AMBULATORY SURGERY CENTER RISK MANAGEMENT SELF-ASSESSMENT

Facility Name ________________________________________________________________

Name of person completing assessment ___________________________________________

Title ___________________________   Phone Number ________________

E-mail Address ________________________________________________________________

This assessment tool is intended to help administrators, managers, and physicians involved in facility operations identify potential risks. Effective systems and processes can reduce patient injuries and malpractice claims. Time spent on this assessment can be very beneficial. Consider involving key staff members in conducting the assessment, allowing them to see firsthand the results of their efforts and areas where improvement would be helpful.

How to Use this Assessment:

1. Be honest, objective, and self-critical. The assessment is designed to help you identify and begin correcting risk management weaknesses in your facility’s systems, policies, and procedures. It will be only as effective as you allow it to be. Analyze your systems carefully and respond accurately.

2. Many Ambulatory Surgery Centers (ASC) discover that although there are policies in place, compliance is low. If you are unsure whether an established policy is effective, check with staff members most directly responsible for its implementation.

3. This assessment addresses risk management issues most often seen in malpractice claims. It does not cover all possible problems in the facility that could lead to patient injuries and lawsuits.

4. The assessment does not evaluate facility quality of care issues. These should be monitored through the appropriate quality assurance and credentialing mechanisms in your facility.

Instructions:

1. Please fill in the appropriate response to the attached questions. Please type or print your responses. If additional space is needed, extra pages may be added.

2. Retain a copy of the Self-Assessment for your records.

3. Please return the completed Self-Assessment to your MMIC Risk Management Consultant as soon as possible.
Governing Board

The Governing Board is ultimately responsible and accountable for the quality of care provided, the performance of physicians and staff, and the effectiveness of the organization’s patient safety, risk management and quality performance programs. The Board carries out its responsibilities through its mission statement, goal prioritizations and allocation of resources.

1. The Board approves the organization’s written scope of services.  
   a. The scope of services defines types of surgery, age-related criteria, and services that are offered at the center.

2. There is a current organizational chart reflecting lines of authority and the overall responsibility for the organization.

3. Bylaws are reviewed on a routine basis and revised as necessary.  
   a. Bylaws address the Board’s role and authority for quality of care.
   b. The Board approves the Risk Management/Quality Improvement/Patient Safety plan.

4. Board approves the medical staff bylaws, rules and regulations.

5. Board approves medical staff credentialing and makes final determination for granting privileges.

6. There is a formal process for clinical contract approval in place.  
   a. Board approves contractual agreements or delegates responsibility to CEO/Administrator.
   b. Clinical contracts include hold harmless agreements.
   c. Clinical contracts include performance expectations and quality activities.
   d. Clinical contracts include competency standards, licensing and continuing education requirements.
   e. All contracts include HIPAA provisions for business associate agreements.

7. The Board has approved a written clinical chain-of-command policy that establishes lines of authority.  
   (The Chain of Command policy statement identifies the process clinical staff should follow when they have concerns about the quality of care a patient is receiving or if the physician is unable to perform or does not respond.)
Medical Staff

An effective risk management/quality performance plan requires active participation from the medical staff.

1. Medical staff bylaw, rules and regulations are reviewed on a routine basis. Y N
2. Credentialing process is monitored for compliance with the established criteria. O O
   a. The credentialing process includes allied health professionals and locum tenens. O O
   b. Liability insurance coverage is annually verified for adequate limits and tail coverage. O O
3. Reappointment and delineation of clinical privileges are done at least every two years. O O
   a. Reappointment procedure includes review of physician’s quality activities when granting of privileges (complication rates, patient complaints, compliance with medical staff bylaws, etc). O O
4. Program is in place to identify and manage physician and CRNA’s whose performance may be affected by mental or physical health or who may be impaired by chemical use and/or abuse. O O
5. The bylaws/medical staff policies address zero-tolerance standards for workplace abuse and define acceptable and non-acceptable behaviors for physicians and allied health professionals which could cause disruption to patient safety. O O
   a. The bylaws/policies identify how reports of workplace abuse will be managed. O O
   b. The bylaws/policies prohibit retaliation against those who report non-acceptable behaviors. O O

