

NATIONAL QUALITY FORUM

Measure Submission and Evaluation Worksheet 5.0

This form contains the information submitted by measure developers/stewards, organized according to NQF's measure evaluation criteria and process. The evaluation criteria, evaluation guidance documents, and a blank online submission form are available on the [submitting standards web page](#).

NQF #: 0267 NQF Project: Patient Safety Measures-Complications Project
(for Endorsement Maintenance Review) Original Endorsement Date: Nov 15, 2007 Most Recent Endorsement Date: Nov 15, 2007
BRIEF MEASURE INFORMATION
De.1 Measure Title: Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant
Co.1.1 Measure Steward: Ambulatory Surgical Center Quality Collaboration
De.2 Brief Description of Measure: Percentage of ASC admissions experiencing a wrong site, wrong side, wrong patient, wrong procedure, or wrong implant event.
2a1.1 Numerator Statement: ASC admissions experiencing a wrong site, wrong side, wrong patient, wrong procedure, or wrong implant
2a1.4 Denominator Statement: All ASC admissions
2a1.8 Denominator Exclusions: None
1.1 Measure Type: Outcome 2a1. 25-26 Data Source: Paper Records 2a1.33 Level of Analysis: Facility
1.2-1.4 Is this measure paired with another measure? No
De.3 If included in a composite, please identify the composite measure (title and NQF number if endorsed): Not applicable

STAFF NOTES (issues or questions regarding any criteria)
Comments on Conditions for Consideration:
Is the measure untested? Yes <input type="checkbox"/> No <input type="checkbox"/> If untested, explain how it meets criteria for consideration for time-limited endorsement:
1a. Specific national health goal/priority identified by DHHS or NPP addressed by the measure (check De.5): 5. Similar/related endorsed or submitted measures (check 5.1): Other Criteria:
Staff Reviewer Name(s):

1. IMPACT, OPPORTUNITY, EVIDENCE - IMPORTANCE TO MEASURE AND REPORT
Importance to Measure and Report is a threshold criterion that must be met in order to recommend a measure for endorsement. All three subcriteria must be met to pass this criterion. See guidance on evidence . Measures must be judged to be important to measure and report in order to be evaluated against the remaining criteria. (evaluation criteria)
1a. High Impact: H <input type="checkbox"/> M <input type="checkbox"/> L <input type="checkbox"/> I <input type="checkbox"/>

NQF #0267 Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant

(The measure directly addresses a specific national health goal/priority identified by DHHS or NPP, or some other high impact aspect of healthcare.)

De.4 Subject/Topic Areas (Check all the areas that apply): [Surgery](#)

De.5 Cross Cutting Areas (Check all the areas that apply): [Safety](#), [Safety : Complications](#)

1a.1 Demonstrated High Impact Aspect of Healthcare: [Frequently performed procedure, Patient/societal consequences of poor quality](#)

1a.2 If "Other," please describe:

1a.3 Summary of Evidence of High Impact (Provide epidemiologic or resource use data):

[As a result of advances in surgery and anesthesia, approximately 80 percent of surgeries in the United States are now performed on an outpatient basis. Ambulatory surgical centers perform approximately 40%, or more than 22 million, of those outpatient surgeries. 1 The risk of a wrong site/site/patient/procedure/implant event must be managed for each of these surgeries.](#)

[There is strong consensus that these events can and must be prevented. The importance of taking steps designed to eliminate these events is consistently highlighted in efforts to ensure surgical patient safety. 2-10](#)

1a.4 Citations for Evidence of High Impact cited in 1a.3: [1 U.S. Department of Health and Human Services. Centers for Medicare & Medicaid Services. <http://www.cms.gov/>.](#)

[2 American Academy of Ophthalmology. Recommendations of American Academy of Ophthalmology Wrong-Site Task Force. \[http://one.aaof.org/ce/practiceguidelines/patient_content.aspx?cid=d0db838c-2847-4535-baca-aebab3011217\]\(http://one.aaof.org/ce/practiceguidelines/patient_content.aspx?cid=d0db838c-2847-4535-baca-aebab3011217\). Accessed August 9, 2011.](#)

[3 American Academy of Orthopaedic Surgeons. Wrong-Site Surgery. Information Statement 1015. <http://www.aaos.org/about/papers/advistmt/1015.asp>. Accessed August 9, 2011.](#)

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

[5 American College of Surgeons. \[ST-41\] Statement on ensuring correct patient, correct site, and correct procedure surgery. \[http://www.facs.org/fellows_info/statements/st-41.html\]\(http://www.facs.org/fellows_info/statements/st-41.html\). Accessed August 9, 2011.](#)

[6 AORN. AORN Position Statement on Preventing Wrong-Patient, Wrong-Site, Wrong-Procedure Events. <http://www.aorn.org/PracticeResources/AORNPositionStatements/PositionCorrectSiteSurgery/>. Accessed August 9, 2011.](#)

[7 Institute of Medicine. *To Err is Human: Building a Safer Health System*. Washington, DC: National Academy Press, 2000.](#)

