

ASC Quality Measures: Implementation Guide

Version 2.0

ASC Quality Collaboration



www.ascquality.org

TABLE OF CONTENTS

<u>Background</u>	1
<u>Using This Implementation Guide</u>	3
<u>Measure Information: Appropriate Surgical Site Hair Removal</u>	5
<u>Measure Information: Hospital Transfer/Admission</u>	7
<u>Measure Information: Patient Burn</u>	9
<u>Measure Information: Patient Fall in the ASC</u>	12
<u>Measure Information: Prophylactic IV Antibiotic Timing</u>	14
<u>Measure Information: Wrong Site, Side, Patient, Procedure or Implant</u>	18
<u>Appendix A: Data Dictionary</u>	20
<u>Appendix B: Sample Data Collection Tools</u>	21
<u>Appendix C: Sample Data Collection Logs</u>	28

Background Information

The ASC Quality Collaboration

The ASC Quality Collaboration (ASC QC) is a cooperative effort of organizations and companies interested in ensuring that ASC quality data is measured and reported in a meaningful way. The ASC QC was formed early in 2006 to initiate the process of developing standardized ASC quality measures. The organization's stakeholders include ASC corporations, ASC associations, professional societies and accrediting bodies with a focus on health care quality and safety. Current contributors to the activities of the ASC QC include the Accreditation Association on Ambulatory Health Care; Ambulatory Surgery Foundation; Ambulatory Surgical Centers of America; American College of Surgeons; American Osteopathic Association, Division of Healthcare Facilities Accreditation Program; AmSurg; Association of periOperative Registered Nurses; Florida Society of Ambulatory Surgery Centers; Hospital Corporation of America, Ambulatory Surgery Division; Nueterra Healthcare; Outpatient Ophthalmic Surgery Society; Surgery Partners; Surgical Care Affiliates; Symbion; The Joint Commission; and United Surgical Partners International.

ASC Quality Measure Development by the ASC Quality Collaboration

When the ASC QC was formed, it undertook a detailed evaluation of existing nationally endorsed quality measures to determine which could be directly applied to the outpatient surgery facility setting. This survey included the measures and standards of the following organizations: National Quality Forum (NQF), Surgical Care Improvement Project (SCIP), The Joint Commission, Accreditation Association for Ambulatory Health Care (AAAHC), Ambulatory Care Quality Alliance (AQA), Agency for Healthcare Research and Quality (AHRQ), and Surgical Quality Alliance (SQA). Though several existing measures addressed surgical care, none had been developed specifically for the ASC setting.

Finding no nationally endorsed measures designed for public reporting and accountability specific to facilities performing outpatient surgery, the ASC QC developed a number of facility-level measures of ASC quality. These measures were based on those already commonly used by the ASC community for internal quality assessment and external benchmarking. The ASC QC focused on outcomes and processes that ASC facilities could influence or impact, outcomes that ASC facilities would be aware of given their limited contact with the patient, and outcomes that would be understandable and important to key stakeholders in ASC care - including patients, providers and payers. The ASC QC made no attempt to limit these measures to any particular patient population or procedure in order to allow broad participation and reporting of quality measures.

On November 15, 2007, five ASC QC facility-level measures were endorsed by the NQF after having gone through rigorous evaluation and consensus building. These five ASC quality measures are:

- Patient Burn
- Prophylactic IV Antibiotic Timing
- Patient Fall in the ASC

- Wrong Site, Side, Patient, Procedure or Implant
- Hospital Transfer/Admission

On October 17, 2008, a sixth ASC QC facility-level measure was endorsed by the NQF after having gone through rigorous evaluation and consensus building. The sixth quality measure is:

- Appropriate Surgical Site Hair Removal

About the National Quality Forum

The National Quality Forum (NQF) is a voluntary consensus standard setting organization established to standardize health care quality measurement and reporting through its consensus development process. The mission of the NQF is to improve the quality of American health care by setting national priorities and goals for performance improvement, endorsing national consensus standards for measuring and publicly reporting on performance, and promoting the attainment of national goals through education and outreach programs.

The NQF's consensus development process is rigorous. The six ASC QC facility-level measures went through the following steps prior to being endorsed:

- 1) Evaluation by a Technical Advisory Panel
- 2) Evaluation by a Steering Committee
- 3) Public and NQF member comments
- 4) NQF member vote
- 5) Consensus Standards Approval Committee review
- 6) Approval by the Board of the National Quality Forum

To learn more about the NQF and its activities, please visit the NQF website at:

<http://www.qualityforum.org/>.

Using This Implementation Guide

The ASC QC has developed this implementation guide to help ASCs implement and collect data for the six NQF-endorsed ASC facility-level quality measures it has developed. This guide is updated periodically.

The measures developed by the ASC QC include both *outcome measures* and *process measures*. An *outcome measure* assesses patients for a specific result of health care intervention. A *process measure* evaluates a particular aspect of the care that is delivered to the patient.

Of the six ASC QC measures, four are outcome measures. These measures include 1) patient falls, 2) patient burns, 3) hospital transfer/admission and 4) wrong site/wrong side/wrong patient/wrong procedure/wrong implant. The fifth and sixth measures are infection control process measures that evaluate the timing of the administration of intravenous antibiotics for prophylaxis of surgical site infection and appropriate surgical site hair removal.

In the sections that follow, details regarding each measure are presented first in tabular form, followed by additional supporting information. The table displayed below shows both the general format for sharing key information regarding the measure as well as an explanation of each element.

Name of Measure	
Measure Type	States whether the measure is an outcome measure or a process measure.
Intent	A brief description of what is measured.
Numerator/Denominator	Numerator: Patient population experiencing the outcome or process of care being measured.
	Denominator: The patient population evaluated.
Inclusions/Exclusions	Numerator Inclusions: Patients to be included in the patient population experiencing the outcome or process of care being measured.
	Numerator Exclusions: Patients to be excluded from the patient population experiencing the outcome or process of care being measured.
	Denominator Inclusions: Patients included in the population to be evaluated.
	Denominator Exclusions: Patients to be excluded from the population to be evaluated.
Data Sources	The documents that typically contain the information needed to determine the numerator and denominator.
Definitions	Specific definitions for the terms included in the numerator and denominator statements.

To report the results for each measure as a rate, count the number of patients meeting the numerator criteria and the number of patients meeting the denominator criteria. To calculate your results as a percentage, divide the numerator by the denominator and multiply by 100.

