Approved for 2023 by NSS Governing Board on 12-28-2022, prior to 03-01-2023 deadline.

Facility Name: Nevada Surgical Suites - 8322
Facility Name: Nevada Surgical Suites - 7661

2023 QUALITY AND PATIENT SAFETY PLAN

DATE: 03-01-2023
VERSION: 1.5

This plan was created and revised by the Nevada Surgical Suites Patient Safety committee/team. Implementation of this plan is intended to optimize the healthcare quality and patient safety outcomes, encourage recognition, reporting, and acknowledgment of risks to patient, visitor, and employee safety, as well as reduce the medical/healthcare errors and /or preventable events.

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Commitment to Patient Safety

Nevada Surgical Suites is committed to a comprehensive approach to improving healthcare quality and patient safety by aligning with our Mission, Vision, and Values, creating an environment that supports a dynamic, proactive, and safe culture for patients, family members, visitors, and employees, through continuous learning and improving patient safety policies, systems, and processes.

Mission, Vision, and Values

In support of our mission, vision, and values, Nevada Surgical Suites Patient Safety and Quality Improvement program promotes:

- Collaboration of healthcare, leadership, medical staff, and other healthcare providers to deliver integrated and comprehensive high-quality healthcare.
- Communicate honestly and openly to foster trusting and cooperative relationships among healthcare providers, staff members, and patients and their families, to ensure accountability for the patient safety priorities.
- Preservation of dignity and value for each patient, family member, employee, and other healthcare providers.
- Responsibility for every healthcare related decision and action.
- A focus on continuous learning and improving, system design, and the management of choices and changes, bringing the best possible outcomes or performances to the facility.
- Incorporation of evidence-based practice guidelines to deliver high quality healthcare.
- Education of staff and physicians to assure participation of healthcare providers.

Scope and Purpose

The scope of this Quality and Patient Safety Plan is organizational-wide/hospital-wide/agency-wide which includes but is not limited to

- Patient safety
- Visitor safety
- Employee safety

All staff in Nevada Surgical Suites are required to fully support and participate in this plan, and devote their expertise to the patient safety and healthcare quality improvement process.

This plan is action oriented and solution focused. The purpose of this plan is to address patient safety related concerns, challenges and revise the program to better serve the patients and their families. To this end, Nevada Surgical Suites has developed this Patient Safety plan.

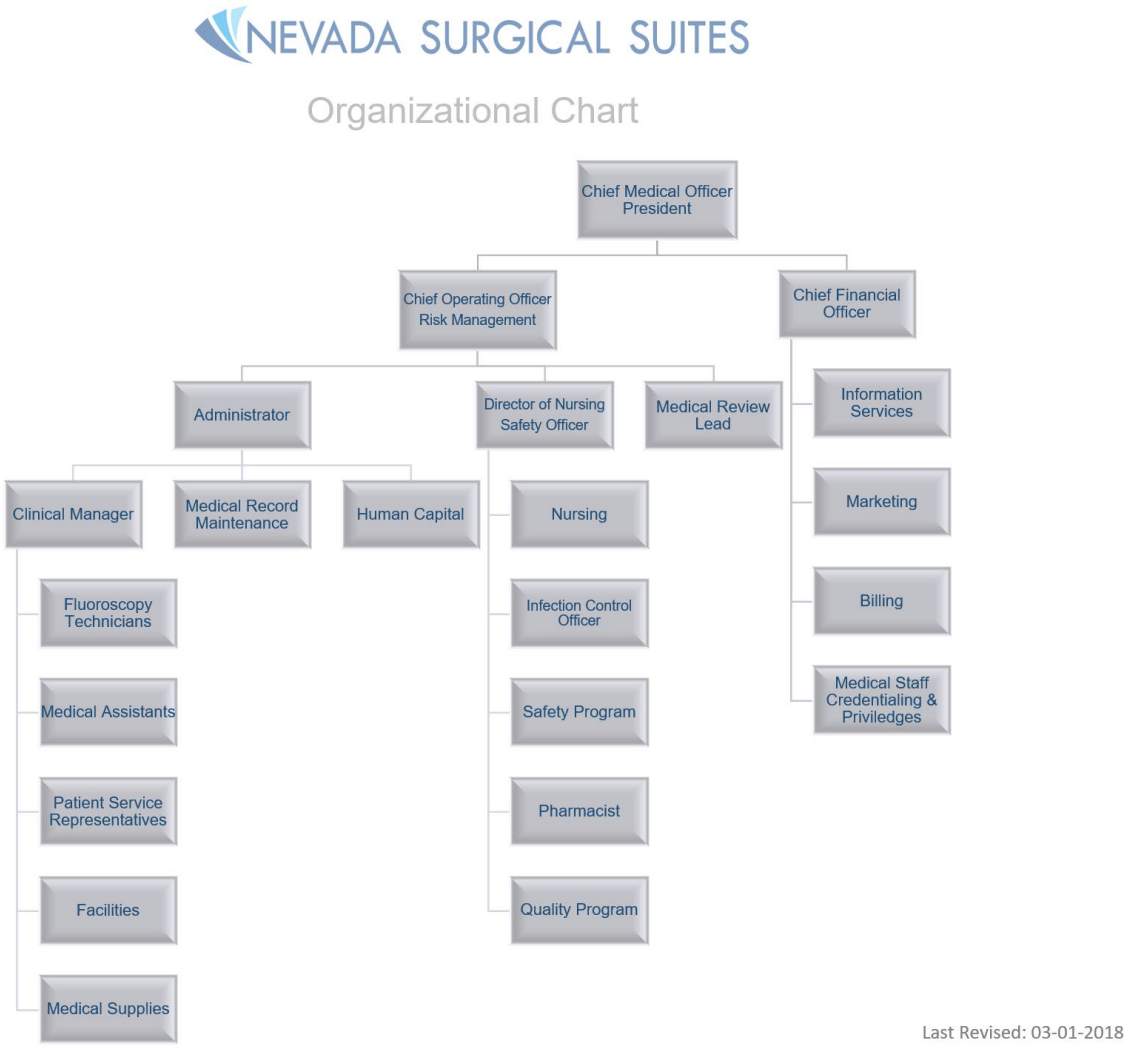
The plan focuses on the process rather than the individual, and recognizes both internal and external customers, as well as facilitates the need of analyzing and improving processes. The core principles of this plan include:

