Chubb Healthcare

Ambulatory Surgery Risk Management Self-Assessment Tool

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Ambulatory Surgery Centers (ASCs) in the U.S. have increased dramatically in the past decade, for reasons both clinical and financial. More than two-thirds of operations performed in the United States now occur in ASCs. As the volume and types of ambulatory surgery procedures continue to expand, so have the liability exposures. To minimize those exposures, it is critical for a successful ASC to have an effective and proactive risk management program.

Chubb Healthcare has developed the following self-assessment tool that may help identify areas of actual or potential loss exposure in the ASC setting. The tool highlights risk management considerations related to patient safety. Organizations can utilize this tool to help evaluate whether certain practices are in place and which practices they may need to implement
or strengthen.

The self-assessment tool reviews ambulatory surgery practices and procedures that range from proper patient selection to informed consent process for comprehensive credentialing programs. These strategies may assist in reducing risks to patients and/or minimize losses to the organization.

Before implementing comprehensive and proactive risk reduction strategies, organizations must honestly assess their operations, work to uncover areas of concern and evaluate potential solutions. This self-assessment tool can help identify opportunities for improvement, engage and educate healthcare providers while helping to improve the organization's risk management efforts.

The following tool is designed to assist ambulatory surgery administrators and risk managers evaluate a range of potential liability exposures, identify areas for clinical and operational improvement, and implement potential safeguards***.

Standard to be Measured	Yes	No	N/A	Comments
Risk Managment Program				
Is a written risk management program clearly communicated to staff during orientation, which describes the program's scope, components, and methods for identifying and mitigating risks?				
Is responsibility for the program's implementation and enforcement delegated to one individual?				
Is a system in place to identify and track unusual events, enabling staff to document on a standardized form any events that deviate from routine care?				
Are patient satisfaction surveys circulated and analyzed through quality assurance/ performance improvement activities?				
Are complaints formally responded to and tracked internally to indicate areas requiring improvement?				
Are risk awareness and safety programs for employees and medical staff offered annually, affording them a basic understanding of existing risks and how they can help protect themselves and others?				
Do institutional policies mandate thorough and complete patient care record documentation, and are deficits addressed with employees and medical staff?				
Are remedial measures taken post-adverse incident to minimize the impact of an event, and are follow-up action plans monitored and audited for their effectiveness?				
Is root cause error analysis conducted and documented for all sentinel or near-miss events?				
Provider Credentialing				
Is there a formal process to credential and privilege medical staff, inclusive of nurse practitioners and surgical assistants, that complies with accreditation standards and federal and state laws?				
Do all medical staff members undergo a formal orientation program, including documentation requirements and clinical safeguards?				
Is a credentialing committee charged with defining qualifying criteria in such areas as: • Board certaification • Education and training? • Professional experience? • Admitting privileges at Medicare participating hospital? • Licensing requirements and Drug Enforcement Administration certification? • Medical professional liability claim history? • References?				
Are credentialing qualifications and procedures set forth in staff rules and regulations, as well as policies and procedures, to ensure their systematic and consistent application?				
Do clinical privilege categories include scope of practice for all medical provider types and reflect new technologies/interventions?				

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Do medical staff application forms comply with local, state, and federal regulations including, but not limited to, inquiries into prior professional disciplinary actions, criminal charges, and state board of examiners' investigations?				
Are applications thoroughly vetted by a committee including, but not limited to, a check of employment history, references, National Practitioner Data Bank reports, Medicare/Medicaid sanctions, and insurance coverage limits?				
Is a list of active medical staff members maintained and are annual performance appraisals of assigned privileges conducted, considering such quality indicators as drug utilization, delinquent patient care records, peer-review findings, communication skills, and patient satisfaction levels?				
Staffing Level Considerations				
Do patient selection criteria reflect available nursing skills, as well as the risks posed by anesthesia and surgery in relation to the patient's physical status, potential complications and comorbidity levels?				
Are job descriptions for all nursing and clinical ancillary staff reviewed and updated as necessary to maintain continuity of care?				
Are nurses assessed upon hire for competency levels, and are findings and deficiencies documented?				
Are staffing ratios set for all procedures based on applicable state regulations and professional association/accreditation guidelines (e.g., 1:1 for operating rooms, 1:2 for post-anesthesia care units)?				
Does written policy define actions to take when patient care requirements exceed internal capabilities, including criteria for when to transfer patients to an acute care setting?				
Do staffing levels factor in key variables, including:				
Acuity and complexity of case mix?				
Number of reserved procedure and/or operating rooms?				
Average length of patient stay?				
Training and experience of nurses?				
Overall staff skills and competencies?				
Availability of ancillary staff support?				
Do staffing models emphasize flexible shifts between 8 and 12 hours?				
Are nursing staff members cross-trained in at least two phases of operative care?				
Are staffing levels analyzed monthly for the following nursing-sensitive patient outcomes: Shock? Hemorrhage? Reintubations? Bloodstream infections? Pneumonia? Failure-to-rescue occurrences? Malignant hyperthermia? Transfer to an acute care setting? Thirty-day mortality rates?				