The appendices to this guide include a Data Dictionary (Appendix A), sample data collection tools for each measure (Appendix B), and sample data collection logs for the Prophylactic IV Antibiotic Timing and Appropriate Surgical Site Hair Removal measures (Appendix C).

Frequently Asked Questions about the ASC QC's Quality Measures

Do we count patients who are treated at the ASC, but not in an OR/procedure room? An example would be patients who come for a YAG Capsulotomy.

All ASC admissions are counted.

Do the measures offer opportunity for improvement?

Given there is little in the literature on ASC performance and outcomes, implementing these measures will provide a better understanding of the true incidence of these outcomes. The use of common definitions allows for standardized reporting of this information on a nationwide basis. This also allows ASCs to benchmark their results and focus their quality improvement efforts.

Why are these measures important to ASC industry?

These measures are important for several reasons:

- 1) There is very little in the literature that is specific to ASC performance and outcomes yet these adverse outcomes are significant and do occur. However, the frequency of these events is not currently known and only data collection will help determine the actual rate of occurrence.
- 2) Since most ASCs track some of these outcomes, they already recognize these as important measures of quality and therefore there is a greater opportunity for acceptance by the ASC industry, a greater chance that systems are in place to track, and a greater chance for compliance with reporting. Current utilization and statistics for internal quality improvement purposes attests to usability and measurability in the industry.
- 3) The outcomes and processes can be applied to any setting that performs outpatient surgery such as hospital outpatient departments, freestanding ASCs, and physician's offices - allowing the opportunity to apply these measures across patient care different settings.

How will the measures be updated?

These measures are updated by re-evaluating and updating the specifications on an annual or as needed basis. The measures also undergo a periodic maintenance process under the auspices of the National Quality Forum in order to remain endorsed.

Who can I contact with questions?

If your question is not answered after you read the implementation guide, you can access www.ascquality.org for more information.

How do I collect data for these measures?

Sample data collection tools are available in Appendix A. For process measures, additional sample data collection logs are available in Appendix B.

Measure Information: Appropriate Surgical Site Hair Removal

Appropriate Surgical Site Hair Removal	
Measure Type	Process
Intent	To capture the number of admissions (patients) who have appropriate surgical site hair removal.
Numerator/Denominator	Numerator: ASC admissions with surgical site hair removal with a razor or clippers from the scrotal area, or with clippers or depilatory cream from all other surgical sites.
	Denominator: All ASC admissions with surgical site hair removal.
Inclusions/Exclusions	Numerator Inclusions: ASC admissions with surgical site hair removal with a razor or clippers from the scrotal area, or with clippers or depilatory cream from all other surgical sites.
	Numerator Exclusions: None
	Denominator Inclusions: None
	Denominator Exclusions: ASC admissions who perform their own hair removal.
Data Sources	Potential data sources include records such as a pre-surgical checklist, nursing notes, operating room record, and operative report documenting the method of hair removal. Clinical logs designed to capture information relevant to preoperative hair removal are also potential sources.
Definitions	Admission: completion of registration upon entry into the facility.

Rationale

Razors can cause microscopic cuts and nicks to the skin, not visible to the eye. Use of razors prior to surgery increases the incidence of wound infection when compared to clipping, depilatory use or no hair removal at all. (Seropian. *Am J Surg.* 1971;121:251)

Clinical Practice Guidelines

The CDC's guidelines for the prevention of surgical site infection include recommendations which specifically address preoperative hair removal practices. The CDC guidelines state that providers should not remove hair preoperatively unless the hair at or around the incision site will interfere with the operation. If hair is removed, it should be removed immediately before the operation, and preferably with electric clippers. See the Guideline for Prevention of Surgical Site Infection, 1999. Hospital Infection Control Practices Advisory Committee. *Infect Control Hosp Epidemiol.* 1999;20:250-78.

AORN's standards of recommended practice are in alignment with this measure.

Frequently Asked Questions for Appropriate Surgical Site Hair Removal

Do we capture data for all patients who are admitted to the ASC?

No, only those patients with surgical site hair removal are counted.

Do we count ASC patients who shave themselves?

No, ASC admissions that perform their own hair removal are excluded.

How do I collect data for this measure?

A sample data collection tool is available in Appendix A. A sample data collection log is available in Appendix B.

References

- Alexander JW, Fischer JE, Boyajian M, Palmquist J, Morris MJ. The influence of hair-removal methods on wound infections. *Arch Surg*. 1983 Mar;118(3):347-52.
- Balthazar ER, Colt JD, Nichols RL. Preoperative hair removal: a random prospective study of shaving versus clipping. *South Med J*. 1982 Jul;75(7):799-801.
- Court-Brown CM. Preoperative skin depilation and its effect on postoperative wound infections. *J R Coll Surg Edinb*. 1981 Jul;26(4):238-41.
- Kjonniksen I, Andersen BM, Sondenaa VG, Segadal L. Preoperative hair removal--a systematic literature review. *AORN J*. 2002 May;75(5):928-38, 940.
- Ko W, Lazenby WD, Zelano JA, Isom OW, Krieger KH. Effects of shaving methods and intraoperative irrigation on suppurative mediastinitis after bypass operations. *Ann Thorac Surg*. 1992 Feb;53(2):301-5.
- Mangram AJ, Horan TC, Pearson ML, Silver LC, Jarvis WR. Guideline for prevention of surgical site infection, 1999. Hospital Infection Control Practices Advisory Committee. *Infect Control Hosp Epidemiol*. 1999;20:250 -78.
- Powis SJ, Waterworth TA, Arkell DG. Preoperative skin preparation: clinical evaluation of depilatory cream. *Br Med J*. 1976 Nov 13;2(6045):1166-8.
- Seropian R, Reynolds BM. Wound infections after preoperative depilatory versus razor preparation. *Am J Surg*. 1971 Mar;121(3):251-4.
- Tanner J, Moncaster K, Woodings D. Preoperative hair removal to reduce surgical site infection. *Cochrane Database Syst Rev*. 2006 Jul 19;3:CD004122.
- Thur de Koos P, McComas B. Shaving versus skin depilatory cream for preoperative skin preparation. A prospective study of wound infection rates. *Am J Surg*. 1983 Mar;145(3):377-8.
- Gurkan I, Wenz Sr, JF. Perioperative infection control: an update for patient safety in orthopedic surgery. *Orthopedics*. 2006 Apr;29(4):329.
- Fletcher N, Sofianos D, Berkes MB, Obremsky WT. Prevention of perioperative infection. *J Bone Joint Surg Am*. 2007;89:1605-18.
- Cruse P. Wound infection surveillance. *Rev Infect Dis* 1981; 3:734-737.
- Cruse PJ, Foord R. The epidemiology of wound infection: a 10-year prospective study of 62,939 wounds. *Surg Clin North Am* 1980; 60:27-40.
- Anderson DJ et al. Strategies to prevent surgical site infections in acute care hospitals. *Infect Control Hosp Epidemiol* 2008 Oct;29 Suppl 1:S51-61.
- Association of Operating Room Nurses. Recommended practices for skin preparation of patients. *AORN J*. 2002 Jan;75(1):184-7.