- All staff have the same goal and contribute their knowledge, vision, skill, and insight to improve the process of the Patient Safety Plan.
- Decisions will be based on data and facts, and staff will be encouraged to learn from the experiences.
- Customer based including patients, families, and visitors.
- Promote systems thinking.
- Employ well-trained and competent staff maintaining high healthcare quality.

Roles and Responsibilities

According to NRS 439.875, a medical facility shall establish a Patient Safety Committee (PSC). The PSC should ensure that the Quality and Patient Safety Plan is promoted and executed successfully.

The Patient Safety Committee Organization



Roles and Responsibilities

- In accordance with NRS 439.875, a patient safety committee must be comprised of:

- The infection control officer of the medical facility;
- The patient safety officer of the medical facility, if he or she is not designated as the infection control officer;
- At least three providers of healthcare who treat patients at the medical facility, including but, without limitation, at least one member of the medical, nursing and pharmaceutical staff of the medical facility; and
- One member of the executive or governing body of the medical facility.

Based on NAC 439.920, a medical facility that has fewer than 25 employees and contractors must establish a patient safety committee comprised of:

- The patient safety officer of the medical facility;
- At least two providers of healthcare who treat patients at the medical facility, including but without limitation, one member of the medical staff and one member of the nursing staff of the medical facility; and
- The Chief Executive Officer (CEO) or Chief Financial Officer (CFO) of the medical facility.

The roles and responsibilities are defined below:

- Member 1: Medical Provider, Governing Board Member, Executive Team Member
- Member 2: Governing Board Member, Billing Manger
- Member 3: Governing Board Member, Pharmacist
- Member 4: Medical Provider, Governing Board Member, Executive Team Member
- Member 5: Clinical Manager
- Member 6: Chief Financial Officer, Governing Board Member, Executive Team Member
- Member 7: Governing Board Member, Director of Nursing, Infection Control & Safety Officer
- Member 8: Governing Board Member, Administrator

Patient Safety Committee Responsibilities (based on NRS 439.875 and NRS 439.877)

- Monitor and document the effectiveness of the patient identification policy.
- **On or before July 1** of each year, submit a report to the Director of the Legislative Counsel Bureau for development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted pursuant to NRS 439.877(4)(b).
- Receive reports from the patient safety officer pursuant to NRS 439.870.
- Evaluate actions of the patient safety officer in connection with all reports of sentinel events alleged to have occurred.
- Review and evaluate the quality of measures carried out by the facility to improve the safety of patients who receive treatment.
- Review and evaluate the quality of measures carried out by the facility to prevent and control infections.
- Make recommendations to the executive or governing body of the medical facility to reduce the number and severity of sentinel events and infections that occur.
- At least once each calendar month (or quarter depending on the number of employees and contractors in the facility), report to the executive or governing body of the facility regarding:
  (1) The number of sentinel events that occurred at the medical facility during the preceding calendar month (or quarter);
  (2) The number and severity of infections that occurred at the facility during the preceding calendar month or quarter; and

(3) Any recommendations to reduce the number and severity of sentinel events and infections that occur at the medical facility.

- Adopt patient safety checklists and patient safety policies as required by NRS 439.877, review the checklists and policies annually and revise the checklists and policies as the patient safety committee determines necessary.

Root Cause Analysis (RCA) Team Responsibilities

- Root Cause interviews, analysis, investigation, and corrective action plan implementations.
- Participates in the RCA meetings and discussions.
- Communicate honestly and openly about only data and facts to the team members and their supervisors/leaders.

Patient Safety Officer Responsibilities (based on NRS 439.870)

- Serve on the patient safety committee.
- Supervise the reporting of all sentinel events alleged to have occurred at the facility, including, without limitation, performing the duties required pursuant to NRS 439.835.
- Take such action as he or she determines to be necessary to ensure the safety of patients as a result of an investigation of any sentinel event alleged to have occurred at the facility.
- Report to the patient safety committee regarding any action taken in accordance with the responsibilities above.

Infection Control Officer Responsibilities (based on NRS 439.873)

- Serve on the patient safety committee.
- Monitor the occurrences of infections at the facility to determine the number and severity of infections.
- Report to the patient safety committee concerning the number and severity of infections at the facility.
- Take such action as determines is necessary to prevent and control infections alleged to have occurred at the facility.
- Carry out the provisions of the infection control program adopted pursuant to NRS 439.865 and ensure compliance with the program.

RCA team leader Responsibilities

- Organize and coordinate the RCA process.
- Assemble and encourage a supportive and proactive team.
- Assign investigative and implementation tasks to the team members.
- Conduct and be actively involved in the investigation, RCA, and corrective action plan implementation process.
- Communicate the progress of the investigation, institutional barriers, and finalized action plan to executive leadership.
- Monitor goals and progress towards completion of the Corrective Action Plans.
- Provide training, education and direction to create RCA process that incorporate the Patient Safety and Quality Improvement elements.