Standard to be Measured	Yes	No	N/A	Comments
Patient Selection				
Are all new-patient protocols in writing and regularly reviewed/revised?				
Do admission protocols reflect the entity's scope of services, capabilities and competencies, as well as its limitations?				
Do written selection criteria address patient age and health status, including obesity, respiratory and cardiac disease, physical disabilities, and other risk factors?				
Are contraindications to patient selection delineated in facility policy, such as clotting disorders, unstable angina, asymptomatic asthma, or multiple co-morbidities, and is the necessary laboratory/diagnostic testing performed pre-operatively?				
Are selection criteria consistently implemented and incorporated into documentation formats?				
Are patient care records checked for compliance with screening criteria during periodic quality improvement reviews?				
Is there a system in place to resolve questions regarding patient appropriateness if they are identified during the pre-screening process?				
Do all surgical procedures fit within applicable state and federal ambulatory surgery regulations and clinical restrictions, especially regarding such factors as blood loss, fluid shifts, and sedation?				
Are surgical appropriateness decisions based upon established criteria and guidelines, such as the American Society of Anesthesiology's (ASA's) Physical Status Classification?				
Are surgical suites equipped to manage all patients that meet selection criteria, including children requiring pediatric supplies and equipment?				
Informed Consent & Pre Assessment				
Is there an informed consent process which allows patients to ask questions in preparation for treatment?				
Does the consent form address special situations, such as administration of blood; tissue use and disposal; experimental status of a procedure; photography or videotaping; and the presence of sales representatives in the operating room?				
Are patients asked to state the planned procedure, point to the area to be operated on, and pose any remaining questions prior to signing the consent form?				
Is a separate consent form for anesthesia presented to patients, outlining the risks and benefits associated with anesthesia care?				
Is there a system in place for obtaining consent for minors, as well as for adults with impaired cognition?				
Is a medical evaluation conducted within thirty days of the scheduled procedure and fully documented in the patient care record?				
Is an appropriate pre-anesthesia evaluation and examination conducted by an anesthesiologist or certified registered nurse anesthetist, which includes an anesthesia plan?				
Is the pre-anesthesia evaluation re-evaluated immediately before induction?				

Standard to be Measured	Yes	No	N/A	Comments
Are pertinent laboratory values re-assessed on the day of surgery?				
Are physicians notified promptly when pre-surgical assessment indicates the need to cancel a scheduled procedure?				
Is there a process to ensure that the treatment team receives all pertinent information prior to preparing the patient for treatment?				
Surgical Check Protocols				
While in the holding area, is the presence of the following data confirmed by an RN:				
The surgical informed consent form, notating the procedure and the site, side, level and digit, as necessary?				
The specific system or device to be implanted or removed, if applicable?				
Harvest and donor site facts?				
All radiological images germane to the case?				
Special equipment requirements?				
Blood product requirements?				
Is the correct person, procedure, and site confirmed and documented a second time before the patient leaves the holding area?				
Before induction of anesthesia, does the anesthesia provider and circulating RN confirm the incision or insertion site was marked:				
By the individual performing the surgery/procedure?				
In a clear and unambiguous manner?				
With three legible initials, rather than an X?				
At operative sites only?				
In areas visible after patient prepping and draping?				
With an FDA-approved “permanent” marker?				
Before skin incision, does the designated surgical team suspend activities to audibly confirm the correct: • Patient? • Side and site? • Procedure? • Body position? • Implants and special equipment?				
If inconsistencies or other issues arise, does written policy require the team members to: • Suspend all activity until the inconsistency or problem is resolved? • Follow organizational policy for conflict management? • Document all actions taken and decisions made to resolve the situation?				
Before the patient leaves the operating room, does the circulating RN confirm: • Sponge, sharp, and instrument counts? • Identified and labeled specimens? • Key concerns of the surgical team for patient recovery and management?				

