PATIENT SAFETY IN OFFICE BASED SURGERY

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THIS TOPIC = THE SIZE OF THE TREE

OUR SESSION TIME = THE SIZE OF THE MEN AT THE BASE OF THE TREE...
CULTURE OF SAFETY

- CULTURE OF BLAME IN THE PAST
- FEAR OF RETRIBUTION
- RESULTED IN HIDING MEDICAL ERRORS AND NEAR MISSES RATHER THAN REPORTING THEM
- MISSED OPPORTUNITIES FOR LEARNING
MISTAKES WILL HAPPEN

CULTURE OF SAFETY - ERRORS AND NEAR MISSES REPORTED WITHOUT FEAR OF PUNISHMENT

COLLABORATION ACROSS THE RANKS TO SEEK SOLUTIONS TO SYSTEM VULNERABILITIES

NOT WHO, BUT WHAT IS THE CAUSE
- SYSTEM FLAWS SET UP GOOD PEOPLE TO FAIL
- CIRCUMVENTING ROUTINE PROCESSES LEADS TO NORMALIZATION OF DEVIANCE AND POTENTIAL ERRORS
- NEED TO ENCOURAGE INDIVIDUAL ACCOUNTABILITY FOR SAFETY
COMMUNICATION

- Communication errors responsible for > 60% of serious adverse incidents in healthcare and of these incidents, 74% of the patients died.

- In 70% of the airline accidents studied in the 1970’s, someone in the cockpit knew there was a problem and was unable to find a way to communicate it.
COMMUNICATION SAFETY

- Double check, redundant verification
  - Checklists
- Flattened hierarchy
  - Free and open communication between team members regardless of rank/position
- Interactive handoff communication with Q&A
  - Without interruptions
- Verbal orders written down, read back, and confirmed
- Two patient identifiers
- Charts kept current and accurate
  - Must be **legible**!
  - Allergies prominently noted
- PHONE SYSTEM/ANSWERING SERVICE USER FRIENDLY FOR PATIENTS
- “0” = LIVE PERSON
- TOLD TO HANG UP AND CALL 911 IMMEDIATELY FOR TRUE EMERGENCY
- TELEPHONE MESSAGES DELIVERED TO THE APPROPRIATE PARTY – CALLS RETURNED
- PATIENTS UNDERSTAND THE “RULES” FOR EMAIL - THAT THEY NEED TO CONTACT THE OFFICE BY PHONE FOR TIME SENSITIVE QUESTIONS OR CONCERNS
- RELIABLE INTERPRETER AVAILABLE
- IMPLEMENT POST OP PHONE CALLS
- DOCUMENT CHRONOLOGICALLY ALL COMMUNICATION WITH PATIENTS INCLUDING NIGHTS AND WEEKENDS IN THE CHART
DISCLOSURE OF ADVERSE OCCURRENCES

- LEGAL OBLIGATION IN SOME STATES
- ETHICAL OBLIGATION
- PATIENTS WANT INFORMATION
  - TO MAKE INFORMED DECISIONS REGARDING CARE POST OCCURRENCE
  - WANT AN APOLOGY
  - WANT TO KNOW THAT STEPS ARE BEING TAKEN TO HELP PREVENT THIS IN THE FUTURE
STATE REGULATIONS

- 50% OF STATES HAVE OFFICE SURGICAL REGULATIONS IN PLACE
- REQUIRE COMPLIANCE WITH REGULATIONS REGARDING STAFFING AND CREDENTIALS, PROCEDURE LIMITATIONS, EQUIPMENT, MEDICATIONS, PATIENT CANDIDACY (ASA), INFECTION CONTROL, DOCUMENTATION, OVERNIGHT STAYS, POLICIES AND PROCEDURES, LOGS, EMERGENCY PROTOCOLS, REPORTING OF ADVERSE INCIDENTS, RISK MANAGEMENT/PI
- SOME STATES REQUIRE OR WILL REQUIRE ACCREDITATION FOR OFFICE BASED SURGICAL FACILITIES
EVEN IF ACCREDITED +/- OR STATE REGULATED, OBS FACILITY MUST ALSO BE COMPLIANT WITH:

- FEDERAL, STATE AND LOCAL CODES AND REGULATIONS, EX:
  - OSHA, HIPAA, ADA, FDA, DEA, CLIA
  - NFPA/LOCAL FIRE CODES
  - STATE DEPT. OF HEALTH BIOHAZARDOUS WASTE, RADIATION CONTROL, ETC.
MEDICAL IDENTITY THEFT

• FTC’s RED FLAG/ADDRESS DISCREPANCY RULES
  ▪ FINANCIAL INSTITUTIONS AND CREDITORS MUST DETECT, PREVENT AND MITIGATE ID THEFT
  ▪ NEED POLICIES AND PROCEDURES
  ▪ MUST TRAIN STAFF
  ▪ PHYSICIANS WERE EXEMPTED BY CLARIFICATION ACT OF 2010

SOCIAL MEDIA

- SAFETY = FREEDOM FROM DANGER OR HAZARD; EXEMPTION FROM HURT, INJURY OR LOSS.
- 51% OF AMERICANS ON FACEBOOK
- 70+ BILLION PIECES OF CONTENT SHARED MONTHLY ON FACEBOOK
- 190+ MILLION TWEETS PUBLISHED DAILY
- 92+ BILLION VIDEO VIEWS YOUTUBE MONTHLY
- BREACH OF IDENTIFIABLE PATIENT INFO = UNAUTHORIZED DISCLOSURE
  - PERSON POSTING AND HEALTHCARE ORGANIZATION SUBJECT TO CIVIL AND CRIMINAL PENALTIES (FINES AND PRISON TIME)
HUMAN RESOURCES
CREDENTIALING