Measure Information: Hospital Transfer/Admission

Hospital Transfer/Admission	
Measure Type	Outcome
Intent	To capture any ASC admissions (patients) who are transferred or admitted to a hospital upon discharge from the ASC.
Numerator/Denominator	Numerator: Ambulatory Surgery Center (ASC) admissions requiring a hospital transfer or hospital admission upon discharge from the ASC. Denominator: All ASC admissions.
Inclusions/Exclusions	Numerator Inclusions: ASC admissions requiring a hospital transfer or hospital admission upon discharge from the ASC. Numerator Exclusions: None. Denominator Inclusions: All ASC admissions. Denominator Exclusions: None.
Data Sources	ASC medical records, incident/occurrence reports and variance reports are potential data sources.
Definitions	Admission: completion of registration upon entry into the facility. Hospital transfer/admission: any transfer/admission from an ASC directly to an acute care hospital including hospital emergency room. Discharge: occurs when the patient leaves the confines of the ASC.

Rationale

The need for transfer/admission is an unanticipated outcome and could be the result of insufficient rigor in patient or procedure selection. Hospital transfers/admissions can result in unplanned cost and time burdens that must be borne by patients and payers.

Selected states have expressed an interest in the public reporting of such events. While hospital transfers and admissions undoubtedly represent good patient care when necessary, high rates may be an indicator that practice patterns or patient selection guidelines are in need of review.

Clinical Practice Guidelines

No clinical practice guidelines addressing transfers or admissions from ASCs to acute care hospitals are available at this time.

Frequently Asked Questions for Hospital Transfer/Admission

Should patients who go to a hospital emergency room sometime after their discharge be counted?

To allow consistent reporting, only patients who are directly transferred or directly admitted to the hospital upon their discharge from the ASC are counted for purposes of this measure.

Do we count ASC patients who are admitted to the hospital sometime after their discharge from the ASC secondary to a complication of surgery?

No, only patients who are directly transferred or admitted to the hospital upon their discharge from the ASC should be counted. This helps ensure the rates reported are consistent.

Do we capture data for all ASC patients who are directly transferred or admitted to the hospital setting regardless of reason?

Yes, all transfers or admissions to the hospital that take place upon discharge from the ASC should be counted, regardless of the reason for the transfer or admission.

Do we count patients who are transferred to the hospital setting in an automobile upon discharge?

Yes. All transfers or admissions upon discharge from the ASC are counted, regardless of the mode of transportation.

How could a facility benefit from this measure?

If transfers/admissions are determined to be at a level higher than expected, ASCs could assess their center's guidelines for patient and/or procedure selection. If commonalities are found in patients who are transferred or admitted, guidelines may require revision.

How do I collect data for this measure?

A sample data collection tool is available in Appendix A.

References

Coley K et al. Retrospective evaluation of unanticipated admissions and readmissions after same day surgery and associated costs. *J Clin Anesth.* 2002;14:349-353.

Lin D, Dalgorf D, Witterick IJ. Predictors of unexpected hospital admissions after outpatient endoscopic sinus surgery: retrospective review. *J Otolaryngol Head Neck Surg.* 2008 Jun;37(3):309-11.

Hofer RE, Kai T, Decker PA, Warner DO. Obesity as a risk factor for unanticipated admissions after ambulatory surgery. *Mayo Clin Proc.* 2008 Aug;83(8):908-16.

Tewfik MA, Frenkiel S, Gasparrini R, Zeitouni A, Daniel SJ, Dolev Y, Kost K, Samaha M, Sweet R, Tewfik TL. Factors affecting unanticipated hospital admission following otolaryngologic day surgery. *J Otolaryngol.* 2006 Aug;35(4):235-41.

Shirakami G, Teratani Y, Namba T, Hirakata H, Tazuke-Nishimura M, Fukuda K. Delayed discharge and acceptability of ambulatory surgery in adult outpatients receiving general anesthesia. *J Anesth.* 2005;19(2):93-101.

Lau H, Brooks DC. Predictive factors for unanticipated admissions after ambulatory laparoscopic cholecystectomy. *Arch Surg.* 2001 Oct;136(10):1150-3.

Junger A, Klasen J, Benson M, Sciuk G, Hartmann B, Sticher J, Hempelmann G. Factors determining length of stay of surgical day-case patients. *Eur J Anaesthesiol.* 2001 May;18(5):314-21.

Fortier J, Chung F, Su J. Unanticipated admission after ambulatory surgery—a prospective study. *Can J Anaesth.* 1998 Jul;45(7):612-9.

Margovsky A. Unplanned admissions in day-case surgery as a clinical indicator for quality assurance. *Aust N Z J Surg.* 2000 Mar;70(3):216-20.

Lledó JB, Planells M, Espí A, Serralta A, García R, Sanahuja A. Predictive model of failure of outpatient laparoscopic cholecystectomy. *Surg Laparosc Endosc Percutan Tech.* 2008 Jun;18(3):248-53.

Shaikh S, Chung F, Imarengiaye C, Yung D, Bernstein M. Pain, nausea, vomiting and ocular complications delay discharge following ambulatory microdiscectomy. *Can J Anaesth.* 2003 May;50(5):514-8.

Measure Information: Patient Burn

Patient Burn	
Measure Type	Outcome
Intent	To capture the number of admissions (patients) who experience a burn prior to discharge.
Numerator/Denominator	Numerator: Ambulatory Surgery Center (ASC) admissions experiencing a burn prior to discharge. Denominator: All ASC admissions.
Inclusions/Exclusions	Numerator Inclusions: ASC admissions experiencing a burn prior to discharge.
	Numerator Exclusions: None.
	Denominator Inclusions: All ASC admissions.
	Denominator Exclusions: None.
Data Sources	ASC medical records, as well as incident/occurrence reports, and variance reports are potential data sources.
Definitions	Admission: completion of registration upon entry into the facility.
	Burn: Unintended tissue injury caused by any of the six recognized mechanisms: scalds, contact, fire, chemical, electrical or radiation, (e.g. warming devices, prep solutions, electrosurgical unit or laser).
	Discharge: Occurs when the patient leaves the confines of the ASC.