Administrative Leadership

Leadership demonstrates support for risk management/quality performance and a commitment to patient safety throughout the facility by having processes and policies in place conducive to promoting an environment that protects patients from injury. Y N

1. The ASC has documented evidence of credentials, privileges, and orientation to the facility for all contracted, locum tenens, or agency staff. O O
2. New procedures are not permitted unless it falls within the scope of service and the physician has approved privileges to perform the procedure.  
   Y  N  O  O

3. Staff are trained on usage of new equipment prior to usage.  
   Y  N  O  O
   a. Training and competence is documented.  
   Y  N  O  O

4. Criminal background checks are conducted on physicians, allied health professionals, and all employees prior to hire.  
   Y  N  O  O

5. There are written and approved job descriptions in place for all positions that reflect the knowledge, skills and abilities required to perform the job.  
   Y  N  O  O
   a. Written performance review of all staff, based upon the job description, is conducted and addresses competency to perform job requirements.  
   Y  N  O  O
   b. There is documentation of staff education related to new policies, procedures and equipment.  
   Y  N  O  O

6. Personnel policies are in place describing how to identify and manage employees whose performances may be affected by mental or physical health or who may be impaired due to use or abuse of chemicals (medications, drugs, alcohol).  
   Y  N  O  O

7. A zero-tolerance policy addresses workplace abuse that defines acceptable and non-acceptable behaviors by staff which could cause disruption to patient safety.  
   Y  N  O  O
   a. The policy identifies reporting process and defines management of non-acceptable behaviors.  
   Y  N  O  O
   b. The policy prohibits retaliation against those who report non-acceptable behaviors.  
   Y  N  O  O

8. A written transfer agreement with receiving hospital is in place in the event that a patient requires transport.  
   Y  N  O  O
   a. There are required documentation standards on patients prior to being transported.  
   Y  N  O  O

9. All administrative and department policies are reviewed on a routine basis and updated to reflect current standards and practice.  
   Y  N  O  O

10. Outdated policies and procedures are retained pursuant to your state statute of limitations.  
    Y  N  O  O
Risk Management/Quality Performance

Accountability and responsibility for risk management/quality performance vary with the facilities individual characteristics. Regardless, the risk management plans will need to identify reporting relationships and systems for identifying and managing risks.

1. The ASC has an integrated Risk Management/Quality/Safety program implemented throughout the facility.  
2. RM/QI/Safety reports are prepared, analyzed and presented to the Board and other committees as appropriate.  
   a. Minutes reflect actions taken.
3. Written process is in place for reporting, tracking/trending, and investigating incidents/occurrences/events.
4. Staff members and physicians receive specific education in identifying and reporting patient safety concerns, adverse events, near misses and medical errors.
5. Written policy is in place describing how legal documents, correspondence, investigation and potential claims are handled.  
   a. A person (position) is designated to accept service of summons and complaint, subpoena or other legal documents.  
   b. Protocol is in place for reporting to MMIC all lawsuits, claims, Board of Medicine complaints and other incidents that have potential to develop into claims.  
   c. Communication with MMIC and defense attorneys is kept in a separate correspondence file, not the patient medical record.  
   d. Patient medical record is protected from alteration when a potential claim has been identified.  
   e. Medical equipment and devices involved in a patient injury are identified and sequestered.
6. A written policy is in place on photographing and videotaping.  
7. There is a written policy governing provider and employee activity on social networking (i.e. Facebook, MySpace or twitter).  
8. There is a policy enforced on use of cell phones and camera phones by employees, patients and visitors.
Culture of Safety – Patient Safety

Historically, safety programs have focused on environmental safety. Since the IOM report, “To Err is Human: Building a Safer Health System” (1999), safety programs have emphasized the organizational “culture” and clinical patient safety initiatives. “Culture of Safety” characteristics include a value on safety over productivity, open communication, value on learning as opposed to punishing, and value on improving system performance rather than on individual blame.