[8 Joint Commission. 2011 National Patient Safety Goals. \[http://www.jointcommission.org/standards_information/npsgs.aspx\]\(http://www.jointcommission.org/standards_information/npsgs.aspx\). Accessed August 9, 2011.](#)

[9 National Quality Forum. *Serious Reportable Events in Healthcare – 2006 Update: A Consensus Report*. March 2007.](#)

[10 World Health Organization. *WHO Guidelines for Safe Surgery 2009*. \[http://whqlibdoc.who.int/publications/2009/9789241598552_eng.pdf\]\(http://whqlibdoc.who.int/publications/2009/9789241598552_eng.pdf\). Accessed August 9, 2011.](#)

[\(Please note this is not intended to be an exhaustive list of the organizations issuing statements or guidance related to wrong-site events.\)](#)

1b. Opportunity for Improvement: H M L I

(There is a demonstrated performance gap - variability or overall less than optimal performance)

1b.1 Briefly explain the benefits (improvements in quality) envisioned by use of this measure:

[This measure supports the quality improvement vision articulated by the NQF in its "Serious Reportable Events in Healthcare -](#)

2006 Update: A Consensus Report" by giving ASCs a means to consistently measure and publicly report wrong site, wrong side, wrong procedure, wrong patient and wrong implant events. As noted in the report, these occurrences are among those included in the list of serious reportable events, "a list of unambiguous, serious, preventable adverse events that concern both the public and healthcare providers and could form the basis for a national reporting system that would lead to substantial improvements in patient safety. The events on the list are identifiable and measurable, and the risk of occurrence of these events is significantly influenced by the policies and procedures of healthcare organizations. ...[p]ublic reporting of these events raises the awareness of all healthcare organizations regarding the potential for such occurrences and should stimulate the critical review of systems for their prevention."

1b.2 Summary of Data Demonstrating Performance Gap (*Variation or overall less than optimal performance across providers*): **[For Maintenance** – *Descriptive statistics for performance results for this measure - distribution of scores for measured entities by quartile/decile, mean, median, SD, min, max, etc.]*

Although data for 1,184 ASCs are included in our public reporting of this indicator, many ASCs report their data to their corporate managing partner. This data is aggregated and reported in total rather than being reported individually by an ASC. As a result, although the ASC QC database includes data 1,184 facilities for this measure, center-level rates are only available for 541 ASCs. The statistics reported below are based on the 541 individually-reporting ambulatory surgery centers, which are located throughout the US.

The rates for this measure were collected for 541 ambulatory surgery centers throughout the US for services provided during January to March 2011.

The rate for surgeries involving the wrong site, side, patient, procedure or implant ranged from a minimum of 0.00% to a maximum of 0.31%. The mean rate was 0.00% (SD: 0.02%), while the median rate was 0.00%. The maximum rate for surgeries involving the wrong site, side, patient, procedure or implant of 0.31% demonstrates that there is an opportunity for improvement in this measure.

This study sample was a convenience sample, which is drawn from ASCs that actively participate in the public quality reporting project sponsored by the ASC Quality Collaboration. Participation in the ASC QC's reporting project is voluntary. Given this, the sample is likely biased toward those ASCs that have taken an interest in the quality measurement and reporting activities of the ASC QC. In addition, those ASCs that volunteer may choose to collect and submit data on a measure-by-measure basis. For this reason, it is possible that the sample may also be biased towards those with higher levels of performance for this measure.

1b.3 Citations for Data on Performance Gap: **[For Maintenance** – *Description of the data or sample for measure results reported in 1b.2 including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included]*

A convenience sample of 541 ambulatory surgery centers reporting individual data was selected to assess the opportunity for improvement for this measure. The centers were located throughout the US. Services from the first calendar quarter of 2011 were included in this portion of the study.

1b.4 Summary of Data on Disparities by Population Group: **[For Maintenance** – *Descriptive statistics for performance results for this measure by population group]*

The data the ASC Quality Collaboration currently receives for this measure is collected at the ASC-level or at the level of the corporate parent of the ASC. Corporate parent data submissions combine data from multiple ASCs. Disparity measures by population group require the collection of patient-level data or collection of the data for individual populations of patients. At this time, the ASC Quality Collaboration does not have access to any patient-level or individual population level data that would allow for analysis of subpopulation disparities based on race, sex and age. However, we understand the importance of subpopulation data and are taking steps that would allow us to collect the necessary data. We are actively pursuing the development of a registry that would allow us to develop subpopulation performance data for this measure and others. Potential registry development vendors have been identified and initial communications regarding the project have already taken place. We plan to select a vendor by fourth quarter of 2011, initiate the development of the registry database immediately upon contract acceptance, and have a functioning registry three months thereafter.