Rationale

There are numerous case reports in the literature regarding patient burns in the surgical and procedural setting. The diversity of the causative agents underscores the multitude of potential risks that must be properly mitigated to avoid patient burns.

The literature on burns suggests that electrosurgical burns are most common. A recent publication from the ECRI highlights the increased risk of burns with newer surgical devices that apply higher currents at longer activation times. Although electrical burns are most prevalent, other mechanisms of burn injury are frequently reported in case studies and case series. These include chemical and thermal burns.

Surgical fires are rare; however, their consequences can be grave, killing or seriously injuring patients and surgical staff. The risk of surgical fire is present whenever and wherever surgery is performed, whether in an operating room, a physician's office, or an outpatient clinic.

Recognizing the diversity of mechanisms by which a patient could sustain an unintentional burn in the ASC setting, the definition of burn is broad, encompassing all six recognized means by which a burn can occur - scalds, contact, fire, chemical, electrical, or radiation. This will allow stakeholders to develop a better understanding of the incidence of these events and further refine means to ensure prevention.

Clinical Practice Guidelines

The risk of burns related to laser use can be reduced by adherence to the guidelines published by the ANSI (American National Standards Institute) for safe use of these devices in the health

care setting. Similarly, the risk of burns related to the use of electrosurgical devices can be reduced by following the electrosurgery checklist published by ECRI.

The risk of surgical fires can be reduced by minimizing ignition, oxidizer, and fuel risks (the “classic triangle”). The American Society of Anesthesiologists’ Practice Advisory for the Prevention and Management of Operating Room Fires seeks to prevent the occurrence of OR fires, reduce adverse outcomes associated with OR fires and identify the elements of a fire response protocol. These guidelines are available here: <http://www.asahq.org/For-Members/Practice-Management/Practice-Parameters.aspx>. Guidance for the prevention of surgical fire has also been published by AORN.

Frequently Asked Questions Regarding the Patient Burn Measure

Do all ASCs have conditions that would result in a patient burn?

Yes, because the definition of burn in this measure is comprehensive, every ASC has the potential for a patient to experience a burn during an episode of care.

Did the ASC Quality Collaboration consider stratifying by type of burn?

Stratification by type of burn was considered, but consensus of the workgroup was that a burn is an unexpected outcome in an ASC and should not occur regardless of the source, degree or type of burn.

How do I collect data for this measure?

A sample data collection tool is available in Appendix A.

References

American National Standards Institutes (ANSI) Z136.3 (2005) - Safe Use of Lasers in Health Care Facilities, 2005 Revision.

American Society of Anesthesiologists Task Force on Operating Room Fires, Caplan RA, Barker SJ, et al. Practice advisory for the prevention and management of operating room fires. *Anesthesiology* 2008 May;108(5):786-801.

Anesthesia Patient Safety Foundation (APSF). Prevention and management of surgical fires [video]. February 2010. http://www.apsf.org/resources_video.php.

ECRI Institute. New clinical guide to surgical fire prevention: patients can catch fire—here’s how to keep them safer [guidance article]. *Health Devices* 2009 Oct;38(10):314-32.

ECRI. Electrosurgery Checklist. http://www.mdsr.ecri.org/summary/detail.aspx?doc_id=8271.

National Fire Protection Association (NFPA). NFPA 99: standard for health care facilities. Quincy (MA): NFPA; 2005.

Association of Operating Room Nurses (AORN). AORN Guidance Statement: Fire Prevention in the Operating Room in Standards, Recommended Practices, and Guidelines. Denver, CO: AORN, 2006.

AORN. Fire safety Tool Kit. 2011. <http://www.aorn.org/PracticeResources/ToolKits/FireSafetyToolKit/>.

National Quality Forum. Serious Reportable Events in Healthcare 2006 Update. Washington, DC: NQF, 2007.

Joint Commission. Joint Commission Sentinel Event Alert. Issue 12, February 4, 2000. Operative and Postoperative Complications: Lessons for the Future. Chicago, IL

Tucker R. Laparoscopic electro-surgical injuries: survey results and their implications. *Surg Laparosc Endosc.* 1995;5(4):311-7.

ECRI. Higher currents, greater risks: preventing patient burns at the return-electrode site during high-current electro-surgical procedures. *Health Devices.* 2005;34(8):273-9.

Demir E, O'Dey D, and Pallua N. Accidental burns during surgery. *J Burn Care Res.* 2006 ;27(6):895-900.

Cheney F, Posner K, Caplan R, and Gild W. Burns from warming devices in anesthesia. A closed claims analysis. *Anesthesiology.* 1994;80(4):806-10.

Barker S and Polson J. Fire in the operating room: a case report and laboratory study. *Anesth Anal.* 2001;93:960-965.

ECRI. Devastation of patient fires. *Health Devices.* 1992;21:3-39.

Bhananker S, Posner K, Cheney F, Caplan R, Lee L, and Domino K. Injury and liability associated with monitored anesthesia care: a closed claims analysis. *Anesthesiology.* 2006;104(2):228-34.

Measure Information: Patient Fall in the ASC

Patient Fall in the ASC	
Measure Type	Outcome
Intent	To capture the number of admissions (patients) who experience a fall within the ASC.
Numerator/Denominator	Numerator: Ambulatory Surgery Center (ASC) admissions experiencing a fall within the confines of the ASC.
	Denominator: All ASC admissions.
Inclusions/Exclusions	Numerator Inclusion: ASC admissions experiencing a fall within the confines of the ASC.
	Numerator Exclusion: ASC admissions experiencing a fall outside the ASC.
	Denominator Inclusion: All ASC admissions.
	Denominator Exclusions: None
Data Sources	ASC medical records, as well as incident/occurrence reports, and variance reports are potential data sources.
Definitions	Admission: completion of registration upon entry into the facility.
	Fall: a sudden, uncontrolled, unintentional, downward displacement of the body to the ground or other object, excluding falls resulting from violent blows or other purposeful actions. (National Center for Patient Safety)

Rationale

“Falls per 100,000 patient days” has been endorsed as a serious reportable event by the NQF. While ASCs have a relatively low incidence of adverse events in general, information regarding the incidence of patient falls is not currently available. However, stakeholders have expressed a general interest in the public reporting of such adverse events. Due to the use of anxiolytics, sedatives, and anesthetic agents as adjuncts to procedures, patients undergoing outpatient surgery are at increased risk for falls.