Executive or Governing Body Staff Responsibilities

- Provide vision and leadership to Patient Safety and Quality Improvement process, and develop and foster a safe learning and improving culture.
- Provides oversight to the healthcare quality improvement processes and teams.
- Plan, discuss, and generate the organization patient safety goals and activities, in conjunction with the patient safety action plans

The Patient Safety Committee will meet monthly (or quarterly) to accomplish the following:

- Report and discuss sentinel events which include:
  - Number of sentinel events from previous calendar month (or quarter).
  - Number of severe infections that occurred in the facility.
- Corrective Action Plan for the sentinel events and infections
  - Evaluate the corrective action plan.
- Patient safety policies and checklists
  - At least annually evaluate Patient Safety policies and checklists
  - Revise the patient safety policies and checklists as needed.
  - Monitor and document the effectiveness of the patient safety policy.

A RCA meeting will meet as needed to accomplish the following:

- Define the healthcare issues or potential risks.
- Conduct Root Cause Analysis
  - Reviewing and analyzing the data.
  - Reviewing the RCA process and quality improvement related activities and timelines.
  - Brainstorming issues or the potential risks by using the fishbone diagrams.
  - Identify the contributing factors and conduct the Root Cause Analysis.
- Conduct Corrective Action Plan
  - Identifying the Plan-Do-Study-Act (PDSA) topics.
  - Discussing corrective action process and activities.
  - Discussing and presenting possible changes in procedure to improve areas indicated.
  - Identifying strengths and areas that need improvement.
  - Developing strategies, solutions, and steps to take next.
- Identify barriers and technical assistance needs for supporting the RCA efforts.

A meeting agenda and minutes noting follow-up tasks will be kept.

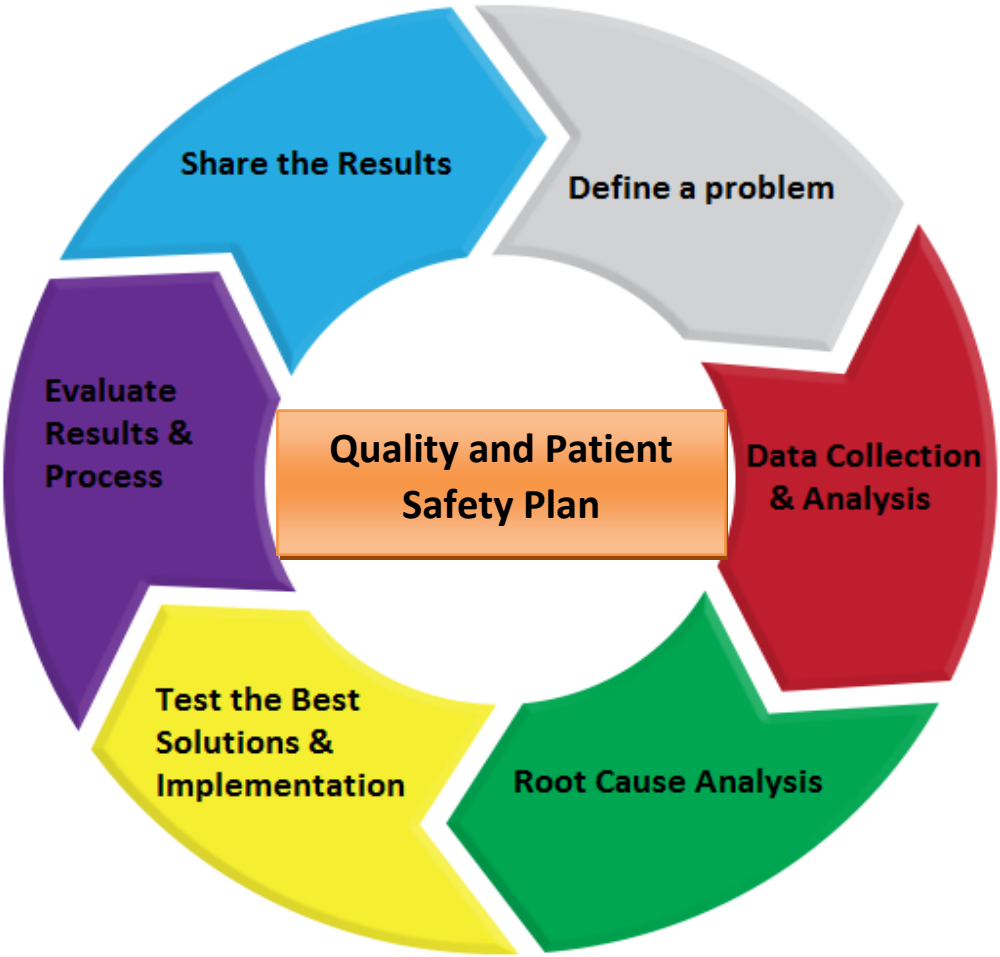
Objectives and Goals of the Quality and Patient Safety Plan

Objective	Goals	Plan	Planned Completion Date	Responsible Party
Medication Reconciliation	Increase accuracy to ≥ 90%	Increase chart audits with focused training	12-31-2023	Pharmacist
Allergy Documentation	Increase accuracy to ≥ 100%	Continue chart audits with focused training	12-31-2023	Pharmacist
Hand Washing	90% compliance	Observations, training	12-31-2023	Clinical Team

Components and Methods

Pursuant to NRS 439.837**,** a medical facility shall, upon reporting a sentinel event pursuant to NRS 439.835, conduct an investigation concerning the causes or contributing factors, or both, of the sentinel event and implement a plan to remedy the causes or contributing factors, or both, of the sentinel event."