- PRIMARY SOURCE VERIFICATION OF LICENSURE (CAN BE DONE ONLINE IN MOST STATES)
- REFERENCE CHECKS
- VERIFICATION OF PREVIOUS EMPLOYMENT
- DEA - SEPARATE REGISTRATION REQUIRED WHERE CONTROLLED SUBSTANCES ARE STORED, ADMINISTERED OR DISPENSED
  - STATE LICENSE MAY BE REQUIRED IN ADDITION TO DEA
- TRAINING/BOARD CERTIFICATION
- MALPRACTICE
• HOSPITAL PRIVILEGES – DELINEATION AND CURRENT LETTER – INCLUDE PROCEDURES DONE IN OFFICE
• CURRENT ACLS/BLS (PALS IF PEDIATRICS)
• GOVERNMENT ISSUED PHOTO ID, I-9
• CV
• CONTINUING EDUCATION
• SUPERVISORY PROTOCOLS (NP/CRNA, PA)
• ADDITIONAL DOCUMENTATION AS REQUIRED BY STATE AND/OR ACCREDITATION AGENCY
SCOPE OF PRACTICE

- Are clinical personnel wearing ID?
- Need written job descriptions and responsibilities
- Make sure right person for the job
- Are assistants performing nursing or medical functions?
- Are nurses performing advanced practice or physician functions?
- Are physicians / nurses supervising unlicensed activity?
- Are personnel adequately trained?
  - Orientation check list for new staff members/competency testing
• IS THERE ADEQUATE COVERAGE WHEN SURGEON OUT OF TOWN?
• IS THERE RELIANCE ON UNLICENSED OFFICE STAFF TO SEE AND TREAT PATIENTS?
• DOES THE SURGEON PRE-SIGN PRESCRIPTIONS FOR STAFF TO FILL IN WHILE MD OUT OF TOWN?
• DO YOU HAVE ADEQUATE NUMBERS OF QUALIFIED PERSONNEL TO DO THE JOB SAFELY?
  - ARE SURGICAL PERSONNEL FULFILLING TWO ROLES AT ONCE?
    - ANESTHESIA PROVIDER ADMINISTERING ANESTHESIA AND CIRCULATING?
    - RN RECOVERING AND CIRCULATING?
  - IS STAFF WELL RESTED?
  - FATIGUE IS A SIGNIFICANT SAFETY ISSUE
BEWARE OF IMPAIRED HEALTH CARE PERSONNEL

- DANGER TO PATIENTS DUE TO IMPAIRED JUDGMENT AND PERFORMANCE
- PATIENTS RECEIVE INADEQUATE PAIN CONTROL IF NARCOTICS DILUTED DUE TO DIVERSION
- SOME STATE BOARDS HAVE REHAB PROGRAMS IN PLACE TO HELP LICENSEES
  - IN SOME STATES CAN AVOID DISCIPLINARY ACTION IF ENROLLED
As per the **Federation of State Medical Boards** in their 2000 report on professional conduct and ethics: “While disruptive behavior may not, in and of itself, constitute a clear violation of the medical practice act, **the effects of this behavior have serious implications on the quality of patient care and patient safety.** Patterns of disruptive behavior can have a deleterious impact on patient care and can result in errors in clinical judgment and performance. Additionally, the increased anxiety and intimidation associated with a disruptive physician’s behavior may severely compromise the effectiveness of the health care team providing patient care by increasing the level of workplace stress and creating an environment in which errors are more likely to occur.”
• PROFANE OR DISRESPECTFUL LANGUAGE
• DEMEANING OR INTIMIDATING BEHAVIOR
• SEXUAL COMMENTS OR INNUENDO
• INAPPROPRIATE TOUCHING, SEXUAL OR OTHERWISE
• RACIAL OR ETHNIC JOKES
• DEMEANING COMMENTS
• OUTBURSTS OF RAGE OR VIOLENT BEHAVIOR
• THROWING INSTRUMENTS, CHARTS OR OTHER OBJECTS
• INAPPROPRIATELY CRITICIZING HEALTH CARE PROFESSIONALS IN FRONT OF PATIENTS OR OTHER STAFF
• BOUNDARY VIOLATIONS WITH STAFF, PATIENTS, SURROGATES OR KEY THIRD PARTIES
• COMMENTS THAT UNDERMINE A PATIENT’S TRUST IN ANOTHER HEALTHCARE PROVIDER OR HEALTHCARE FACILITY
• INAPPROPRIATE CHART NOTES OR DELINQUENT CHART DOCUMENTATION
• UNETHICAL OR DISHONEST BEHAVIOR
• DIFFICULTY WORKING COLLABORATIVELY WITH OTHERS
• REPEATED FAILURE TO RESPOND TO CALLS
• INAPPROPRIATE ARGUMENTS WITH PATIENTS, FAMILY, STAFF AND OTHER PHYSICIANS
• RESISTANCE TO RECOMMENDED CORRECTIVE ACTION
• REFUSAL TO ADHERE TO HEALTHCARE FACILITY PROTOCOLS
PERIOPERATIVE CARE
CONSULTATION/PREOP ASSESSMENT

- APPROPRIATE CANDIDATE FOR THE OFFICE AND PROCEDURE?
  - REALISTIC EXPECTATIONS
  - OUTCOME
  - HOW MUCH SURGERY CAN BE ACCOMPLISHED IN ONE DAY
  - SURGERY IS INDICATED
  - THIS IS SURGERY YOU ROUTINELY PERFORM
  - HEALTHY ENOUGH FOR OFFICE BASED (ASA I OR II)
  - WILL BE COMPLIANT WITH INSTRUCTIONS
  - RECOVERY TIME, ACTIVITY RESTRICTIONS AND FOLLOW UP CARE
- SPOUSE OR FAMILY MEMBER AWARE OF PROCEDURE AND AGREES TO SUPPORT PATIENT
  - CAREGIVER, DRIVER
  - CAN HANDLE COST OF PROCEDURE
    - INCLUDING RECOVERY DOWNTIME
    - POSSIBLE REVISIONS/COMPLICATIONS
PATIENT SELECTION CRITERIA