1. “Culture of Safety” surveys staff/employees are periodically conducted.  
2. Patient satisfaction surveys are periodically conducted.  
3. Patients and families are informed on how to report concerns about safety.  
4. Written fall assessment and prevention program is in place.  
5. Written latex allergy protocol is in place.  
6. Written policy is in place prohibiting the use of dangerous abbreviations, acronyms, and symbols.  
   a. A standardized “do not use” list of abbreviations (such as ISMP) has been adopted.  
   b. Use of abbreviations, acronyms, and symbols is prohibited on all medication orders and prescriptions.  
   c. Use of abbreviations, acronyms and symbols is prohibited on all orders and notes identifying procedures, surgeries, site verification and on the written verification (permit).  
   d. Compliance monitoring occurs to assure adherence to the policies.  
7. Written policy is in place prohibiting turning off alarms on any equipment.  
8. Process is in place that defines critical test results and reporting processes.  
   a. Policy is in place requiring the person receiving critical test results to record and then “read-back” the test results.  
9. Written policy is in place that requires use of at least two patient identifiers.  
   a. The policy applies to medication administration.  
   b. The policy applies to collection of laboratory specimens.  
10. A standardized approach to “hand-off” communication is used when transferring care from one person to another.  
11. Policy and procedure are in place to reduce the risk of DVT/PE.  
12. Written policy defines how communications of adverse outcomes happen and includes disclosure of medical errors.
13. Interpreters trained in medical terminology are available for hearing impaired or English as second language patients.  

14. All patient education materials are written at the 5th grade reading level and individualized for the specific patient.  

15. Physicians and staff receive education on health literacy and techniques to promote patient understanding and active participation in health care decisions.  

16. Patients receive written postoperative and follow-up care instructions.  

17. Patients who receive other than local anesthesia are discharged with a responsible adult.  
   a. Responsible adult/relationship is documented in the medical record.  

18. A licensed physician is in attendance at the ASC during patient treatment and recovery.  

19. In facilities providing overnight care, a licensed physician is immediately available by telephone.  

**Medications**  

1. All medication orders and discharge prescriptions are required to have the medication use or purpose written on the prescription.  

2. Written policy is in place identifying “high risk” medications and the permitted practices related to use. Policy includes:  
   b. Standardization of available drug concentrations available.  
   c. Listing of look-alike/sound-alike medications and the precautions to be used to prevent confusion.  

3. Controlled substances are stored under lock and key. There is a sign-out system in place.  

4. Complete list of medications is provided to the patient at discharge.  

5. Drug samples and other medications are kept in an area accessible only to designated staff.  
   a. Sample and medication area are locked/secured after office hours.
Environmental/Equipment Safety

1. Written safety plans are in place (fire, tornado, bomb threat, and internal disaster, pandemics and disaster recovery).  
2. Written plan in place to manage hazardous materials and waste.  
3. All equipment is inspected, tested, and maintained based on established criteria.  
4. Preventive maintenance is provided by qualified staff or vendor.  
5. Documentation is maintained on all testing and quality control performed on equipment.
6. There is a policy in place for handling of defective or malfunctioning equipment. It addresses:
   a. Removal of equipment from service  
   b. Equipment involved in patient injury is not sent to the manufacturer  
   c. Third party is used to examine equipment involved in patient injury  
7. Emergency power is readily available for critical patient equipment.  
8. Equipment is available for patient population served (pediatric patients, infants).  
9. Surgery center staff, anesthesia, and providers are educated on how to control heat sources and manage fuels. There are guidelines in place to minimize oxygen concentration under drapes.  
10. There is a policy/procedure in place to handle supplier notification or recalls.  
11. All staff, anesthesia providers and physicians have annual surgical fire safety training

Infection Prevention and Control

1. A designated and qualified professional with training in infection control is assigned responsibilities for infection control activities.  
2. There are written infection control policies based on identified risk for acquisition and transmission of infectious agent. (Such as prevalence of resistant pathogens in community)  
3. Written documentation supports monitoring of infection control practices.  
4. Standardized policies and procedures are in place for cleaning and disinfecting medical equipment, devices, and supplies.
5. Sterilization protocols follow manufacturer’s guidelines and infection control standards.