Nevada Surgical Suites will use RCA process to determine the contributing factors and the underlying reasons for the deficiencies or failures. The Plan-Do-Study (check)-Act (PDSA or PDCA) is the model, which was developed by the Institute of Health Care Improvement, that we will use to test the changes.



Root Cause Analysis

A Root Cause Analysis is a process for identifying the root causes of the problem(s). It focuses on the process, instead of individuals.

Before analyzing the root causes, defining problems based on facts and data is essential for successfully conducting root cause analysis.

Root cause analysis and action plan framework table, which was introduced by the Joint Commission. It contains 24 analysis questions. It guides the organization to the steps in a root cause analysis. Not all the questions apply to all the events or cases. This table can be used individually or with the fishbone diagram.

5 Whys technique will be used in Nevada Surgical Suites to explore the cause and effect relationship underlay a problem. One can find the root causes by asking "why" no less than five times. This technique can be used individually or as a part of the fishbone diagram.

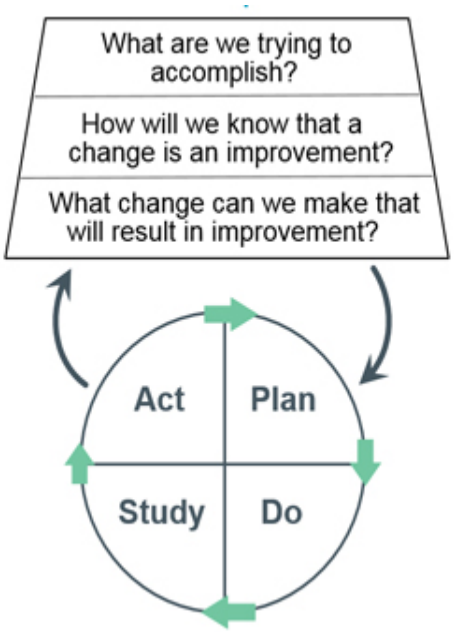
Fishbone Diagram

Once the problems are identified, a Fishbone Diagram (Appendix C) will be used for analyzing the problems. You can use the fishbone diagram individually to analyze the root causes, or use it with the root cause analysis and action plan framework table.

A Fishbone Diagram, also called a Cause-and-Effect diagram, is a useful tool for a team to structurally brainstorm by discovering possible underlying factors or root causes from different major categories for the chosen problems. General categories used include: people, methods, materials, measurements, education, procedures, process, location, environment, etc. RCA team members will brainstorm and ask multiple times, "why did this happen?" for each cause until all ideas are exhausted. The highest priority root causes will be chosen for PDSA topics. Once all the categories are established on the fishbone diagram, 5 Why's technique also can be used to drill down the problem and find the root causes.

Model for Improvement

The Model for Improvement is a collaborative and ongoing effort model to improve the product and services quality and process. It provides multi-disciplinary quality team guidance from identifying the root causes; conducting the best tests to assess possible changes, and working in collaboration for implementation of the new approaches and solutions. It guides the test of a change to determine if the change is an improvement.



The cycle is defined as follows:

- Plan--collect data and establish appropriate goals. Identify the problem and the possible root causes and answer the following questions.
  - What is the objective of the test?
  - What are the steps for the test - who, what, when?
  - How will you measure the impact of the test?
  - What is your plan to collect the data needed?
  - What do you predict will happen?

- Do--make changes designed to correct or improve the situation. Use the following questions for the guidance.
  - What were the results of the test?
  - Was the cycle carried out as designed or planned?
  - What did you observe that was unplanned or expected?

- Study -- Study the effect of the changes on the situation. Data should be collected on the new process and compared to the baseline or expected results. Results should be evaluated and by using the following questions as guidance.
  - Did the results match your prediction?
  - What did you learn?
  - What do you need to do next?

- Act--If the result is successful or desirable, standardize the changes and then work on the next prioritized problem or the further improvements. If the outcome is not yet successful, look for different ways to identify the causes or change the testing process.

PDSA worksheet will be used to map the potential change strategies and to establish a course of action. The PDSA worksheet and the PDSA progress report are attached in Appendix D-1.

Data Collection and Reporting

Data should drive any quality and patient safety effort. Nevada Surgical Suites is using (data system names) for tracking the sentinel events, healthcare infection data, and (any other database) for internal data collection.

External data sources are those data sources which are collected outside the supervisory structure of the case. External data which will be utilized for Quality and Patient Safety plan include the data from:

- AHRQ: Agency for Healthcare Research & Quality
- CDC: Centers for Disease Control and Prevention
- CMS: Centers for Medicare & Medicaid Services
- NQF: National Quality Forum
- NHSN: National Healthcare Safety Network

- TJC: The Joint Commission

Ongoing Reporting and Review

Data points such as the following will be reviewed according to the schedule prescribed:

Monthly	Quarterly	Annually
1) Sentinel event monthly report 2) Severity of infection report 3) RCA assessment	1) Sentinel event quarterly report 2) Severity of infection report 3) Review and evaluate the measure of improvement of patient safety 4) Review and evaluate the measurement to prevent and control infections	1) Quality and Patient Safety Plan update 2) Checklists and Policies reviewing and revising

Assessment of the Quality and Patient Safety Plan

Quality and Patient Safety Plan is updated annually and submitted through the REDcap Sentinel Event Registry after approval by the organization governing board.

Patient Safety Checklists and Patient Safety Policies

By NRS 439.865, the patient safety plan must include the patient safety checklists and patient safety policies for use by:

- Providers of healthcare who provide treatment to patients at the facility;
- Other personnel of the facility who provide treatment or assistance to patients;
- Employees of the facility who do not provide treatment to patients but whose duties affect the health or welfare of the patients at the facility, including, without limitation, a janitor of the medical facility; and
- Persons with whom the facility enters into a contract to provide treatment to patients or to provide services which may affect the health or welfare of patients.