Clinical Practice Guidelines

According to the Agency for Healthcare Research and Quality’s *Prevention of Falls in Acute Care* guideline, patient falls may be reduced by following a four-step approach: 1) evaluating and identifying risk factors for falls in the older patient; 2) developing an appropriate plan of care for prevention; 3) performing a comprehensive evaluation of falls that occur; and 4) performing a post-fall revision of plan of care as appropriate.

Frequently Asked Questions for Patient Fall in the ASC

Should we count assisted falls under this measure?

Yes, assisted falls are considered falls for the purposes of this measure.

What about falls in the parking lot? Should those be counted?

The physical plant and location of ASCs is highly variable. In order to assure that the measure would be applicable to all settings, reportable falls are limited to those which occur within the confines of the facility itself. Falls in the parking lot should not be counted.

Should we count falls that are not witnessed?

All patient falls are counted, regardless of whether they are witnessed or not.

How do I collect data for this measure?

A sample data collection tool is available in Appendix A.

References

Institute for Clinical Systems Improvement (ICSI). Prevention of falls (acute care). Health care protocol. Bloomington (MN): Institute for Clinical Systems Improvement (ICSI); 2010 Apr. p 34.

Boushon B, Nielsen G, Quigley P, Rutherford P, Taylor J, Shannon D. Transforming Care at the Bedside How-to Guide: Reducing Patient Injuries from Falls. Cambridge, MA: Institute for Healthcare Improvement; 2008.

ECRI Institute. Falls Prevention Resources. https://www.ecri.org/Products/Pages/Fall_Prevention_Resources.aspx.

Joint Commission. 2011-2012 National Patient Safety Goals. http://www.jointcommission.org/standards_information/npsgs.aspx.

National Center for Patient Safety: United States Department of Veterans Affairs. <http://www.patientsafety.gov/CogAids/FallPrevention/index.html#page=page-1>.

National Quality Forum. Serious Reportable Events in Healthcare – 2006 Update: A Consensus Report. March 2007.

Gray-Micelli D. Preventing falls in acute care. In: Capezuti E, Zwicker D, Mezey M, Fulmer T, editor(s). Evidence-based geriatric nursing protocols for best practice. 3rd ed. New York (NY): Springer Publishing Company; 2008. p. 161-98.

American Geriatrics Society, British Geriatrics Society, American Academy of Orthopedic Surgeons (AGS/BGS/AAOS) Guidelines for the Prevention of Falls in Older Persons (2001). Journal of American Geriatrics Society, 49, 664–672.

American Medical Directors Association (AMDA). Falls and fall risk. Columbia, MD: American Medical Directors Association.

ECRI Institute: Falls Prevention Strategies in Healthcare Settings (2006). Plymouth Meeting, PA.

Institute for Clinical Systems Improvement. Prevention of Falls (Acute Care). Second Edition. April 2010.

Resnick, B. (2003). Preventing falls in acute care. In: M. Mezey, T. Fulmer, I. Abraham (Eds.) & D. Zwicker (Managing Ed.), Geriatric nursing protocols for best practice (2nd ed., pp. 141–164). New York: Springer Publishing Company, Inc.

University of Iowa Gerontological Nursing Interventions Research Center (UIGN). (2004). Falls prevention for older adults. Iowa City, IA: University of Iowa Gerontological Nursing Interventions Research Center, Research Dissemination Core.

(Please note this is not intended to be an exhaustive list of the organizations issuing statements or guidance related to falls.)

Measure Information: Prophylactic IV Antibiotic Timing

Prophylactic IV Antibiotic Timing	
Measure Type	Process
Intent	To capture whether intravenous antibiotics given for prevention of surgical site infection were administered on time.
Numerator/Denominator	Numerator: Number of Ambulatory Surgery Center (ASC) admissions with an order for a prophylactic IV antibiotic for prevention of surgical site infection who received the prophylactic antibiotic on time.
	Denominator: All ASC admissions with a preoperative order for a prophylactic IV antibiotic for prevention of surgical site infection.
Inclusions/Exclusions	Numerator Exclusions: None.
	Denominator Exclusions: ASC admissions with a preoperative order for a prophylactic IV antibiotic for prevention of infections other than surgical site infections (e.g. bacterial endocarditis); ASC admissions with a preoperative order for a prophylactic antibiotic not administered by the intravenous route.
Data Sources	ASC medical records, as well as medication administration records, and variance reports may serve as data sources. Clinical logs designed to capture information relevant to prophylactic IV antibiotic administration are also potential sources.
Data Element Definitions	Admission: completion of registration upon entry into the facility.
	Antibiotic administered on time: Antibiotic infusion is <i>initiated</i> within one hour prior to the time of the initial surgical incision or the beginning of the procedure (e.g., introduction of endoscope, insertion of needle, inflation of tourniquet) or two hours prior if vancomycin or fluoroquinolones are administered.
	Intravenous: Administration of a drug within a vein, including bolus, infusion or IV piggyback.
	Order: a written order, verbal order, standing order or standing protocol.
	Prophylactic antibiotic: an antibiotic prescribed with the intent of reducing the probability of an infection related to an invasive procedure. For purposes of this measure, the following antibiotics are considered prophylaxis for surgical site infections: Ampicillin/sulbactam, Aztreonam, Cefazolin, Cefmetazole, Cefotetan, Cefoxitin, Cefuroxime, Ciprofloxacin, Clindamycin, Ertapenem, Erythromycin, Gatifloxacin, Gentamicin, Levofloxacin, Metronidazole, Moxifloxacin, Neomycin and Vancomycin.

Rationale

The CMS Surgical Infection Prevention performance measure states, “Surgical site infections occur in 2-5 percent of clean extra-abdominal surgeries and up to 20 percent of intra-abdominal surgeries. Each infection is estimated to increase a hospital stay by an average of 7 days and add over \$3,000 in charges (1992 data). Patients who develop surgical site infections are 60 percent more likely to spend time in an ICU, five times more likely to be readmitted to the hospital, and have twice the incidence of mortality. Despite advances in infection control practices, surgical site infections remain a substantial cause of morbidity and mortality among hospitalized patients. Studies indicate that appropriate preoperative administration of antibiotics

is effective in preventing infection. Systemic and process changes that promote compliance with established guidelines and standards can decrease infectious morbidity.”