6. If reprocessing single use devices, the practice is consistent with regulatory and professional standards.

7. There is an identified protocol to prevent infections related to IV therapy.

8. Staff receives education on Hand Hygiene protocols following the CDC hygiene guidelines.

### Anesthesia

1. Written anesthesia policies and procedures are in place and current.

2. Policies and procedures adhere to American Society of Anesthesiologists (ASA) and American Association of Nurse Anesthetists (AANA) standards.

3. Written policy defines control, accountability and distribution of controlled substances and anesthetic agents.

4. All syringes containing medications are labeled at the time they are drawn-up.

5. Informed consent for, and the type of anesthesia to be administered, is obtained and documented by anesthesia personnel.

6. Patients are assessed and screened for appropriateness of treatment at a surgery center. Criteria may include:
   a. ASA classification (4 & 5 are not admitted to surgery center)
   b. age
   c. psychosocial difficulties
   d. limitations of surgical facility or providers
   e. malignant hypothermia
   f. sleep apnea

7. There is documentation of pre-anesthesia evaluations/visits.

8. There is a written policy requiring anesthesia equipment be checked prior to each case to ensure proper function.

9. There is an established standardized approach for “hand-off” communication between anesthesia providers when anesthesia personnel change during a procedure.

10. A written policy defining discharge criteria from PACU is in place.
Surgery

1. Written policies and procedures are in place and current.  
2. Informed decision making (consent) for the specific procedure is documented in the medical record.  
3. Patient consent is obtained prior to permitting any vendors and/or visitors in the surgical suite.  
4. A current list of approved clinical privileges for medical staff and midlevel practitioners is available in the surgical area.  
   a. Written policy requires review of approved privilege list prior to scheduling procedure.  
   b. Written policy requires notification of person in authority for any request outside of the approved list of clinical privileges.  
   c. Written policy defines the process for reviewing requests for additional privileges and for making decision for adding surgical procedures to the scope of service.  
5. Patient identification is verified and documented by surgical personnel according to Universal Protocol following these steps:  
   a. Use of 2 patient identifiers.  
   b. Patient identification is confirmed and verified prior to entering OR suite.  
   c. Physician has marked the site prior to entering OR suite.  
   d. There is verification of patient, procedure and surgical site after patient enters OR suite.  
   e. There is “Time Out” in the OR suite after patient is prepped and draped that involves the entire team.  
      i. “Time Out” requires each person in the room to verbally acknowledge participation.  
6. A checklist is used prior to starting the procedure to assure implants, devices and special equipment are available.  
7. All personnel in attendance in OR suite are recorded in the medical record.  
8. All medications, medication containers (syringes, medicine cups, basins) or other solutions both on and off the sterile field are labeled.  
9. Sponge, sharp and instrument counts are conducted and documented in accordance with AORN standards.  
   a. Only radiopaque sponges and devices are used.  
   b. Standardized counting procedures are utilized including sponge
counts for vaginal procedures.

c. High-risk conditions/situations are identified and require visual inspection prior to closure.

10. Written policy in place on retained devices and fragments.
   a. Instruments/devices are inspected to assure all parts are intact and removed from the surgical site.

11. Written policy to prevent surgical site infections. Policy includes:
   a. Appropriate use of antibiotics
   b. Appropriate hair removal
   c. Perioperative glucose control
   d. Perioperative normothermia