The patient safety checklists must follow protocols to improve the health outcomes of patients at the medical facility and must include, without limitation:

- Checklists related to specific types of treatment. Such checklists must include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of healthcare.
- Checklists for ensuring that employees of the medical facility and contractors with the medical facility who are not providers of healthcare follow protocols to ensure that the room and environment of the patient is sanitary.
- A checklist to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received:
    - Proper instructions concerning prescription medications;
    - Instructions concerning aftercare;
    - Any other instructions concerning his or her care upon discharge; and
    - Any other checklists which may be appropriate to ensure the safety of patients at the facility.

The patient safety policies must include, without limitation:

- A policy for appropriately identifying a patient before providing treatment. Such a policy must require the patient to be identified with at least two personal identifiers before each interaction with a provider of healthcare. The personal identifiers may include, the name and date of birth of the patient.
- A policy regarding the nationally recognized standard precautionary protocols to be observed by providers of healthcare at the medical facility including, without limitation, protocols relating to hand hygiene.

- A policy to ensure compliance with the patient safety checklists and patient safety policies adopted pursuant to this section, which may include, active surveillance. Active surveillance may include a system for reporting violations, peer-to-peer communication, video monitoring and audits of sanitation materials.

Based on NRS 439.865, the patient safety plan must also include an infection control program that carries out the infection control policy. The policy must consist of:

- The current guidelines appropriate for the facility's scope of service developed by a nationally recognized infection control organization as approved by the State Board of Health which may include, the Association for Professionals in Infection Control and Epidemiology (APIC), the Centers for Disease Control and Prevention (CDC), the World Health Organization (WHO) and the Society for Healthcare Epidemiology of America (SHEA); and
- Facility-specific infection control developed under the supervision of a certified Infection Preventionist.

The patient safety checklists are listed in Appendix E. (The following links provide some patient safety checklists for your reference— a checklist example is shown in **Appendix E**.)

http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf

http://www.who.int/patientsafety/implementation/checklists/en/

The patient safety policies are listed in Appendix F. (The following link provides you some patient safety policies for your reference—a policy example is shown in **Appendix F**.) https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1

Approval of Patient Safety Plan

According to NRS 439.865, a medical facility shall submit its patient safety plan to the governing board of the facility for approval. After a facility's patient safety plan is approved, the facility shall notify all providers of healthcare who provide treatment to patients of the existence and requirements of the plan.

The patient safety plan must be reviewed and **updated annually** in accordance with the requirements for approval set forth in this section.

According to NRS 439.843, on or before March 1 of each year, a copy of the most current patient safety plan established to NRS 439.865 must be submitted to the Division of Public and Behavioral Health.

Reference

- Root Cause Analysis Toolkit http://www.health.state.mn.us/patientsafety/toolkit/
- Quality and Service Improvement Tools http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/plan_do_study_act.html
- CQI 101 An Introduction to Continuous Quality Improvement: https://www.coursehero.com/file/13827355/CQI-Overviewppt/
- Quality Improvement http://www.hrsa.gov/quality/toolbox/methodology/qualityimprovement/
- Root Cause Analysis http://www.patientsafety.va.gov/professionals/onthejob/rca.asp
- Patient Safety Systems Chapter, Sentinel Event Policy and RCA2 https://www.jointcommission.org/sentinel_event.aspx
- Hospital Policies https://www.mercyhospital.org.nz/about-us/mercy-hospital/policies/ruleFile/1
- Checklists to Improve Patient Safety http://www.hpoe.org/Reports-HPOE/CkLists_PatientSafety.pdf
- Patient Safety Checklists http://www.who.int/patientsafety/implementation/checklists/en/
- Minutes of the Meeting of the Quality and Patient Safety Committee http://www.cookcountyhhs.org/wp-content/uploads/2013/12/09-23-14-QPS-scan-Minutes.pdf
- Title 40 – Public Health and Safety https://www.leg.state.nv.us/NRS/NRS-439.html

Appendix A: Terms and Definitions

Patient Safety: The Agency for Healthcare Research Quality (AHRQ) defines patient safety as "a discipline in the healthcare sector that applies safety science methods toward the goal of achieving a trustworthy system of healthcare delivery. Patient safety is also an attribute of healthcare systems; it minimizes the incidence and impact of, and maximizes recovery from, adverse events."
http://www.ahrq.gov/downloads/pub/advances2/vol1/advances-emanuel-berwick_110.pdf

Sentinel event (NRS 439.830)

1. Except as otherwise provided in subsection 2, "sentinel event" means an event included in Appendix A of "Serious Reportable Events in Healthcare--2011 Update: A Consensus Report," published by the National Quality Forum.
2. If the publication described in subsection 1 is revised, the term "sentinel events" means the most current version of the list of serious reportable events published by the National Quality Forum as it exists on the effective date of the revision which is deemed to be:

(a) January 1 of the year following the publication of the revision if the revision is published on or after January 1 but before July 1 of the year in which the revision is published; or

(b) July 1 of the year following the publication of the revision if the revision is published on or after July 1 of the year in which the revision is published but before January 1 of the year after the revision is published.

3. If the National Quality Forum ceases to exist, the most current version of the list shall be deemed to be the last version of the publication in existence before the National Quality Forum ceased to exist.

(Added to NRS by 2002 Special Session, 13; A 2005, 599; 2013, 217)

Institute for Healthcare Improvement (IHI) defines **medical harm** as "unintended physical injury resulting from or contributed to by medical care (including the absence of indicated medical treatment) that requires additional monitoring, treatment or hospitalization, or results in death."