There is no literature available on variation in adherence to recommended prophylactic IV antibiotic timing among ASC providers. However, variability in the accuracy of timing of administration has been demonstrated in other settings.

Clinical Practice Guidelines

This performance measure is aligned with current surgical infection prevention guidelines recommending that prophylactic antibiotics be administered within one hour prior to surgical incision, or within two hours prior to incision when vancomycin or fluoroquinolones are used.

Frequently Asked Questions for Prophylactic IV Antibiotic Timing:

What is the goal for this measure?

A reasonable goal for this measure is an on-time administration rate in the 99%-100% range.

For prophylactic antibiotics, do we only count those ordered for IV administration? Not eye drops when used for the same purpose?

Only patients with orders that specify an intravenous route of administration should be counted.

If an antibiotic is ordered that is not included in the list of prophylactic antibiotics for this measure, should we count it?

No, the only antibiotics that are considered for inclusion in this measure are those that are included in the definition of “prophylactic antibiotic”.

If an antibiotic is ordered for the prophylaxis of spontaneous bacterial endocarditis (SBE), should we count it?

No, the only antibiotics administered for the prophylaxis of surgical site infection are included for measurement.

What happens when two or more prophylactic antibiotics are given to the same patient for the same procedure?

The infusion of all prophylactic IV antibiotics ordered for surgical site infection would need to be initiated within the one-hour time frame (two hours for vancomycin or fluoroquinolones). In cases involving more than one antibiotic, all antibiotics must be initiated within the appropriate time frame in order for the case to meet criteria.

Does the timing of the antibiotic start at the completion of the antibiotic or the start of the antibiotic?

The timing begins at the time the antibiotic infusion is initiated. To meet the intent the antibiotic should be initiated within one hour of the initial surgical incision or the beginning of the procedure (two hours for vancomycin or fluoroquinolones).

Do you include patients who do not have an order for prophylactic IV antibiotics?

Patients without an order for prophylactic IV antibiotics are not included.

If the order for the antibiotic is given after the procedure has started, should the case be counted?

If the order for the antibiotic is given after the procedure has started, the case should not be included. The denominator for this measure specifically requires a preoperative order.

This measure is difficult to track. Why did you develop an IV antibiotic timing measure?

This measure was developed to harmonize with a similar measure under Surgical Care Improvement Project (SCIP). Evidence shows initiating prophylactic antibiotics within one hour of incision, procedure, or tourniquet results in better outcomes.

Is tourniquet time a substitute for incision time?

Tourniquet time is included based on published studies that demonstrate higher tissue concentrations of prophylactic antibiotics when the administration is prior to tourniquet inflation. The use of tourniquet time is consistent with the American Academy of Orthopedic Surgery Advisory Statement that recommends infusion prior to inflation of a proximal tourniquet, rather than prior to incision.

How was the list of antibiotics developed?

This prophylactic antibiotic timing measure has been specifically designed to harmonize with, and be complementary to, similar measures developed to evaluate physician performance in this area. Therefore, the list of antibiotics included in this measure is the same list of antibiotics designated in the measures submitted by the ACS/AMA PCPI/NCQA for measurement of physician performance.

How do I collect data for this measure?

A sample data collection tool is available in Appendix A. A sample data collection log is available in Appendix B.

References

Horan T, Culver D, Gaynes R, Jarvis W, Edwards J, and Reid C. Nosocomial infections in surgical patients in the United States, January 1986-June 1992. National Nosocomial Infections Surveillance (NNIS) System. *Infect Control Hosp Epidemiol.* 1993;14(2):73-80.

Marton W, Jarvis W, Culver D, and Haley R. Incidence and nature of endemic and epidemic nosocomial infections. In: Bennett J, Brachman P, editor(s). *Hospital infections.* 3rd ed. Boston, MA: Little, Brown and Co.; 1992. 577-596.

Kirkland K, Briggs J, Trivette S, Wilkinson W, and Sexton D. The impact of surgical-site infections in the 1990s: attributable mortality, excess length of hospitalization, and extra costs. *Infect Control Hosp Epidemiol.* 1999;20(11):725-30.

Burke J. Maximizing appropriate antibiotic prophylaxis for surgical patients: an update from LDS Hospital, Salt Lake City. *Clin Infect Dis.* 2001;33(Suppl 2):S78-83.

Classen D et al. The timing of prophylactic administration of antibiotics and the risk of surgical wound infection. *NEJM.* 1992;326(5):281-286.

Silver A et al. Timeliness and use of antibiotic prophylaxis in selected inpatient surgical procedures. The Antibiotic Prophylaxis Study Group. *Am J Surg.* 1996;171(6):548-552.

Papaoiannou N, Kalivas L, Kalavritinos J, and Tsourvakas S. Tissue concentrations of third-generation cephalosporins (ceftazidime and ceftriaxone) in lower extremity tissues using a tourniquet. *Arch Orthop Trauma Surg.* 1994;113(3):167-9.

Dounis E, Tsourvakas S, Kalivas L, and Giamacellou H. Effect of time interval on tissue concentrations of cephalosporins after tourniquet inflation. Highest levels achieved by administration 20 minutes before inflation. *Acta Orthop Scand.* 1995;66(2):158-60.

Friedrich L, White R, Brundage D, Kays M, Friedman R. The effect of tourniquet inflation on cefazolin tissue penetration during total knee arthroplasty. *Pharmacotherapy.* 1990; 10(6):373-7.

Steinberg JP, Barun BI, Hellinger WC, Kusek L, Bozikis MR, Bush AJ, Dellinger EP, Burke JP, Simmons B, Kritchevsky SB, Trial to reduce antimicrobial prophylaxis errors (TRAPE) study group. Timing of antimicrobial prophylaxis and the risk of surgical site infections: results from the trial to reduce antimicrobial prophylaxis errors. *Ann Surg* 2009;250(1):10-6.

Forbes SS, Stephen WJ, Harper WL, Loeb M, Smith R, Christoffersen EP, McLean RF. Implementation of evidence-based practices for surgical site infection prophylaxis: results of a pre- and postintervention study. *J Am Coll Surg.* 2008 Sep;207(3):336-41.

Koopman E, Nix DE, Erstad BL, Demeure MJ, Hayes MM, Ruth JT, Mattias KR. End-of-procedure cefazolin concentrations after administration for prevention of surgical-site infection. *Am J Health Syst Pharm.* 2007 Sep;64(18):1927-34.