- **ASA PHYSICAL CLASS**
  - **P1** NORMAL HEALTHY PATIENT
  - **P2** MILD SYSTEMIC DISEASE
  - **P3** SEVERE SYSTEMIC DISEASE
  - **P4** SEVERE SYSTEMIC DISEASE THAT IS A CONSTANT THREAT TO LIFE
  - ASA I AND II OPTIMAL IN OFFICE BASED AND LAW IN SOME STATES

http://www.plasticsurgery.org/Documents/medical-professionals/health-policy/key-issues/Patient-Selection.pdf
• **THOROUGH ASSESSMENT/H&P**
  - CARDIOVASCULAR / HTN (MEDS >159/99)
  - RESPIRATORY
  - ENDOCRINE/DIABETES
  - BMI – MORBID OBESITY > 40 (ASA III)
  - MEDICATIONS INCLUDING STEROIDS, HERBALS, VITAMINS, ANTICOAGS
  - ALLERGIES
  - BLEEDING DISORDERS/TENDENCIES
  - PSYCH/EATING DISORDERS
  - SMOKER/ALCOHOL/STREET DRUGS
  - PREVIOUS ANESTHESIA COMPLICATIONS
• OBSTRUCTIVE SLEEP APNEA (OSA)

• DEEP VEIN THROMBOSIS (DVT)
  ▪ AMERICAN COLLEGE OF CHEST PHYSICIANS DVT GUIDELINES http://www.chestjournal.org/content/133/6_suppl/71S.full.pdf+html
  ▪ DVT PREVENTION WHILE TRAVELING http://www.aa.com/aa/i18nForward.do?p=/travelInformation/specialAssistance/healthAndWellbeing.jsp&anchorEvent=false
• CRITERIA ESTABLISHED FOR LABS, DIAGNOSTIC TESTING, MEDICAL CLEARANCE

• ELECTIVE SURGERY – PATIENT SHOULD BE OPTIMIZED

• ASC/HOSPITAL FOR PATIENTS WITH COMPLEX MEDICAL HISTORY
INFORMED CONSENT

- Begins with initial consultation
- Meeting of the minds as to what is to be done
- Surgeon’s job to explain/answer questions
- Procedures must be listed on consent in patient understandable terms
- Procedures should specify anatomical locations
- Native language
- Competent patient
PREOP PATIENT TEACHING

- DRIVER/CAREGIVER – PRESENT AT PREOP?
- MEDICATIONS TO AVOID
  - ASA, HERBALS, ANTICOAGULANTS, ETC.
  - FDA ACETAMINOPHEN ADVISORY
- TAKING MEDICATIONS
  - DAY OF SURGERY
  - WHEN TO RESUME D/C’ed MEDS
  - HOW AND WHEN TO TAKE PAIN MEDS
- SMOKING (CDC RECOMMENDS CESSATION 30 DAYS PREOP)
  - ALCOHOL
- ACTIVITY RESTRICTIONS/DRIVING
- DIET
- WOUND CARE
  - DRAINS AND DRESSINGS WITH RETURN DEMONSTRATION
  - HANDWASHING AND GENERAL INFECTION CONTROL (AVOID PETS)
  - S+S INFECTION
  - SHOWERING
- BREATHING
- DVT PREVENTION, S&S
- PDNV
- HOW TO REACH THE SURGEON 24 HOURS/DAY
- WHEN TO CALL 911
- VERBAL AND WRITTEN INSTRUCTIONS
PREOP HOLDING DAY OF SURGERY

- Use a preop checklist to ensure all required elements are present before entering the O.R.
  - Tests/H&P/Medical clearance
  - Consent(s) are signed, allergies noted
  - NPO, Voided, jewelry, contacts, glasses, dentures, hearing aids, pictures, driver/caregiver, Rx’s given
- Surgeon marks surgical site w/pt awake
  - Corresponds w/ signed consent and pt
- Baseline vital signs
- Anesthesia consent signed after patient speaks with anesthesia provider
PREANESTHETIC ASSESSMENT

- PSH/PMH/TEST RESULTS
- HX ANESTHETIC COMPLICATIONS
  - MH (PATIENT AND FAMILY)
  - PONV
    - PATIENT RISK FACTORS
      - FEMALE
      - HISTORY OF PONV
      - HISTORY OF MOTION SICKNESS
      - NONSMOKER
- ANESTHESIA RISK FACTORS
  - INTRA AND POST OP OPIOIDS
  - GENERAL ANESTHESIA
    - USE OF VOLATILE ANESTHETICS (CAUSES PONV WITHIN 0-2 HOURS AFTER SURGERY)
    - USE OF NITROUS OXIDE
- SURGICAL RISK FACTORS
  - LONG DURATION (>60 MINUTES)
  - INCREASE EVERY 30 MINUTES
- TYPES OF SURGERY
  - PLASTIC
  - LAPAROSCOPIC
  - ENT
  - STRABISMUS
  - NEURO
  - BREAST
• 20-30% OF PATIENTS TREATED WITH 5HT3 AGENTS (EX: ZOFRAN, ANZEMET, KYTRIL) HAVE INADEQUATE CONTROL OF EMESIS DUE TO GENETIC DIFFERENCES IN DRUG METABOLISM
• PATIENTS ON SSRIs MAY ALSO HAVE REDUCED EFFECTS FROM THIS CLASS OF DRUGS
• FOR HIGH RISK USE COMBINATIONS OF DRUGS WITH DIFFERENT MECHANISMS OF ACTION
- MEDICATIONS
- SMOKING/ALCOHOL
- ALLERGIES
- DENTURES, CONTACTS, ETC.
- FASTING/NPO
- PHYSICAL EXAM (AIRWAY, HEART, LUNGS, HEIGHT/WEIGHT)
- ASA STATUS
- ANESTHETIC PLAN
Minimal Sedation (Anxiolysis) - patients respond normally to verbal commands. Although cognitive function and physical coordination may be impaired, airway reflexes, and ventilatory and cardiovascular functions are unaffected.

Moderate Sedation/Analgesia (“Conscious Sedation”) - patients respond purposefully** to verbal commands, either alone or with light tactile stimulation. Airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained. ** Reflex withdrawal from a painful stimulus is NOT considered a purposeful response.

Deep Sedation/Analgesia - patients cannot be easily aroused but respond purposefully** following repeated or painful stimulation. Ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.

General Anesthesia - patients are not arousable, even by painful stimulation. Ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

QUALIFIED ANESTHESIA PERSONNEL MUST BE IN THE ROOM THROUGHOUT THE CONDUCT OF ANESTHESIA.

DURING ALL ANESTHETICS, THE PATIENT’S OXYGENATION, VENTILATION, CIRCULATION AND TEMPERATURE SHALL BE CONTINUALLY EVALUATED.