Facility-Associated Infection: (NRS 439.802)

"Facility-acquired infection" means a localized or systemic condition which results from an adverse reaction to the presence of an infectious agent or its toxins and which was not detected as present or incubating at the time a patient was admitted to a medical facility, including, without limitation:

- Surgical site infections;
- Ventilator-associated pneumonia;
- Central line-related bloodstream infections;
- Urinary tract infections; and
- Other categories of infections as may be established by the State Board of Health by regulation pursuant to NRS 439.890.

(Added to NRS by 2005, 599; A 2009, 553)

Medical facility (NRS 439.805)

"Medical facility" means:

- A hospital, as that term is defined in NRS 449.012 and 449.0151;

- An obstetric center, as that term is defined in NRS 449.0151 and 449.0155;
- A surgical center for ambulatory patients, as that term is defined in NRS 449.0151 and 449.019; and
- An independent center for emergency medical care, as that term is defined in NRS 449.013 and 449.0151.

(Added to NRS by 2002 Special Session, 13)

Near miss: An event or a situation that did not produce patient harm, but only because of intervening factors, such as patient health or timely intervention. (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Mandatory reporting: Legal requirement for physicians and other professionals providing health services to report suspected incidents of abuse and neglect. As mandated reporters, they are generally afforded legal immunity for such reports and most jurisdictions impose a civil or criminal penalty for failure to report. (Council on Scientific Affairs. AMA Diagnostic and Treatment Guidelines Concerning Child Abuse and Neglect. JAMA. 1985;254(6):796-800.)

Risk: Possibility of loss or injury. (Merriam-Webster's Online Dictionary, Risk, Available at http://www.merriamwebster.com/dictionary/risk. Last Accessed August 2009.)

Preventable event: Describes an event that could have been anticipated and prepared for, but that occurs because of an error or other system failure (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2009 Update.)

Catheter Associated Urinary Tract Infection (CAUTI): A urinary tract infection (UTI) that occurs in a patient who had an associated indwelling urethral urinary catheter in place within the 7-day period before the onset of the UTI (Centers for Disease Control and Prevention, The National Healthcare Safety Network (NHSN) Manual: Patient Safety Component Protocol; 2009. Available at http://www.premierinc.com/safety/topics/guidelines/downloads/NHSN_Manual_PatientSafetyProtocol_CUR RENT_b.pdf.)

Central Line Associated Bloodstream Infections (CLABSI): Primary bloodstream infections that are associated with the presence of a central line or an umbilical catheter, in neonates, at the time of or before the onset of the infection.

Appendix B: Master Study List

Master Study List – Quality Improvement Initiatives

(Infection Control, Patient Safety, Process Improvement)

Calendar Year/ Study Name		Start Date	Completion Date	Re-Assessment Date	Comments
2015 Study					
1	AAAHC Low Back Injection	01/2015	06/2015	Move to 2016	Evaluating clinical performance measurement and improvement opportunities
2	Medication Reconciliation	01/2015	12/2015	Move to 2016	Room for improvement – Study in 2016
3	Handwashing	01/2015	12/2015	Move to 2016	Room for improvement – Study in 2016
2016 Study					
1	AAAHC Low Back Injection	07/2016	12/2016	Move to 2017	Evaluating clinical performance measurement and improvement opportunities
2	Medication Reconciliation	01/2016	12/2016	Move to 2017	Room for improvement – Study in 2017
3	Handwashing	01/2016	12/2016	Move to 2017	Performing well – will not study in 2017
2017 Study					
1	AAAHC Low Back Study	04/2017	12/2017	Move to 2018	Evaluating clinical performance measurement and improvement opportunities
2	Medication Reconciliation	01/2017	12/2017	Move to 2018	Room for improvement – Study in 2018
3	Q1 2017 ASCA Benchmarking	01/2017	03/2017	Move to Q2	Limited
4	Q2 2017 ASCA Benchmarking	04/2017	06/2017	Move to Q3	Limited
5	Q3 2017 ASCA Benchmarking	07/2017	09/2017	Move to Q4	Limited
6	Q4 2017 ASCA Benchmarking	10/2017	12/2017	Move to 2018	Hold for future reconsideration
2018 Study					
1	Hand Hygiene	01/2018	12/2018	Move to 2019	Room for improvement – Study in 2019
2	AAAHC Low Back Study	01/2018	06/2018	Move to 2019	Evaluating clinical performance measurement and improvement opportunities

3	Medication Reconciliation	01/2018	12/2018	Move to 2019	Room for improvement – Study in 2019
2019 Study					
1	AAAHC Medication Reconciliation Study	06/2019	12/2019	Q3, Q4	Augmenting internal medication reconciliation with external study for greater clinical performance & improvement opportunities
2	Medication Reconciliation	01/2019	12/2019	Move to 2020	Continued improvement need from 2018
3	Hand Hygiene	01/2019	12/2019	Move to 2020	Continued improvement need from 2018
2020 Study					
1	Medication Reconciliation	01/2020	12/2020	Move to 2021	Continued improvement need from 2019
2	Hand Hygiene	01/2020	12/2020	Move to 2021	Continued improvement need from 2019
3	AAAHC Allergy Documentation	07/2020	12/2020	Planned Q3, Q4	External study - Placed on hold to focus on COVID per Governing Board
2021 Study					
1	Medication Reconciliation	01/2021	12/2021	Move to 2022	Continued improvement need from 2020
2	Hand Hygiene	01/2021	12/2021	Move to 2022	Continued improvement need from 2020
3	AAAHC Emergency Preparedness	01/2021	12/2021	Planned Q3, Q4	External study – Placed on hold to focus on COVID per Governing Board
2022 Study					
1	Allergy/Medication Reconciliation	01/2022	12/2022	Move to 2023	Continued improvement need from 2021
2	Hand Hygiene	01/2022	12/2022	Move to 2023	Continued improvement need from 2021
3	Surgical Case Cancellation Rates – ASCA External Clinical Benchmarking	01/2022	12/2022	Move to 2023	External Study - Continued improvement need for 2023
2023 Study					
1	Allergy/Medication Reconciliation	01/2023	12/2023	Planned Q1, Q2, Q3, Q4	Continued improvement need from 2022
2	Hand Hygiene	01/2023	12/2023	Planned Q1, Q2, Q3, Q4	Continued improvement need from 2022
3	Surgical Case Cancellation Rates – ASCA External Clinical	01/2023	12/2023	Planned Q3	External study – Continued improvement need from 2022

