbreaking project being undertaken by the National Quality Forum to create a standard approach to the reporting of healthcare-associated infection (HAI) data. APIC is also working at the state level to shape public reporting legislation. It is a key opportunity and strategy to prevent and reduce HAIs.

HAI Grant to University

As part of Vision 2012, APIC will play a strong role in supporting research related to the prevention of infection and related adverse events. Recently, The Research Foundation—a division of APIC—awarded a $100,000 grant to the Ohio State University Medical Center (OSUMC) to conduct a study on healthcare-associated infection (HAI) data. The study compared HAI data collected through traditional infection control surveillance methods and from administrative databases, which contain billing data and ICD-9 codes.

Playing a Leadership Role in Emergency Preparedness

APIC is a primary participant in the Working Group on Pandemic Influenza Preparedness, which has successfully advocated for pandemic preparedness plans and appropriations at the federal level. As part of this effort, APIC will conduct a second survey in collaboration with the Trust for America's Health to explore hospital preparedness challenges at the state level.

Promoting Zero Tolerance for Healthcare Associated Infections

Embedded in all of APIC's initiatives is the commitment to zero tolerance for healthcare-associated infections. APIC promotes a culture in which health care providers strive to prevent as many healthcare-associated infections as possible.

Endorsement of JCAHO Sentinel Analysis

APIC endorses JCAHO Sentinel Analysis integration to trach and monitor preventable injuries. JCAHO defines a sentinel event as "an unexpected occurrence involving death or serious physical or psychological injury." Serious injury specifically includes loss of limb or function. The JCAHO further

Firestone-Callahan & ASSOCIATES

prescribes a list of “reviewable” sentinel events as:

- Unexpected deaths
- Unanticipated major loss of function
- Infant abduction
- Infant discharged to wrong family
- Rape
- Hemolytic transfusion reaction
- Surgery on the wrong patient or body part
- Patient suicide

Targeting Zero Campaign

APIC's "Targeting Zero" campaign is a series of new educational initiatives promoting best practices and elimination strategies for Clostridium difficile-associated disease and infections that the Centers for Medicare & Medicaid Services (CMS) are planning for reduced reimbursement should these infections occur during a hospital stay.

The APIC/JCAHO Infection Control Workbook

This workbook is a for-sale product From a collaboration between the APIC and JCAHO. The workbook addresses infection control issues in a variety of health care settings. Involving the input of experienced and knowledgeable infection control professionals (ICPs), the workbook is designed to take an organization through the most challenging infection control-related issues facing ICPs and health care organizations today. The workbook format encourages organizations to develop action plans to address infection control issues found in their own self-assessment.

Firestone-Callahan & Associates

The Leapfrog Group

1150 17th Street NW, Suite 600
Washington DC 20036
www.leapfroggroup.org

Phone: (202) 292-6713
Fax: (202) 292-6813
Email: info@leapfroggroup.org

Overview

The Leapfrog Group is a voluntary program aimed at mobilizing employer purchasing power to alert America's health industry that advances in health care safety, quality and customer value will be recognized and rewarded. Among other initiatives, Leapfrog works with its employer members to encourage transparency and easy access to health care information as well as rewards for hospitals that have a proven record of high quality care.

Funding to set up Leapfrog came from the Business Roundtable (BRT) and The Leapfrog Group was officially launched in November 2000. Leapfrog is supported by the BRT, The Robert Wood Johnson Foundation, Leapfrog members and others.

Mission

To trigger giant leaps forward in the safety, quality and affordability of health care by:

- Supporting informed healthcare decisions by those who use and pay for health care; and,
- Promoting high-value health care through incentives and rewards.

Top Patient Safety Initiatives

Leapfrog Hospital Quality and Safety Survey/Hospital Quality Rankings

The Leapfrog Hospital Quality and Safety Survey asks hospitals to report on the steps they take to improve patient care. Leapfrog also asks hospitals to report on their performance through its Leapfrog Hospital Insights program. Results of the survey are available for public viewing on Leapfrog's website.