Manniën J, van Kasteren ME, Nagelkerke NJ, Gyssens IC, Kullberg BJ, Wille JC, de Boer AS. Effect of optimized antibiotic prophylaxis on the incidence of surgical site infection. *Infect Control Hosp Epidemiol.* 2006;27(12):1340-6.

Measure Information: Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant

Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant	
Measure Type	Outcome
Intent	To capture any ASC admissions (patients) who experience a wrong site, side, patient, procedure or implant.
Numerator/Denominator	Numerator: All Ambulatory Surgery Center (ASC) admissions experiencing a wrong site, wrong side, wrong patient, wrong procedure or wrong implant.
	Denominator: All ASC admissions.
Inclusions/Exclusions	Numerator Inclusions: All ASC admissions experiencing a wrong site, wrong side, wrong patient, wrong procedure or wrong implant.
	Numerator Exclusions: None.
	Denominator Inclusions: All ASC admissions.
	Denominator Exclusions: None.
Data Sources	ASC medical records, as well as incident/occurrence reports, and variance reports are potential data sources.
Definitions	Admission: completion of registration upon entry into the facility.
	Wrong: not in accordance with intended site, side, patient, procedure or implant.

Rationale

“Surgery performed on the wrong body part”, “surgery performed on the wrong patient”, and “wrong surgical procedure performed on a patient” have all been endorsed as serious reportable surgical events by NQF. This outcome measure serves as an indirect measure of providers’ adherence to the Joint Commission’s “Universal Protocol” guideline for eliminating wrong site, wrong procedure, wrong person surgery. The Universal Protocol is based on the consensus of experts and is endorsed by more than forty professional medical associations and organizations. In order to encompass the outcomes of all key identification verifications, the ASC Quality Collaboration’s measure incorporates not only wrong site, wrong side, wrong patient and wrong procedure, but also wrong implant in its specifications.

Clinical Practice Guidelines

The Joint Commission’s “Universal Protocol” is based on the consensus of experts from the relevant clinical specialties and professional disciplines and is endorsed by more than 40 professional medical associations and organizations.

Frequently Asked Questions for Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant

Isn't the incidence of wrong site, etc. surgery low in surgery centers?

While the incidence of wrong-site surgeries is low, the potential for wrong-site (bilateral options) and the impact on patient care associated with each incident make this a priority in ASCs.

Do you count a block (preoperative or intraoperative) given on the incorrect side?

Yes, you count any procedure that was done on the wrong side.

Do you count an injection of local given on the incorrect side?

Yes, you count this as a wrong side event.

Should the administration of topical anesthetic drops in the wrong eye be considered a wrong site event?

No, administration of topical anesthetic drops in the wrong eye should not be counted as a wrong site event. Such an occurrence would be considered a medication administration variance.

How do I collect data for this measure?

A sample data collection tool is available in Appendix A.

References

Joint Commission. *Universal Protocol For Preventing Wrong Site, Wrong Procedure, Wrong Person Surgery*. Available at: http://www.jointcommission.org/standards_information/up.aspx. Last accessed December 14, 2010.

American Academy of Ophthalmology. Recommendations of American Academy of Ophthalmology Wrong-Site Task Force. http://one.aao.org/ce/practiceguidelines/patient_content.aspx?cid=d0db838c-2847-4535-baca-aebab3011217.

American Academy of Orthopaedic Surgeons. Wrong-Site Surgery. Information Statement 1015. <http://www.aaos.org/about/papers/advistmt/1015.asp>.

American College of Obstetricians and Gynecologists. ACOG committee opinion #464: patient safety in the surgical environment. *Obstet Gynecol*. 2010;116(3):786-790.

American College of Surgeons. [ST-41] Statement on ensuring correct patient, correct site, and correct procedure surgery. http://www.facs.org/fellows_info/statements/st-41.html

AORN. AORN Position Statement on Preventing Wrong-Patient, Wrong-Site, Wrong-Procedure Events. <http://www.aorn.org/PracticeResources/AORNPositionStatements/PositionCorrectSiteSurgery/>.

Institute of Medicine. *To Err is Human: Building a Safer Health System*. Washington, DC: National Academy Press, 2000.

Joint Commission. 2011 National Patient Safety Goals. http://www.jointcommission.org/standards_information/npsgs.aspx.

National Quality Forum. *Serious Reportable Events in Healthcare – 2006 Update: A Consensus Report*. March 2007.

World Health Organization. *WHO Guidelines for Safe Surgery 2009*. http://whqlibdoc.who.int/publications/2009/9789241598552_eng.pdf.

Appendix A: Data Dictionary

Admission: Completion of registration upon entry into the facility.

Antibiotic administered on time: Antibiotic infusion is *initiated* within one hour prior to the time of the initial surgical incision or the beginning of the procedure (e.g., introduction of endoscope, insertion of needle, inflation of tourniquet) or two hours prior if vancomycin or fluoroquinolones are administered.

Burn: Unintended tissue injury caused by any of the six recognized mechanisms: scalds, contact, fire, chemical, electrical or radiation, (e.g. warming devices, prep solutions, electro-surgical unit or laser).

Discharge: Occurs when the patient leaves the confines of the ASC.

Fall: A sudden, uncontrolled, unintentional, downward displacement of the body to the ground or other object, excluding falls resulting from violent blows or other purposeful actions. (National Center for Patient Safety)

Hospital transfer/admission: Any transfer/admission from an ASC directly to an acute care hospital including hospital emergency room or emergency department.

Intravenous: Administration of a drug within a vein, including bolus, infusion or IV piggyback.

Order: A written order, verbal order, standing order or standing protocol.

Prophylactic antibiotic: An antibiotic prescribed with the intent of reducing the probability of an infection related to an invasive procedure. For purposes of the Prophylactic IV Antibiotic Timing measure, the following antibiotics are considered prophylaxis for surgical site infections: Ampicillin/sulbactam, Aztreonam, Cefazolin, Cefmetazole, Cefotetan, Cefoxitin, Cefuroxime, Ciprofloxacin, Clindamycin, Ertapenem, Erythromycin, Gatifloxacin, Gentamicin, Levofloxacin, Metronidazole, Moxifloxacin, Neomycin and Vancomycin.

Wrong: Not in accordance with intended site, side, patient, procedure or implant.

Appendix B: Sample Data Collection Sheets

On the following pages there are sample data collection sheets for each of the six quality measures developed by the ASC Quality Collaboration and endorsed by the National Quality Forum. These are examples only; their use is not required.