- OXYGEN ANALYZER WITH LIMIT ALARM AND PULSE OXIMETER WITH AUDIBLE ALARM, LIGHTS/EXPOSURE
- VENTILATION MONITORED WITH DISCONNECT ALARM, ETCO₂ TO ENSURE ET TUBE/LMA PLACEMENT
- CONTINUOUS EKG AND AUSCULTATION OF HEART SOUNDS AND VS Q 5 MINS
EVERY PATIENT RECEIVING ANESTHESIA SHALL HAVE TEMPERATURE MONITORED WHEN CLINICALLY SIGNIFICANT CHANGES IN BODY TEMPERATURE ARE INTENDED, ANTICIPATED OR SUSPECTED.

- MALIGNANT HYPERTERMIA http://medical.mhaus.org/
- MH CAN OCCUR AT ANY TIME DURING OR EMERGING FROM ANESTHESIA ADMINISTRATION, INCLUDING IN THE IMMEDIATE POSTOP PERIOD
- THE MOST CONSISTENT INDICATOR OF POTENTIAL MH IN THE O.R. IS AN UNANTICIPATED INCREASE (E.G. DOUBLING OR TRIPLING) OF END TIDAL CO₂ WHEN MINUTE VENTILATION IS KEPT CONSTANT
- Call MH HOTLINE: 1-800-644-9737 or 001-315-464-7079
• UNEXPECTED TACHYCARDIA, TACHYPNEA AND JAW MUSCLE RIGIDITY ARE OFTEN COMMON EARLY SIGNS OF MH
• TEMPERATURE ELEVATION IS A LATE SIGN
  ▪ TEMPERATURE CHANGES SHOULD BE MONITORED BY CORE TEMP (TYMPANIC, NASO - OR OROPHARYNGEAL, ESOPHAGEAL, RECTAL OR PULMONARY ARTERY) IN CASES LONGER THAN 30 MINUTES PER MHAUS
HYPOTHERMIA (CORE TEMP< 96.8 F)

- INCREASED SSI’S, CARDIAC COMPLICATIONS, TISSUE HYPOXIA
- DECREASED IMMUNE RESPONSE, TISSUE PRODUCTION AND REPAIR
- TREND TOWARDS PRE-WARMING TO “BANK” WARMTH
- NEED APPROPRIATE PERIOPERATIVE PATIENT WARMING DEVICES
- HOSING - A MAJOR PATIENT SAFETY ISSUE
- USE THE MICROWAVE FOR LUNCH....
2004 Estimated 20,000-40,000 patients per year experienced awareness.

- **Explicit Recall** – Direct memories of what occurred – most traumatic.
- **Implicit Recall** – Flashbacks, nightmares, and anxiety.

**Post Traumatic Stress Syndrome**

**Contributing Factors:** Light anesthesia due to emergency, use of paralytic agents & blockers masking symptoms, alcohol and drug abuse, equipment failure or misuse, time pressure to turn over the room.

**Bispectral Index (BIS) and Patient State (PSA) Monitor** patient’s level of anesthesia using EEG.
SURGICAL SAFETY

- SCIP PROTOCOLS
  - ANTIBIOTIC TIMING
  - ANTIBIOTIC SELECTION
  - ANTIBIOTIC END
  - GLUCOSE CONTROL
  - HYPOTHERMIA
  - SHAVING
    - SHOWERING
TIME OUT PRIOR TO INCISION!

- RIGHT PATIENT
- RIGHT SURGERY
- RIGHT SITE
- RIGHT SIDE
- RIGHT IMPLANTS
- RIGHT CONSENT FORM
- RIGHT IMAGES DISPLAYED
- AND ANY OTHER PATIENT SPECIFIC CONFIRMATION
# Surgical Safety Checklist (First Edition)

**Before induction of anaesthesia**

<table>
<thead>
<tr>
<th>SIGN IN</th>
<th>TIME OUT</th>
<th>SIGN OUT</th>
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| □ PATIENT HAS CONFIRMED  
  * IDENTITY  
  * SITE  
  * PROCEDURE  
  * CONSENT  
  □ SITE MARKED/NOT APPLICABLE  
  □ ANAESTHESIA SAFETY CHECK COMPLETED  
  □ PULSE OXIMETER ON PATIENT AND FUNCTIONING  
  **DOES PATIENT HAVE A:**  
  □ KNOWN ALLERGY?  
  □ NO  
  □ YES  
  **DIFFICULT AIRWAY/ASPIRATION RISK?**  
  □ NO  
  □ YES, AND EQUIPMENT/ASSISTANCE AVAILABLE  
  **RISK OF >500ML BLOOD LOSS (7ML/KG IN CHILDREN)?**  
  □ NO  
  □ YES, AND ADEQUATE INTRAVENOUS ACCESS AND FLUIDS PLANNED  
| □ CONFIRM ALL TEAM MEMBERS HAVE INTRODUCED THEMSELVES BY NAME AND ROLE  
  □ SURGEON, ANAESTHESIA PROFESSIONAL AND NURSE VERBALLY CONFIRM  
  * PATIENT  
  * SITE  
  * PROCEDURE  
  **ANTICIPATED CRITICAL EVENTS**  
  □ SURGEON REVIEWS: WHAT ARE THE CRITICAL OR UNEXPECTED STEPS, OPERATIVE DURATION, ANTICIPATED BLOOD LOSS?  
  □ ANAESTHESIA TEAM REVIEWS: ARE THERE ANY PATIENT-SPECIFIC CONCERNS?  
  □ NURSING TEAM REVIEWS: HAS STERILITY (INCLUDING INDICATOR RESULTS) BEEN CONFIRMED? ARE THERE EQUIPMENT ISSUES OR ANY CONCERNS?  
| □ NURSE VERBALLY CONFIRMS WITH THE TEAM:  
  □ THE NAME OF THE PROCEDURE RECORDED  
  □ THAT INSTRUMENT, SPONGE AND NEEDLE COUNTS ARE CORRECT (OR NOT APPLICABLE)  
  □ HOW THE SPECIMEN IS LABELLED (INCLUDING PATIENT NAME)  
  □ WHETHER THERE ARE ANY EQUIPMENT PROBLEMS TO BE ADDRESSED  
| □ SURGEON, ANAESTHESIA PROFESSIONAL AND NURSE REVIEW THE KEY CONCERNS FOR RECOVERY AND MANAGEMENT OF THIS PATIENT  
| □ HAS ANTIBiotic PROPHYLAXIS BEEN GIVEN WITHIN THE LAST 60 MINUTES?  
  □ YES  
  □ NOT APPLICABLE  
  □ IS ESSENTIAL IMAGING DISPLAYED?  
  □ YES  
  □ NOT APPLICABLE |