	Benchmarking				
2024 Study					
1					
2					
3					

Appendix C-1: Safety Check List/ Time-Out

NEVADA SURGICAL SUITES

Safety Checklist

Patient:

Area	Done By	Patient or caregiver response
Sedation	☐No Sedation	☐1. Pt/allergies/procedure confirmed. ☐2. Pt. Verbalizes understanding of anesthesia options. ☐3. Pt. Verbalizes understanding of anesthesia and possible post op pain
Operating Room		☐1. Pt/allergies/Procedure confirmed. ☐2. Pt. verbalizes adequate understanding of procedure.

☐	Pt. to RN with RN Assistance ☐Ambulates ☐Stretcher ☐WC
☐	Pt. is positioned upon the O.R. Table and safety strap(s) in use and necessary pillows/cushioning are in place. ☐Prone ☐Supine ☐R Lateral ☐L Lateral
☐	PREP site with: ☐Chloraprep ☐Alcohol-prep with No Reaction noted
☐	"TIMEOUT" Conducted to confirm proper patient, procedure, allergies and site
☐	Procedure **Start time**:
☐	Medications injected: ☐Dexamethasone ☐Lidocaine ☐Marcaine (0.5) (0.25) ☐Omnipaque ☐Magnevist
☐	Radio Frequency ground pad site: ☐R / L Posterolateral thigh ☐R / L posterior thoracic ☐R / L Posterolateral buttocks
☐	Radio Frequency Probe(s) Serial Number:
☐	SCS Trial/Implant Lot Number:
☐	SCS Trial/Implant Serial Number:
☐	Pt Tolerated procedure without complications
☐	Pt Transported via: ☐stretcher (side rails up) ☐WC
☐	Procedure **End time**:
☐	Pt. transferred to PACU without incident. **Time**:

07/20/17 NSS

Appendix C-2: Surgical Handoff

NEVADA SURGICAL SUITES

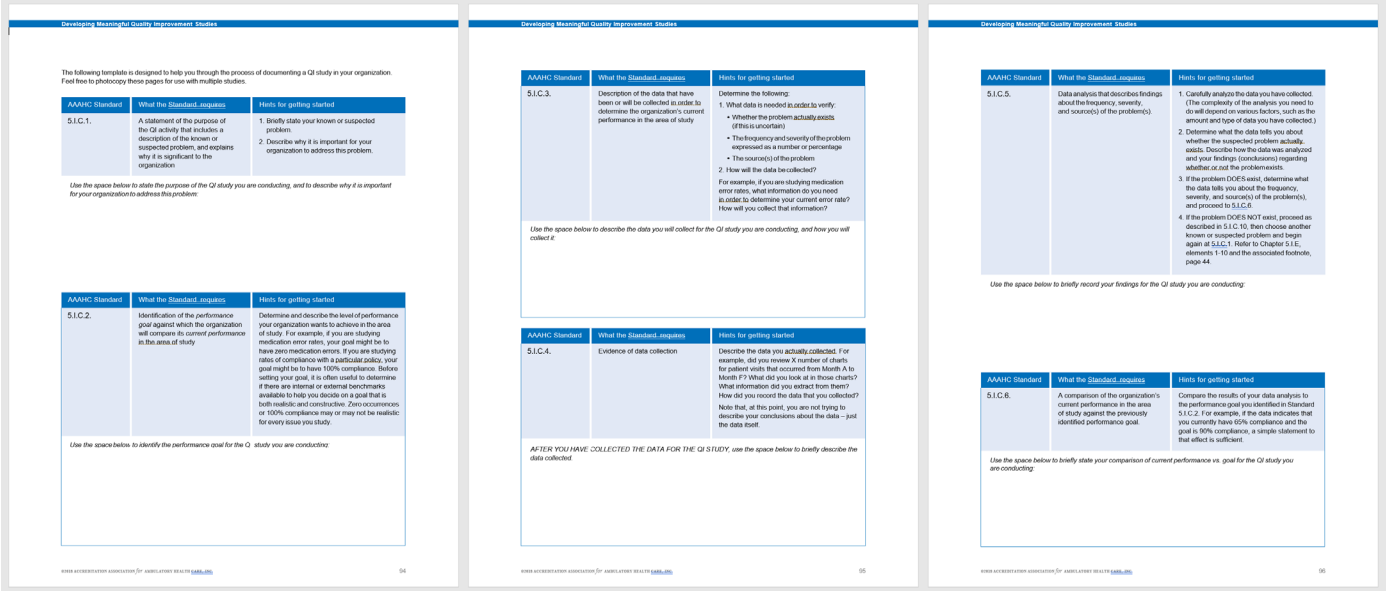
PREPROCEDURE CHECK-IN	SIGN-IN	TIME-OUT	SIGN-OUT
Patient Received by Pre-op RN_____	Patient Received by Intra-op RN _____ Time _____	Time-out _____	Patient received by Post-op RN_____
In Holding Area	**Before Induction of Anesthesia**	**Before Skin Incision**	**Before the Patient Leaves the Operating Room**
Patient/patient representative actively confirms with Registered Nurse (RN):	**RN and anesthesia care provider confirm:**	**Initiated by designated team member** All other activities to be suspended (unless a life-threatening emergency)	**RN confirms:**
Identity □ Yes Procedure and procedure site □ Yes Consent(s) □ Yes Site marked □ Yes □ N/A by person performing the procedure **RN confirms presence of:** History and physical □ Yes Preanesthesia assessment □ Yes Any special equipment, devices, implants □ Yes □ N/A	Confirmation of: identity, procedure, procedure site and consent(s) □ Yes Site marked □ Yes □ N/A by person performing the procedure Patient allergies □ Yes □ N/A Difficult airway or aspiration risk? □ No □ Yes (preparation confirmed) Anesthesia safety check completed □ Yes **Briefing:** All members of the team have discussed care plan and addressed concerns □ Yes	**All:** Confirmation of the following: identity, procedure, incision site, consent(s) □ Yes Site is marked and visible □ Yes □ N/A Relevant images properly labeled and displayed □ Yes □ N/A Any equipment concerns? **Anesthesia Provider:** □ Antibiotic prophylaxis before incision □ Yes □ N/A □ Additional concerns? **Scrub and circulating nurse:** □ Sterilization indicators have been confirmed □ Additional concerns?	Name of operative procedure Any equipment problems to be addressed? □ Yes □ N/A