Sample Data Collection Sheet

Appropriate Surgical Site Hair Removal

Patient Name	Patient Identification Number	Date of Birth	Gender (M or F)
--------------	-------------------------------	---------------	-----------------

Physician Name	Date of Service
----------------	-----------------

Measure Data Collection

Step 1 Determine if the patient is eligible for this measure by answering the questions below.

Did the patient complete the registration process upon entry into the facility? Yes No

Did the patient have hair removal at the surgical site? Yes No

If **Yes** to both questions, proceed to the next step.

If **No** to any of the questions, **STOP**. The patient is not eligible for this measure.

Step 2 Determine if the patient has other requirements for this measure by answering the question below.

Did the patient perform their own hair removal at the surgical site? Yes No

If **Yes**, **STOP**. The patient is not eligible for this measure.

If **No**, proceed to the next step.

Step 3 Determine if the surgical site hair removal was performed according to the measure requirements by answering the question below.

Was hair removal at the surgical site performed with a razor or clippers from the scrotal area, or with clippers or depilatory cream from all other surgical sites? Yes No

If **Yes**, hair removal was performed according to the requirements of this measure.

If **No**, hair removal was not performed according to the requirements of this measure.

Sample Data Collection Sheet

Hospital Transfer/Admission

Patient Name	Patient Identification Number	Date of Birth	Gender (M or F)
--------------	-------------------------------	---------------	-----------------

Physician Name	Date of Service
----------------	-----------------

Measure Data Collection

Step 1 Determine if the patient is eligible for this measure by answering the question below.

Did the patient complete the registration process upon entry into the facility? Yes No

If **Yes**, proceed to the next step.

If **No, STOP**. The patient is not eligible for this measure.

Step 2 Determine if the patient experienced the outcome described by this measure by answering the question below.

Was the patient directly transferred or admitted to a hospital or hospital emergency department on discharge from the facility? Yes No

If **Yes**, the outcome should be reported.

If **No, STOP**. The patient did not experience the outcome described by this measure.

Sample Data Collection Sheet

Patient Burn

Patient Name Patient Identification Number Date of Birth Gender (M or F)

Physician Name Date of Service

Measure Data Collection

Step 1 Determine if the patient is eligible for this measure by answering the question below.

Did the patient complete the registration process upon entry into the facility? Yes No

If **Yes**, proceed to the next step.

If **No**, **STOP**. The patient is not eligible for this measure.

Step 2 Determine if the patient experienced the outcome described by this measure by answering the question below.

Did the patient experience a burn* prior to discharge? Yes No

If **Yes**, the outcome should be reported.

If **No**, **STOP**. The patient did not experience the outcome described by this measure.

* For purposes of this measure, a burn is defined as an unintended tissue injury caused by any of the six recognized mechanisms: scalds, contact, fire, chemical, electrical or radiation, (e.g. warming devices, prep solutions, electrosurgical unit or laser).

Sample Data Collection Sheet

Patient Fall in the ASC

Patient Name	Patient Identification Number	Date of Birth	Gender (M or F)
--------------	-------------------------------	---------------	-----------------

Physician Name	Date of Service
----------------	-----------------

Measure Data Collection

Step 1 Determine if the patient is eligible for this measure by answering the question below.

Did the patient complete the registration process upon entry into the facility? Yes No

If **Yes**, proceed to the next step.

If **No**, **STOP**. The patient is not eligible for this measure.

Step 2 Determine if the patient experienced the outcome described by this measure by answering the question below.

Did the patient experience a fall* while within the confines of the facility? Yes No

If **Yes**, the outcome should be reported.

If **No**, **STOP**. The patient did not experience the outcome described by this measure.

* For purposes of this measure, a fall is defined as a sudden, uncontrolled, unintentional, downward displacement of the body to the ground or other object, excluding falls resulting from violent blows or other purposeful actions. (National Center for Patient Safety)

Sample Data Collection Sheet

Prophylactic IV Antibiotic Timing

Patient Name	Patient Identification Number	Date of Birth	Gender (M or F)
--------------	-------------------------------	---------------	-----------------

Physician Name	Date of Service
----------------	-----------------

Measure Data Collection

Step 1 Determine if the patient is eligible for this measure by answering the questions below.

Did the patient complete the registration process upon entry into the facility? Yes No

Did the patient have a preoperative order for a prophylactic IV antibiotic? Yes No

Was the ordered IV antibiotic one of those listed below? Yes No

Ampicillin/sulbactam, Aztreonam, Cefazolin, Cefmetazole, Cefotetan, Cefoxitin, Cefuroxime, Ciprofloxacin, Clindamycin, Ertapenem, Erythromycin, Gatifloxacin, Gentamicin, Levofloxacin, Metronidazole, Moxifloxacin, Neomycin, Vancomycin

If **Yes** to all questions, proceed to the next step.

If **No** to any of the questions, **STOP**. The patient is not eligible for this measure.

Step 2 Determine if the prophylactic IV antibiotic was administered timely by answering the question below.

Was the antibiotic *initiated* within one hour prior to the initial surgical incision or the beginning of the procedure (e.g., introduction of endoscope, insertion of needle, inflation of tourniquet), or two hours prior if vancomycin or fluoroquinolones (ciprofloxacin, gatifloxacin, levofloxacin, moxifloxacin) was ordered? Yes No

If **Yes**, the patient received the antibiotic timely.

If **No**, the patient did not receive the antibiotic timely.

NOTE: If more than one antibiotic from the list above was ordered, each of the antibiotics must be given timely.

Sample Data Collection Sheet

Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant

Patient Name	Patient Identification Number	Date of Birth	Gender (M or F)
--------------	-------------------------------	---------------	-----------------

Physician Name	Date of Service
----------------	-----------------

Measure Data Collection

Step 1 Determine if the patient is eligible for this measure by answering the question below.

Did the patient complete the registration process upon entry into the facility? Yes No

If **Yes**, proceed to the next step.

If **No, STOP**. The patient is not eligible for this measure.

Step 2 Determine if the patient experienced the outcome described by this measure by answering the question below.

Did the patient experience a wrong site, wrong side, wrong patient, wrong procedure or wrong implant event? Yes No

If **Yes**, the outcome should be reported.

If **No, STOP**. The patient did not experience the outcome described by this measure.

Appendix C: Sample Data Collection Logs

On the following pages there are sample data collection logs for the two process measures (Appropriate Surgical Site Hair Removal and Prophylactic IV Antibiotic Timing) developed by the ASC Quality Collaboration and endorsed by the National Quality Forum. These are examples only; their use is not required.