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This checklist is not intended to be comprehensive. Additions and modifications to fit local practice are encouraged.
- DVT PREVENTION
  - STOCKINGS AND SCD
- POSITIONING
- FIRE PREVENTION
  - ESU/LASER SAFETY
- SPECIMEN LABELING AND TRACKING LOG
- MAINTAINING ASEPSIS
  - O.R. SIZE ADEQUATE?
- SURGICAL COUNTS

http://apsf.org/resources_video.php
EQUIPMENT SAFETY

- **USE DEVICES PER MANUFACTURER’S INSTRUCTIONS**
- **KEEP EXTRA EQUIPMENT FOR ESSENTIAL FUNCTIONS (MONITORS, SUCTION, ETC.)**
- **REPORT TO FDA MEDWATCH FOR EQUIPMENT THAT MALFUNCTIONS ON FORM 3500 (VOLUNTARY)**

https://www.accessdata.fda.gov/scripts/medwatch/medwatch-online.htm

XYZ Biomedical Company
Inspected: 8/24/14
Re-Inspection Due: 2/24/15
• REGULAR BIOMEDICAL INSPECTIONS
• USE DEVICES STILL SUPPORTED BY THE MANUFACTURER
  ▪ DIFFERENCE BETWEEN ELECTRICAL SAFETY (BIOMEDICAL STICKER) AND PERFORMING TO CURRENT STANDARDS
• OBSOLETE ANESTHESIA MACHINES
http://www.asahq.org/~/media/For%2520Members/Standards%2520and%2520Guidelines/ASA%2520Publications%2520-%2520Anesthesia%2520Machine%2520Obsolescence%2520-%25202004.ashx
LASER SAFETY

- BUILT IN LASER SAFETY FEATURES
- LASER CONTROL AREA
  - DOORS LOCKED, WINDOWS COVERED
- LASER SAFETY OFFICER IDENTIFIED
- SIGNAGE
  - TYPE OF LASER
  - WARNINGS TO PREVENT EYE OR SKIN EXPOSURE
  - TYPE OF RADIATION
- EDUCATION AND TRAINING
- MAINTENANCE BY QUALIFIED TECHNICIAN
- APPROPRIATE EYE PROTECTION
- SMOKE EVACUATION SYSTEM
- FIRE EXTINGUISHER NEARBY
- ANSI-136 LASER SAFETY STANDARDS
  www.ansi.org
ALARM FATIGUE

- Alarms sounding constantly - health care providers become desensitized – ignore them or don’t hear them.

- Do not silence alarms without first checking on the patient.

- Make sure that all alarms are appropriately activated - do not disable important functions.

- Make sure that the alarm volume is high enough.

- Become familiar with all monitor functions and meanings of various alarm sounds.

- Train new staff members, including per diem, on the monitors before they care for patients.
ELEVATED NOISE HAS BEEN ASSOCIATED WITH

- POOR TASK PERFORMANCE
- POOR CONCENTRATION
- GREATER ANXIETY
- DECREASED PATIENT SATISFACTION IN PACU

NOISE IS A DISTRACTION THAT INTERRUPTS PATIENT CARE AND POTENTIALLY INCREASES THE RISK OF ERROR
• STRATEGIES TO REDUCE NOISE INCLUDE:

  ▪ INCREASE AWARENESS VIA EDUCATION

  ▪ IDENTIFY SOURCES OF NOISE TO DETERMINE WHETHER, HOW, AND IF THESE NOISES CAN BE LESSENED.

  ▪ MINIMIZE OR ELIMINATE IRRELEVANT CONVERSATION DURING PROCEDURES

  ▪ MINIMIZE # OF PEOPLE PRESENT AND FREQUENCY OF DOOR OPENINGS.

  ▪ ESTABLISH TIMES WHEN NOISE LEVELS ROUTINELY SHOULD BE REDUCED (EG, INDUCTION, EMERGENCE).

  ▪ RECOMMEND THAT CELL PHONES BE LEFT OUTSIDE OF THE OR. IF NOT:
    ▪ LOWER RING-TONE VOLUME
    ▪ LIMIT TELEPHONE CONVERSATIONS
RECOVERY ROOM

- ADEQUATELY SIZED
  - ROOM TO ACCESS THE PATIENT ON ALL SIDES
- ADEQUATE ROOM FOR EMS TO TREAT THE PATIENT IN THIS ROOM
- ENOUGH BEDS FOR PATIENT VOLUME
- PATIENT UNDER DIRECT OBSERVATION AND SUPERVISION UNTIL DISCHARGED FROM RR
- APPROPRIATELY TRAINED/LICENSED PERSONNEL CARING FOR PATIENT AND BACKUP PERSONNEL FOR EMERGENCY
- MONITORS AND EQUIPMENT FUNCTIONING AND IN SUFFICIENT QUANTITY FOR PATIENT VOLUME
- SUFFICIENT O₂ AND IMMEDIATE ACCESS TO EMERGENCY MEDS
- ADEQUATE DOCUMENTATION
  - VITALS PER POLICY
  - DOCUMENTATION OF ADMISSION ASSESSMENT, RECOVERY PROGRESSION, GENERAL PATIENT STATUS, AND SATISFACTION OF DISCHARGE CRITERIA CHECKLIST
- PATIENT GIVEN ENOUGH TIME TO RECOVER ADEQUATELY BEFORE DISCHARGE TO HOME W/CAREGIVER
  - COMPLIANCE WITH OVERNIGHT RULES IN YOUR STATE
FOLLOW-UP