Leapfrog Standards

A range of hospital quality and safety practices are the focus of Leapfrog's hospital ratings via the Leapfrog Hospital Quality and Safety Survey, as well as hospital recognition and reward programs. Endorsed by the National Quality Forum (NQF), the practices are: computer physician order entry; evidence-based hospital referral; intensive care unit (ICU) staffing by physicians experienced in critical care medicine; and the Leapfrog Safe Practices Score.

- Computer Physician Order Entry (CPOE): With CPOE systems, hospital staff enter medication orders via computer linked to prescribing error prevention software. CPOE has been shown to reduce serious prescribing errors in hospitals by more than 50%.
- Evidence-Based Hospital Referral (EHR): Consumers and health care purchasers should choose hospitals with extensive experience and the best results with certain high-risk surgeries and conditions. By referring patients needing certain complex medical procedures to hospitals offering the best survival odds based on scientifically valid criteria — such as the number of times a hospital performs these procedures each year or other process or outcomes data — research indicates that a patient's risk of dying could be reduced by 40%.
- ICU Physician Staffing (IPS): Staffing ICUs with doctors who have special training in critical care medicine, called 'intensivists', has been shown to reduce the risk of patients dying in the ICU by 40%.
- Leapfrog Safe Practices Score: The National Quality Forum-endorsed 30 Safe Practices cover a range of practices that, if utilized, would reduce the risk of harm in certain processes, systems or environments of care. Included in the 30 practices are the three leaps above. This fourth leap assesses a hospitals' progress on the remaining 27 NQF safe practices.

Hospital Insights Measurement Tool

The Leapfrog Hospital Insights measurement tool integrates the first nationally collected set of hospital efficiency measures with standardized clinical measures from JCAHO and the Survey. This broad array of hospital performance measures gives consumers and purchasers a complete picture of overall hospital performance in five clinical areas and is the basis of Leapfrog's Hospital Rewards Program.

Leapfrog Group Position Statement on Never Events

To create an environment that supports making serious reportable adverse events even more rare than they are today, The Leapfrog Group is committed to cooperate with hospitals, health plans, consumer advocacy groups and its own members in the manner outlined below.

In its 2007 Quality and Safety Survey, The Leapfrog Group will give hospitals the opportunity to receive public recognition for agreeing to the following if a never event occurs within their facility:

- We will apologize to the patient and/or family affected by the never event
- We will report the event to at least one of the following agencies: Joint Commission on Accreditation of Healthcare Organizations (JCAHO), as part of its Sentinel Events policy*; state reporting program for medical errors; or a Patient Safety Organization (e.g. Maryland Patient Safety Center)
- We agree to perform a root cause analysis, consistent with instructions from the chosen reporting agency
- We will waive all costs directly related to a serious reportable adverse event

The Leapfrog Group and its members will partner with health plans through the Leapfrog Health Plan User Groups and Health Plan Lily Pad to encourage contracted hospitals to agree to the four steps outlined above for receiving public recognition.

The Leapfrog Group and its members will work with national and local consumer advocacy groups to encourage hospitals to agree to the four steps outlined above for receiving public recognition.

Firestone-Callahan & ASSOCIATES

American Society for Association for Healthcare Risk Managers (ASHRM)

One North Franklin, 28th floor
Chicago, IL 60606
www.ashrm.org

Phone: (312) 422-3980
Fax: (312) 422-4580
E-mail: ashrm@aha.org

Overview

Established in 1980, the American Society for Healthcare Risk Management is a personal membership group of the American Hospital Association with more than 5,200 members representing healthcare, insurance, law and other related professions.

ASHRM promotes effective and innovative risk management strategies and professional leadership through education, recognition, advocacy, publications, networking and interactions with leading health care organizations and government agencies.

ASHRM initiatives focus on developing and implementing safe and effective patient care practices, the preservation of financial resources and the maintenance of safe working environments.

Mission

To advance safe and trusted patient-centered health care delivery, ASHRM promotes proactive and innovative management of organization-wide risk.

Top Patient Safety Initiatives

Among AHSRM's advocacy agenda items, patient safety advocacy remains a high priority. In addition, ASHRM supports JCAHO initiatives and AHA principles.