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Post Operative Monitoring				
Does written policy define required skills of postoperative nursing personnel and the interval for their review?				
Does nursing staff undergo specialized training in postoperative care, with emphasis on assessing and managing the following: • Airway patency? • Level of consciousness? • Pain? • Nausea/vomiting? • Body temperature? • Surgical site intactness? • Patency of drainage tubes? • Patency/rate of intravenous infusions? • Circulation/sensation in extremities?				
Are RNs provided with an opportunity to obtain certification in post- anesthesia care, i.e., to become a certified post anesthesia nurse?				
Patient Handoffs				
• Does written policy address patient handoff practices, emphasizing staff responsibility and communication parameters?				
• Is a standard report format used during handoff process, such as the "I PASS the BATON" technique (i.e., Introduction, Patient Assessment, Situation, Safety, Background, Actions, Timing, Ownership, Next)?				
Are patient handoffs completed at the following critical moments: • Temporary relief or coverage breaks? • Transfer of care from one physician to another? • Initiation or cessation of respiratory support? • Transfer from pre-operative area to OR? • Transfer from surgical areas to the post-anesthesia unit or recovery unit? • Discharge home? • Transfer to an acute care facility?				
Do staff members adhere to approved language during handoffs, repeat- back critical information, and utilize discussion triggers, such as • "I'm concerned about …"?: • "I'm uncomfortable with …"? • "I think we have a safety issue."?				
Does policy require a "read-back" between at least two caregivers upon receipt of critical information (such as STAT test results)?				
Medication Safety				
Are patient medication profiles readily available and do they include allergy notation and weight and height measurements?				
Are laboratory values and diagnostic reports easily accessible to prescribing practitioners?				
Is machine-readable coding used to check patient identity and drug data prior to administration of drugs?				

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Are all medication containers prepared in advance, including IV and oral syringes, vials, bowls and basins, and are they appropriately labeled?				
Do unit-dose medications remain packaged up to the point of hand-off/administration?				
Are all handoffs of prepackaged medications preceded by a spoken exchange of information, which includes patient and drug name, as well as the dose, route and frequency of administration?				
Are verbal drug orders limited to emergencies or sterile procedures?				
Are potential drug side effects clearly communicated at points of transition and documented in handoff reports?				
Are patients who receive high-alert drugs via IV or epidural infusion accompanied by a qualified nurse or licensed practitioner when transported between treatment areas?				
Falls Prevention				
Is a screening tool used to assess patients at-risk for falls, with results documented in the patient care record and patients flagged by a colored wrist band?				
Are patients checked for signs of unsteady gait or poor posture upon admission to the holding area?				
Is the use of medications affecting the central nervous and/or cardiovascular system noted in recovery care record?				
Do wheelchairs have anti-rollback devices and are they locked when in a stationary position?				
Are side rails and wheel locks engaged whenever patients are on procedure tables or gurneys?				
Are procedure tables equipped with proper safeguards, such as side rails, grip handles, and step risers?				
Does physical restraint use comply with local and state regulations?				
Do all care spaces have non-skid flooring, even lighting, and are they free of clutter?				
Are emergency call systems and assistive devices available in bathrooms and changing rooms?				
Are sidewalks, driveways, walkways, parking lots, and other paved areas clearly lighted, well-maintained, and frequently inspected?				
Are post-fall assessments completed, describing details of the incident, immediate causes, contributing risk factors, and medical response?				
Equipment & Injection Safety				
Is a computerized master inventory of all owned and leased medical equipment maintained, logging model and serial type, preventative maintenance and inspection schedules, warranties, and a history of equipment-related incidents?				
Do staff members undergo comprehensive training to ensure a through understating of operational and safety issues, especially including medication devices?				