- ADEQUATE POSTOP APPOINTMENTS WITH THE APPROPRIATE PRACTITIONERS
- MEANS TO TRACK PATIENT APPOINTMENTS FOR “NO SHOWS”
- REINFORCEMENT OF PATIENT INSTRUCTIONS REGARDING DIET, ACTIVITY AND WOUND CARE AS HEALING PROGRESSES
- DOCUMENTATION OF PATIENT PROGRESS
  - OPERATIVE REPORT AND OTHER PATIENT DOCUMENTATION ON THE CHART FOR REFERENCE AT EACH VISIT
INFECTION CONTROL

SPAULDING CLASSIFICATION SYSTEM:

- ITEMS THAT ENTER NORMALLY STERILE TISSUE OR THE VASCULAR SYSTEM ARE CONSIDERED “CRITICAL” AND MUST BE STERILIZED
  - STERILIZATION DESTROYS ALL MICROBIAL LIFE, INCLUDING HIGHLY RESISTANT BACTERIAL ENDOスポRES
• STEAM AUTOCLAVE PREFERRED METHOD FOR ITEMS NOT HEAT SENSITIVE
  ▪ CAN ALSO USE LOW TEMPERATURE STERILIZERS (ETO, HYDROGEN PEROXIDE GAS PLASMA AND PERACETIC ACID (IMMEDIATE USE))
• THOROUGH CLEANING PRIOR TO STERILIZATION IS CRUCIAL
• ALL INSTRUMENTS USED IN PATIENT CARE SHOULD BE PROPERLY STERILIZED
  ▪ EXAM ROOM INSTRUMENTS SHOULD BE STEAM STERILIZED IN PEEL PACKS AS WELL
REUSABLE DEVICES OR ITEMS THAT CONTACT INTACT MUCOUS MEMBRANES ARE "SEMI-CRITICAL" AND REQUIRE HIGH-LEVEL DISINFECTION AT MINIMUM.

- HIGH-LEVEL DISINFECTION KILLS ALL ORGANISMS EXCEPT HIGH LEVELS OF BACTERIAL SPORES.
- TEST PRIOR TO USAGE TO ENSURE "MEC"
- CLEAN, IMMERSE AND RINSE
• HIGH LEVEL DISINFECTION FOR NON-AUTOCLAVABLE ENDOSCOPIC EQUIPMENT?
  • CRITICAL ITEMS SHOULD BE STERILIZED
  • CHECK WITH MANUFACTURER
ITEMS THAT CONTACT INTACT SKIN ARE “NON-CRITICAL” AND REQUIRE LOW OR INTERMEDIATE DISINFECTION

- INTERMEDIATE-LEVEL DISINFECTION KILLS MYCOBACTERIA, MOST VIRUSES, AND BACTERIA WITH A CHEMICAL GERMICIDE REGISTERED AS A “TUBERCULOCIDE” BY THE EPA.
- LOW LEVEL DISINFECTION KILLS SOME VIRUSES AND BACTERIA WITH A CHEMICAL GERMICIDE REGISTERED AS A HOSPITAL DISINFECTANT BY THE EPA.
- MUST FOLLOW DIRECTIONS REGARDING SURFACE CONTACT TIME
CLEAN/SOILED UTILITY

- STRICT SEGREGATION OF CLEAN AND SOILED FUNCTIONS EITHER BY WALLS AND SPACE OR TIME (ONLY ONE FUNCTION OCCURRING AT ONE TIME AND ENTIRE AREA IS DECONTAMINATED BETWEEN FUNCTIONS)

- NEED DIVIDER BETWEEN CLEAN AND SOILED SINK/COUNTER AREAS IF FUNCTIONS NOT PERFORMED IN SEPARATE ROOMS OR ON OPPOSITE SIDES OF A SINGLE ROOM

- SOILED INSTRUMENTS SHOULD NOT BE WASHED IN SCRUB SINK
FLASH STERILIZATION STANDARDS

- DO NOT USE FLASH FOR CONVENIENCE, AS AN ALTERNATIVE TO PURCHASING ADDITIONAL SETS OR TO SAVE TIME
- WHEN USING FLASH: 1) CLEAN ITEM APPROPRIATELY BEFORE PLACING IN MANUFACTURER’S APPROVED FLASH CONTAINER OR TRAY; 2) FLASH USING THE CYCLE PARAMETERS AS SPECIFIED BY THE AUTOCLAVE MANUFACTURER (TIME, TEMPERATURE AND PRESSURE) AND MONITOR STERILIZER FUNCTION WITH MECHANICAL, CHEMICAL AND BIOLOGICAL MONITORS; 3) PREVENT CONTAMINATION OF THE ITEM DURING TRANSPORT FROM STERILIZER TO THE PATIENT
• DO NOT FLASH IMPLANTED SURGICAL DEVICES UNLESS IT IS UNAVOIDABLE
  - NEED RAPID READOUT BIOLOGICAL INDICATOR AND CLASS V CHEMICAL INDICATOR (INTEGRATOR)
• WHEN NECESSARY, USE FLASH STERILIZATION FOR PATIENT CARE ITEMS THAT WILL BE USED IMMEDIATELY, SUCH AS FOR AN INSTRUMENT THAT WAS DROPPED DURING SURGERY
• WHEN NECESSARY, USE FLASH FOR PROCESSING PATIENT CARE ITEMS THAT CANNOT BE PACKAGED, STERILIZED AND STORED BEFORE USE
• STERILE SUPPLIES MUST BE LABELED
  ▪ DATE OF STERILIZATION (ON PLASTIC SIDE OF PEEL PACKS OR FOLD OVER TAB, AND ON TAPE FOR PACKS).
  ▪ AUTOCLAVE IDENTIFIER ON PACKAGE IF MULTIPLE AUTOCLAVES USED IN FACILITY
• LABELER OR PERMANENT MARKER THAT WON’T RUN OR TEAR PACKAGE (EX: SHARPIE # 13601 BLACK FINE POINT)
  ▪ PACKS SEALED WITH AUTOCLAVE TAPE
• WEEKLY SPORE TESTING AT MINIMUM (CONSISTENT WITH AAMI, CDC, AND AORN STANDARDS FOR AMBULATORY SURGERY)
  ▪ NEED LOG FOR ONSITE TESTING OR RESULTS OF MAIL-AWAY TESTS FOR EACH AUTOCLAVE
  ▪ NEED POLICY FOR DEALING WITH POSITIVE SPORE TESTS
• EACH STERILE PACKAGE NEEDS CHEMICAL INDICATOR INSIDE AND OUT
• STERILIZATION LOG
STERILE STORAGE