Surgical Handoff

12/06/2016 NSS

Appendix C-3: 1—Element QI Study Template

Nevada Surgical Suites utilizes AAAHC 10-Element Quality Improvement Study template for initiatives.



Developing Meaningful Quality Improvement Studies

The following template is designed to help you through the process of documenting a QI study in your organization. Feel free to photocopy these pages for use with multiple studies.

AAAHC Standard	What the Standard requires	Hints for getting started
5.I.C.1.	A statement of the purpose of the QI activity that includes a description of the known or suspected problem, and explains why it is significant to the organization	1. Briefly state your known or suspected problem. 2. Describe why it is important for your organization to address this problem.

Use the space below to state the purpose of the QI study you are conducting, and to describe why it is important for your organization to address this problem:

AAAHC Standard	What the Standard requires	Hints for getting started
5.I.C.2.	Identification of the *performance goal* against which the organization will compare its *current performance* in the area of study	Determine and describe the level of performance your organization wants to achieve in the area of study. For example, if you are studying medication error rates, your goal might be to have zero medication errors. If you are studying rates of compliance with a particular policy, your goal might be to have 100% compliance. Before setting your goal, it is often useful to determine if there are internal or external benchmarks available to help you decide on a goal that is both realistic and constructive. Zero occurrences or 100% compliance may or may not be realistic for every issue you study.

Use the space below to identify the performance goal for the QI study you are conducting:

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Developing Meaningful Quality Improvement Studies

AAAHC Standard	What the Standard requires	Hints for getting started
5.I.C.3.	Description of the data that have been or will be collected in order to determine the organization's current performance in the area of study	Determine the following: 1. What data is needed in order to verify: • Whether the problem actually exists (if this is uncertain) • The frequency and severity of the problem expressed as a number or percentage • The source(s) of the problem 2. How will the data be collected? For example, if you are studying medication error rates, what information do you need in order to determine your current error rate? How will you collect that information?

Use the space below to describe the data you will collect for the QI study you are conducting, and how you will collect it:

AAAHC Standard	What the Standard requires	Hints for getting started
5.I.C.4.	Evidence of data collection	Describe the data you actually collected. For example, did you review X number of charts for patient visits that occurred from Month A to Month F? What did you look at in those charts? What information did you extract from them? How did you record the data that you collected? Note that, at this point, you are not trying to describe your conclusions about the data – just the data itself.

AFTER YOU HAVE COLLECTED THE DATA FOR THE QI STUDY, use the space below to briefly describe the data collected:

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Developing Meaningful Quality Improvement Studies

AAAHC Standard	What the Standard requires	Hints for getting started
5.I.C.5.	Data analysis that describes findings about the frequency, severity, and source(s) of the problem(s).	1. Carefully analyze the data you have collected. (The complexity of the analysis you need to do will depend on various factors, such as the amount and type of data you have collected.) 2. Determine what the data tells you about whether the suspected problem actually exists. Describe how the data was analyzed and your findings (conclusions) regarding whether or not the problem exists. 3. If the problem DOES exist, determine what the data tells you about the frequency, severity, and source(s) of the problem(s), and proceed to 5.I.C.6. 4. If the problem DOES NOT exist, proceed as described in 5.I.C.10, then choose another known or suspected problem and begin again at 5.I.C.1. Refer to Chapter 5.I.E, elements 1-10 and the associated footnote, page 44.

Use the space below to briefly record your findings for the QI study you are conducting:

AAAHC Standard	What the Standard requires	Hints for getting started
5.I.C.6.	A comparison of the organization's current performance in the area of study against the previously identified performance goal.	Compare the results of your data analysis to the performance goal you identified in Standard 5.I.C.2. For example, if the data indicates that you currently have 65% compliance and the goal is 90% compliance, a simple statement to that effect is sufficient.

Use the space below to briefly state your comparison of current performance vs. goal for the QI study you are conducting:

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Appendix D: Policies

Chapter 5: Quality and Risk mangement

Chapter 7 Sub-Chapter 1 & 2: Infection Control and Safety

Chapter 8: Emergency Preparedness