Standard to be Measured	Yes	No	N/A	Comments
Do written procedures exist for monitoring and responding to equipment notices and recalls, and is there a database that tracks actions taken pursuant to an alert/recall?				
Does a written protocol delineate the procedure for monitoring, evaluating, and reporting device-related incidents involving the death, serious injury or illness of any individual as required by the Safe Medical Devices Act?				
Are IV and epidural infusions prominently labeled with the intended route of administration?				
Are the type and number of syringe pumps used to deliver medications limited, and are all pumps clearly marked to prevent mistakes?				
Are the distal ends of all tubing clearly labeled for patients receiving multiple solutions via different routes, such as peripheral, central venous, arterial, epidural, enteral, bladder or other access sites?				
Are brightly colored, standardized labels utilized to cue staff to certain high-risk line placements, such as epidural, intrathecal, and arterial catheters?				
Are pneumatic blood pressure cuffs prominently labeled to avoid connection to a patient's IV line and minimize the risk of an air embolism?				
Does written policy prohibit the administration of IV boluses via an infusion pump, unless smart pump technology allows programming for bolus doses?				
Clinical Alarm Safety				
Is telemetry alarm safety training provided to staff upon hire, focusing on: • Basic safety considerations? • Safe alarm-setting practices? • Baseline documentation for alarm use, status, and settings? • Response to high risk patients? • Monitoring alarm functionality and addressing potential problems? • Documenting individualized alarm settings? • False positive alarm conditions and consequences? • Communication guidelines for handoff situations? • Incident reporting protocols?				
Does written policy distinguish between low- or high-priority alarm conditions, with each level of urgency producing a distinct auditory signal?				
Does written policy establish alarm-related documentation parameters, including standardized, setting-specific formats?				
Do written alarm management protocols dictate when: • Clinical parameters can be modified to minimize alarm signals? • Non-actionable alarms can be eliminated? • Alarm delays are indicated? • Default settings may be adjusted according to set criteria and by physician order? • Alarms may be silenced? • Alarms may be altered to accommodate a patient's baseline parameters?				

Standard to be Measured	Yes	No	N/A	Comments
Does written protocol explicitly prohibit patients/family from altering alarm settings, and address how to obtain assistance when telemetry devices sound?				
Does written protocol delineate responsibility for primary alarm response and establish tiers of back-up alarm coverage?				
Are alarms checked for operation and appropriate monitoring parameters upon patient admission to the pre-operative holding area, after a change in the patient's condition, and during handoffs?				
Are changes in alarm parameters based on documented clinical conditions and/or age-appropriate standards?				
Are alarms set at an adequate level of audibility?				
Are locking alarm limits, smart alarm systems, minimum volume lockouts, and other safety design features in place to ensure that alarms will function as designed?				
Burns & Malignant Hyperthermia				
Are surgical staff members trained to detect and mitigate potential sources of burns, including: • Fuel risks associated with alcohol fumes, petroleum-based as opposed to water-soluble ointments, dry sponges, and prepping agents? • Oxidizer risks associated with high oxygen concentrations around a patient? • Ignition risks associated lasers, electrosurgery equipment, and conventional drills and burrs?				
Is fire and life safety training provided to staff members on an annual basis and are regular fire drills conducted?				
Are ORs equipped with a CO2 fire extinguisher which undergoes routine safety and maintenance checks?				
Is a water source or saline solution always present in the OR in case of a fire in or near the patient's airway?				
Is there a formal reporting protocol for surgical fires and are they reported to the Joint Commission and relevant state and federal agencies?				
Does the surgical center collaborate with local fire departments and the state fire marshal when developing organizational fire prevention and response strategies?				
Are training sessions held for physicians, certified registered nurse anesthetists, perioperative nurses, and other healthcare professionals on the risk of malignant hyperthermia (MH), including the clinical treatment protocol promulgated by the Malignant Hyperthermia Association of the United States (MHAUS)?				
Does a rapid response protocol exist to ensure that clinicians are prepared to take immediate action at the first sign of an MH crisis?				