• STERILE SUPPLIES SHOULD BE REMOVED FROM OUTER SHIPPING CARTONS AND STORED IN CLOSED CABINETS OR DRAWERS OR AWAY FROM POTENTIAL CONTAMINATION HAZARDS SUCH AS
  ▪ HEAVY TRAFFIC
  ▪ MOISTURE (AUTOCLAVE STEAM, WATERPIPES, UNDER SINKS)
  ▪ DIRT/DUST
• EXPIRATION IS EVENT RELATED UNLESS THE PACKAGE CONTENTS ARE MADE OF MATERIALS THAT HAVE DEFINED SHELF LIFE
  ▪ CONTAMINATING EVENTS – BREACH, MOISTURE, DIRT
SURGICAL HAND HYGIENE

PER CDC GUIDELINES:

- CLEAN NAILS UNDER RUNNING WATER
- USE ANTIMICROBIAL SOAP OR ALCOHOL-BASED HAND RUB WITH PERSISTENT ACTIVITY
- FOR ANTIMICROBIAL SOAP SCRUBS, SHORTER SCRUB TIMES RECOMMENDED (2-6 MINUTES)
- FOLLOW MANUFACTURER’S INSTRUCTIONS FOR ALCOHOL BASED:
  - PREWASH WITH NON-ANTIMICROBIAL SOAP AND DRY
  - AFTER APPLICATION, LET HANDS DRY BEFORE DONNING GLOVES
  - FOLLOW MANUFACTURER’S INSTRUCTIONS
GENERAL CLINICAL HAND HYGIENE

- **NOT VISIBLY SOILED** – ALCOHOL BASED HANDRUB OR ANTIBACTERIAL SOAP AND WATER WASH FOR 15 SECONDS

- **VISIBLY SOILED, BEFORE MEALS, AFTER RESTROOM** – SOAP (ANTIBACTERIAL OR PLAIN) AND WATER WASH FOR 15 SECONDS

- **ARTIFICIAL NAILS ASSOCIATED WITH INCREASED INCIDENCE OF INFECTION**

- **http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5116a1.htm**
“40,000 PATIENTS MAY HAVE BEEN EXPOSED TO HEPATITIS C IN NEVADA” - FEB 2008

Unsafe Injection Practices and Disease Transmission

Reuse of syringes combined with the use of single-dose vials for multiple patients undergoing anesthesia can transmit infectious diseases. The syringe does not have to be used on multiple patients for this to occur.

1. A clean syringe and needle are used to draw the sedative from a new vial.
2. It is then administered to a patient who has been previously infected with hepatitis C virus (HCV). Backflow into the syringe contaminates the syringe with HCV.
3. The needle is replaced, but the syringe is reused to draw additional sedative from the same vial for the same patient, contaminating the vial with HCV.
4. A clean needle and syringe are used for a second patient, but the contaminated vial is reused. Subsequent patients are now at risk for infection.
PER THE CDC AND APIC:

- Do not administer medications from one syringe to multiple patients, even if the needle is changed.
- Do not use single-dose vials/ampules for multiple patients or combine leftover contents for later use.
- Optimal to use single-dose vials for parenteral meds.
- If multidose vials must be used, both needle or cannula and syringe used to access the multidose vial must be sterile.
- Store multidose vials per manufacturer's recommendations; discard if sterility is compromised/questionable.
- Use fluid infusion/administration sets for single patient.
- Never use bags/bottles of IV solution for multiple patients.
- Use a new syringe and a new needle for each entry into a vial or IV bag.
- Do not use spiking devices, even with 1-way valves, for multiple uses or patients.
IDENTIFY AND SEPARATE SOUND ALIKE/LOOK ALIKE MEDICATIONS
MAKE SURE ALL MEDICATIONS ARE LABELED ON AND OFF THE FIELD
REVIEW AND REPLACE OUTDATED DRUGS
MULTIDOSE VIAL SHOULD BE DATED ONCE OPENED AND DISCARDED WITHIN 28 DAYS
MEDICATIONS REQUIRING REFRIGERATION SHOULD BE STORED IN REFRIGERATOR WITH DAILY TEMPERATURE CHECKS
- 36-46 DEGREES F
JOIN FDA MEDWATCH FOR SAFETY ALERTS ON MEDICATIONS AND DEVICES
http://www.fda.gov/Safety/MedWatch/ucm168422.htm
MEDICATION SAFETY - COMPOUNDING

- 2012 NEW ENGLAND COMPOUNDING CENTER (NECC) SHIPPED 17,676 STEROID INJECTIONS FOR BACK PAIN TO HEALTHCARE FACILITIES IN 23 STATES.
- 750 SICK/64 DEAD DUE TO FUNGAL CONTAMINATION
- 200 ADVERSE EVENTS INVOLVING 71 COMPOUNDED PRODUCTS AFFECTING THOUSANDS OVER PAST 20 YRS
- NUMEROUS DRUG SHORTAGES - FACILITIES TURN TO COMPOUNDERS TO FILL THE VOID
- 16,000 US COMPOUNDING PHARMACIES CURRENTLY - NO FDA OVERSIGHT PREVIOUSLY – CAN NOW REGISTER ON VOLUNTARY BASIS FOR INSPECTION BY FDA
- CHOOSE PCAB ACCREDITED COMPOUNDERS

http://www.pcab.org/
MUST KEEP DRUGS IN A SECURELY LOCKED, SUBSTANTIALLY CONSTRUCTED CABINET OR SAFE – DOUBLE LOCK RECOMMENDED

MUST KEEP RECORDS OF DRUGS DISPENSED
- INVENTORY WITH TWO LICENSED HEALTHCARE PROVIDERS DAY OF SURGERY AND WEEKLY AT MINIMUM
- MUST BE ABLE TO FOLLOW THE DRUG FROM RECEIPT TO ADMINISTRATION

INVENTORY MUST BE SET UP LIKE A BALANCED CHECKBOOK

EXPIRED CONTROLLED SUBSTANCES MUST BE RETURNED TO REVERSE DISTRIBUTORS AS PER THE DEA

http://www.deadiversion.usdoj.gov/offices_n_dirs/field_div/index.html
EMERGENCY PREPAREDNESS