Patient Safety Curriculum/Patient Safety Leadership Fellow

ASHRM builds upon its established leadership in the dynamic patient safety arena with the updated Patient Safety Curriculum – a unique program specifically designed to help healthcare risk management professionals understand and apply their key contributions to improved patient care and outcomes.

Patient Safety Curriculum participants qualify for nursing CE credits upon completion of the course. The program also counts toward ASHRM designations of FASHRM (Fellow) and DFASHRM (Distinguished Fellow), and toward CPHRM renewal.

Patient Safety Interest Network

The American Society for Healthcare Risk Management established its Interest Networks in recognition of the diversity of contributions its members make in managing healthcare risks.

The ASHRM Interest Networks deliver timely content via a quarterly newsletter for those managers of risk who may be more engaged in patient safety efforts or traditional risk management issues of risk financing and claims administration.

Each Interest Network:

- Delivers four e-newsletters during the year
- Supports a dedicated web page of relevant content, including newsletter archives and resource lists
- Provides educational opportunities for ASHRM Interest Network members

Firestone-Callahan & Associates

American Association of Resource Materials Managers (AHRMM)

One North Franklin
Chicago, IL 60606
www.ahrmm.org

Phone: (312) 422-3840
Fax: (312) 422-4573
E-mail: ahrmm@aha.org

Overview

The Association for Healthcare Resource & Materials Management (AHRMM) is the premier membership group for healthcare supply chain professionals. AHRMM strives to provide the education, information, and resources necessary for its members to remain at the top of their field. With approximately 4,000 members worldwide, AHRMM offers numerous opportunities for professionals to reach their highest potential and network with the best.

Mission

To advance healthcare through supply chain excellence.

Top Patient Safety Initiatives

AHRMM supports patient safety through advocating initiatives that protect, preserve, and promote patient rights and safety. Specifically, AHRMM avocates for public policy on quality; patient safety; and technology for safe patient care.

AHRMM View on Materials Management's Role in Patient Safety

Patient safety has added a new dimension to the role of materials managers. Materials managers serve as the 'gatekeepers' ensuring clinical staff is provided uniform system and products at the appropriate time and place. Materials management also provides staff education before an item arrives on the unit. Policing vendor access in the hospital also ensures only items properly reviewed are brought into the facility.

When evaluating products, safety and clinical efficacy is the first priority, followed closely by price. This ensures the best care is being delivered. To effective address patient safety, materials managers must integrate safety into their existing product evaluation and value analysis processes. Clinicians must be involved from the onset to help assess the operational impact of any system and/or product.

The materials manager's value analysis teams should be aware of items identified as "safety items". Another safety issue to consider is new products and stock outs. Will the new product be readily available during and after the trial? Finally, materials managers need to educate themselves about regulatory issues regarding patient safety. They need to keep ahead of the issues so they will no be taken by surprise or locked into a solution that is ineffective or harmful.

GS1 Healthcare Leadership Team

The executive director of the Association for Healthcare Resource & Materials Management (AHRMM), has been named to the GS1 Healthcare US Leadership Team – a group of 16 officials who are focused on implementing supply chain data standards into the U.S. healthcare system.

GS1 Healthcare US is an organization that focuses on driving the adoption and implementation of GS1 standards in the healthcare field to improve patient safety and supply chain efficiency. It brings together members from all segments of the healthcare field to address the issues that most impact healthcare in the U.S.

The GS1 Healthcare US Leadership Team includes 14 voting members with two members each representing a different part of the healthcare supply chain: acute care providers, alternate site care providers, distributors, pharmaceutical manufacturers, medical device manufacturers, group purchasing organizations and retail pharmacy. In addition, there are a maximum of two non-voting members from healthcare associations, healthcare education, government, and /or solution providers and two representatives from GS1 Healthcare US.

AHRMM Educational Organization Grants

The Board of Directors of the Association for Healthcare Resource & Materials Management (AHRMM) has donated over $175,000 in research grants to three groups supported by collegiate institutions, the SCMetrix™ program of the W.P. Carey School of Business at Arizona State University (ASU), the Massachusetts Institute of Technology's Efficient Healthcare Delivery Group (MEHD), and the University of Arkansas' Center for Innovation in Healthcare Logistics (CIHL).