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Do pre-operative forms identify individuals at-risk for MH, asking patients about: • Patient or family history of any problems with anesthesia? • Signs of an illness during the week prior to surgery, including an elevated temperature or flu-like symptoms? • Patient or family history of an increased heart and/or respiratory rate during or following a surgical procedure? • Patient or family history of severe muscle pain after anesthesia, heat stroke during exercise or chronic muscle weakness? • Patient or a family history of producing dark urine following anesthesia and surgery?				
Are posters of the MHAUS protocol displayed in surgical areas to alert staff to the following red-flag symptoms: • Elevated carbon dioxide levels? • Rapid respiratory and heart rates? • Muscle rigidity? • Respiratory and/or metabolic acidosis upon blood gas sampling? • Quick rise in body temperature to 105 degrees or higher?				
Emergency Response Protocols				
Are staff members trained annually in cardiac life support proficiency and is a physician skilled in resuscitation available when anesthesia is administered and surgery is performed?				
Are competency checklists completed on all responding staff for basic tasks, including CPR, delivering oxygen, and changing regulators?				
Are skills in airway management assessed annually, especially regarding use of a bag-valve mask?				
Are emergency response drills held at least annually, covering emergency patient management with and without a physician, as well as documentation practices and procedures for handoff to emergency transporters?				
Are standardized response protocols located in treatment areas for common high-risk conditions, such as blood loss, chest pain, and anaphylaxis?				
Are emergency response code carts and equipment present, based on presenting population and risks?				
Are staff members trained to utilize effective communication strategies in stressful situations, including expressing the urgency of the situation, summarizing the medical crisis, repeating back laboratory results and medications administered, and explaining the course of treatment?				

Standard to be Measured	Yes	No	N/A	Comments
Are emergency response records maintained in a consistent manner, encompassing the following information: • Patient name? • Reason for presentation/treatment? • Clinical observations? • Time of code? • Time of emergency medical service notification and arrival? • Emergency care rendered before arrival? • Name(s) of cardiopulmonary resuscitation providers? • Vital signs monitored? • Therapeutic interventions? • Time and mode of transfer (if applicable)? • Patient's disposition upon transfer or discharge? • Names of family members and/or other persons present and/or notified? • Time referring physician was notified?				
Are all medications on code carts and in pharmacy drug boxes labeled in large-print font, including generic and brand names, recommended dosages and routes, formats (e.g., cartridge, ampule, vial), and safety instructions?				
Are sound-alike and look-alike medications rendered visually distinguishable, using color-coded caps or tape?				
Do staff members undergo annual competency testing on emergency medication safety, with results carefully recorded?				
Acute Transfers				
Are written patient transfer agreements executed between the surgical center and selected hospitals, delineating responsibility for patient care during transport and related issues?				
Are transfer agreements reviewed by legal counsel?				
Are agreements to indemnify, defend, and hold harmless the other party for negligent acts limited to those situations where the other party did not cause or contribute to the act or omission?				
Are EMS staff members informed of patient status prior to placement in the transport vehicle, and are details of the report recorded in the patient's transfer record?				
Is a transfer and referral form sent with the patient, which summarizes current medical findings, diagnoses, and the course of treatment, among other vital clinical and administrative information?				
Are photocopies of records transferred with patients, rather than original documents?				
Is a debriefing held soon after patient transfer or discharge in order to address any problems that may have arisen during the event, and also to suggest improvements to the patient emergency management protocol?				
Are family members or healthcare/legal guardians, as well as the referring practitioner, swiftly notified of the patient's current medical status and location?				