- EMERGENCY MEDICATIONS (PER CURRENT ACLS PROTOCOLS) SHOULD BE READILY AVAILABLE (CHECK PAR LEVELS AND EXPIRATIONS MONTHLY)
- NEED CURRENT ACLS ALGORITHMS AND MH PROTOCOL ON WHEELED CRASH CART
- IF MALIGNANT HYPERTERMIA TRIGGERING AGENTS USED http://www.mhaus.org
  ▪ NaHCO₃, DANTROLENE AND DILUENT MUST BE KEPT ONSITE – COLD SALINE IRRIGATION, SALINE IV, ICE
  ▪ INSTANTLY DISSOLVING DANTROLENE NOW AVAILABLE

WWW.MHAUS.ORG
• DEFIBRILLATOR OR AED (CHECKED DAILY ON SURGICAL DAYS AND WEEKLY AT MINIMUM - LOG)
• SUCTION, CATHETERS, & YANKAUER
• INTUBATION EQUIPMENT/SUPPLIES
  ▪ BACKUP BATTERIES AND BULBS
  ▪ EMERGENCY AIRWAY/DIFFICULT INTUBATION EQUIPMENT
• ORAL/NASAL AIRWAYS
• OXYGEN AND AMBU BAG/MASK
• IV SUPPLIES INCLUDING MINI DRIP SOLUTION SETS
• BP CUFF/STETHOSCOPE
• ACLS/BLS TRAINING
• EMERGENCY PROTOCOLS
  • EMERGENCY TRANSFER TO HOSPITAL
  • CARDIO-RESPIRATORY COMPLICATIONS
  • ALLERGIC REACTIONS
  • ASPIRATION
  • INCAPACITATED SURGEON/ANESTHESIA PROVIDER
  • POWER FAILURE
  • UNANTICIPATED RETURN TO THE OR
  • SECURITY EMERGENCIES/BOMB THREAT
  • FIRE/EMERGENCY EVACUATION
  • FLOOD, HURRICANE, EARTHQUAKE, TORNADO
• REGULAR EMERGENCY DRILLS/TRAINING
  • ANESTHESIA COMPLICATIONS
  • FIRE SAFETY
**EMERGENCY BACK UP POWER**

- SHOULD POWER ESSENTIAL:
  - MONITORS
  - ANESTHESIA EQUIPMENT
  - SURGICAL EQUIPMENT
  - LIGHTING

- MONTHLY CHECK TO ENSURE FUNCTIONING APPROPRIATELY AND ANNUAL 2 HOUR TEST (OR AS REQUIRED BY STATE/ACCREDITATION)
FACILITY SAFETY - HAZARD SURVEILLANCE
INTERNAL STRUCTURE

- Furniture stable and in good repair
- Carpet/flooring in good condition (no trip/fall hazards)
- Ceiling in good condition
- Hallways and entrances/exits clear (no clutter/obstructions)
- Restroom handrails secure
- Lighting adequate and functioning
• COMPRESSED GAS TANKS SECURED

• EXPLOSIVE AND COMBUSTIBLE MATERIALS STORED AND HANDLED SAFELY WITH APPROPRIATE VENTILATION

• SUPPLIES STORED SAFELY, SHELVING SECURE

• ELECTRICAL OUTLETS USED APPROPRIATELY (NO OVERLOADING)

• ELECTRICAL CORDS IN GOOD CONDITION – USING APPROVED ELECTRICAL DEVICES

• PLUMBING IN GOOD REPAIR, NO LEAKS
• FIRE EXIT SIGNS ILLUMINATED
• EMERGENCY LIGHTS FUNCTIONING
• SMOKE DETECTORS/SPRINKLERS FUNCTIONING
• FIRE EXTINGUISHERS CHECKED – RECHARGED, ADEQUATE QUANTITY, TYPE AND LOCATION
• NO SMOKING SIGNS IN PLACE
• FACILITY EVACUATION PLAN POSTED
External Structure

- LIGHTING ADEQUATE AND FUNCTIONING
- STRUCTURE INTACT (NO TRIP HAZARDS ON GROUND, NO OVERHEAD HAZARDS)
- ENTRANCE CLEAN AND ACCESSIBLE TO ALL (INCLUDING HANDICAPPED)
- HANDRAILS/GUARDRAILS SECURE
- PARKING ADEQUATE
- PUBLIC PROTECTED FROM AREAS UNDER CONSTRUCTION
- PARKING LOT INTACT (NO TRIP HAZARDS ON GROUND, NO OVERHEAD HAZARDS)
- TREES AND SHRUBBERY TRIMMED (NO OBSTRUCTION OR HANGING BRANCHES)
POLICIES AND PROCEDURES

- SHOULD INCLUDE P & P FOR PERIOPERATIVE CARE, INFECTION CONTROL, DOCUMENTATION, MEDICATIONS, EMERGENCY PROTOCOLS, FACILITY SAFETY, CREDENTIALING/DUTIES, QA/PERFORMANCE IMPROVEMENT
- SHOULD BE BASED ON ACCEPTED STANDARDS
  - AORN
  - CDC
  - ASPS/ASPSN GUIDELINES
  - ACCREDITATION STANDARDS
  - STATE REGULATIONS
QA/PERFORMANCE IMPROVEMENT

- REGULAR MEETINGS
- IDENTIFY, INVESTIGATE, AND ANALYZE PATIENT ADVERSE OCCURRENCES AND NEAR MISSES
- IDENTIFY TRENDS/PATTERNS
- DEVELOP MEASURES TO CORRECT, REDUCE, MINIMIZE OR ELIMINATE RISK OF ADVERSE OCCURRENCES TO PATIENTS
- MANDATORY ADVERSE INCIDENT REPORTING
- PROVIDE PATIENT WITH A STATEMENT OF PATIENT’S RIGHTS AND RESPONSIBILITIES AT INITIAL CONSULT
- COLLECT AND REVIEW SATISFACTION SURVEYS
  - ASK PATIENT IF HE OR SHE FELT SAFE IN YOUR CARE
QUESTIONS??????