Standard to be Measured	Yes	No	N/A	Comments
Are specimen-handling processes and responsibilities delineated according to specimen type?				
Are specimen containers durable and designed to minimize the risk of contamination, crushing or tearing?				
Is there a written protocol to establish a chain of custody and to ensure accountability in the transfer process?				
Are there written communication protocols regarding specimen handling, e.g., audible verification of patient identity and specimen type during transfer?				
Is the following critical information documented during transfer of specimens? • Name of the person releasing the specimen? • Name of the courier receiving the specimen? • Release date and time? • Patient name and key identifiers? • Specimen number and description?				
Is there a written protocol governing specimen delivery to off-site locations, including documentation of training and proficiency of couriers?				
Are specimens stored in a central location and at an appropriate temperature pending transfer and/or analysis?				
Are abnormal results or values subject to automatic retesting in order to reduce the possibility of erroneous results?				
Are daily laboratory specimen logs cross-checked against computer order entry logs to verify receipt, and are discrepancies investigated and reconciled?				
Are protocols established for the written and verbal communication of test results to ordering physicians, including time frames and documentation requirements?				
Are abnormal results promptly reported to the ordering physician or patient, and is a consultation offered?				
Discharge Readiness				
Is the discharge process guided by an accepted protocol, such as the Post Anesthesia Discharge Scoring System of the ASA?				
Are patients discharged pursuant to a written physician order and after medical re- assessment?				
Are patients discharged in the company of a responsible adult who is briefed on potential danger signs?				
Are discharge instructions reviewed with patients, including medication use, possible side effects, signs and symptoms to report, conditions requiring immediate medical intervention, recommended follow-up, and emergency contact information?				
Are patients and family members educated about the risks related to procedures performed, and are they provided information on how to manage and minimize emergencies post-discharge?				
Are photocopies of records transferred with patients, rather than original documents?				

Standard to be Measured	Yes	No	N/A	Comments
Is a debriefing held soon after patient transfer or discharge in order to address any problems that may have arisen during the event, and also to suggest improvements to the patient emergency management protocol?				
Are family members or healthcare/legal guardians, as well as the referring practitioner, swiftly notified of the patient's current medical status and location?				
Does the patient have reasonable access to medications, such as required antibiotics and pain medications?				
Are adverse events monitored through a call-back system on the first post-operative day including, but not limited to, presence of bleeding or surgical site infections, pain level, and problems related to medication intake?				
Is the date and time of the call documented in the patient care record, along with follow-up instructions, physician notification, and actions taken?				
Discharge Readiness				
Does a written Violence Prevention Program (VPP) clearly describe protocols to be taken to avoid violence and abuse, and are they capable of being implemented and adhered to by staff?				
Has a violence and abuse analysis been performed in the surgical center, ensuring that: • ID badges have been issued and are frequently checked? • Facility entrances are secured after normal operational hours? • Doors leading outside lock automatically? • Visitor access is controlled with sign-in sheets and ID check? • Protective glass surrounds registration desks and work stations in receiving areas? • Emergency alarm and communication systems are regularly tested, and test results are logged? • Local police and fire departments are linked to the alarm system?				
Does the VPP address bomb threats, hostage situations, and armed intruder occurrences?				
Is a background check performed on all new hires, and does it include criminal convictions and sex offender status?				
Have staff members been adequately trained in calming and restraining out-of-control patients, and in personal safety in case of attack?				
Is there a rapid response protocol for violent crisis situations?				
Are post-incident evaluations conducted, documented, and reviewed, including any changes made to clinical and operational protocols?				

References

Accreditation Association for Ambulatory Health Care (AAAHC), at www.aaahc.org

Ambulatory Surgery Center Association (ASC Association), at www.ascassociation.org

American Academy of Ambulatory Care Nursing (AAACN), at www.aaacn.org

American Association for Accreditation of Ambulatory Surgery Facilities, Inc. (AAAASF), at www.aaaasf.org

American Society of Anesthesiologists® Physical Status Classification System, at https://www.asahq.org/clinical/physicalstatus.htm

Federal Regulations for Ambulatory Surgery Centers, at http://www.ascassociation.org/medicareregulations/

Malignant Hyperthermia Association of the United States, at https://mhaus.site-ym.com/store/view_product.asp?id=1157088

Contact Us

Chubb Healthcare
Caroline Clouser
Executive Vice President
O 215.640.1056
E caroline.clouser@chubb.com

Diane Doherty
Vice President
O 212.703.7120
E diane.doherty@chubb.com

www.chubb.com

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