1b.5 Citations for Data on Disparities Cited in 1b.4: **[For Maintenance** – *Description of the data or sample for measure results reported in 1b.4 including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included]*

Not available. Please see 1b.4. above and recopied here: The data the ASC Quality Collaboration currently receives for this

measure is collected at the ASC-level or at the level of the corporate parent of the ASC. Corporate parent data submissions combine data from multiple ASCs. Disparity measures by population group require the collection of patient-level data or collection of the data for individual populations of patients. At this time, the ASC Quality Collaboration does not have access to any patient-level or individual population level data that would allow for analysis of subpopulation disparities based on race, sex and age. However, we understand the importance of subpopulation data and are taking steps that would allow us to collect the necessary data. We are actively pursuing the development of a registry that would allow us to develop subpopulation performance data for this measure and others. Potential registry development vendors have been identified and initial communications regarding the project have already taken place. We plan to select a vendor by fourth quarter of 2011, initiate the development of the registry database immediately upon contract acceptance, and have a functioning registry three months thereafter.

1c. Evidence (*Measure focus is a health outcome OR meets the criteria for quantity, quality, consistency of the body of evidence.*)
Is the measure focus a health outcome? Yes No **If not a health outcome, rate the body of evidence.**

Quantity: H M L I **Quality:** H M L I **Consistency:** H M L I

Quantity	Quality	Consistency	Does the measure pass subcriterion1c?
M-H	M-H	M-H	Yes <input type="checkbox"/>
L	M-H	M	Yes <input type="checkbox"/> IF additional research unlikely to change conclusion that benefits to patients outweigh harms: otherwise No <input type="checkbox"/>
M-H	L	M-H	Yes <input type="checkbox"/> IF potential benefits to patients clearly outweigh potential harms: otherwise No <input type="checkbox"/>
L-M-H	L-M-H	L	No <input type="checkbox"/>

Health outcome – rationale supports relationship to at least one healthcare structure, process, intervention, or service

Does the measure pass subcriterion1c?
 Yes IF rationale supports relationship

1c.1 Structure-Process-Outcome Relationship (*Briefly state the measure focus, e.g., health outcome, intermediate clinical outcome, process, structure; then identify the appropriate links, e.g., structure-process-health outcome; process- health outcome; intermediate clinical outcome-health outcome*):

This measure focuses on an intermediate clinical outcome. Verifying correct site/side/procedure/patient/implant for each procedural and surgical service helps ensure the correct site/side/patient/procedure/implant is identified for each patient.

1c.2-3 Type of Evidence (*Check all that apply*):

Clinical Practice Guideline, Other, Selected individual studies (rather than entire body of evidence), Systematic review of body of evidence (other than within guideline development)

Expert opinion as reflected in publications such as position statements and consensus reports; State adverse event database reports

1c.4 Directness of Evidence to the Specified Measure (*State the central topic, population, and outcomes addressed in the body of evidence and identify any differences from the measure focus and measure target population*):

The body of evidence addresses the frequency and harm associated with wrong site events, as well as the processes and effectiveness of those processes to assure correct site surgery in the surgical patient population.

This measure focuses on the frequency with which wrong site, side, patient, procedure and implant events occur in ASCs.

1c.5 Quantity of Studies in the Body of Evidence (*Total number of studies, not articles*): Based on a literature search for English language articles published between 1990 and the present, using "wrong site" as the search term, 23 studies were identified.

1c.6 Quality of Body of Evidence (*Summarize the certainty or confidence in the estimates of benefits and harms to patients across studies in the body of evidence resulting from study factors. Please address: a) study design/flaws; b) directness/indirectness of the evidence to this measure (e.g., interventions, comparisons, outcomes assessed, population included in the evidence); and c) imprecision/wide confidence intervals due to few patients or events*): There is certainty that wrong site, wrong side, wrong patient, wrong procedure and wrong implant events are harmful to patients. There is agreement that even when the event does not result in significant bodily harm, there is a loss of confidence that is harmful.

The evidence speaks directly to this measure in terms of outcomes assessed and interventions. The body of evidence looks at a broader surgical patient population than is seen in ambulatory surgical centers, although one study (Clarke, 2007) included ambulatory surgical centers.

Estimates of the frequency of these events vary in the body of evidence. These variations reflect the uncommon occurrence of these events.

1c.7 Consistency of Results across Studies (*Summarize the consistency of the magnitude and direction of the effect*): The studies that evaluate wrong site surgery rates consistently affirm the low incidence of these events. No study suggests that efforts to reduce these events have no value, though there is inconsistency in these estimates of the degree to which interventions (such as employing the Universal Protocol or a preoperative checklist that includes the surgical site, and any implants to be placed) influence the rate of wrong site surgery.

1c.8 Net Benefit (*Provide estimates of effect for benefit/outcome; identify harms addressed and estimates of effect; and net benefit - benefit over harms*):

The evidence suggests a net benefit of implementing processes designed to prevent wrong site events, though no intervention has been found to be universally successful. The evidence does not suggest any harm from processes to reduce wrong site events.

1c.9 Grading of Strength/Quality of the Body of Evidence. Has the body of evidence been graded? **Yes**

1c.10 If body of evidence graded, identify the entity that graded the evidence including balance of representation and any disclosures regarding bias: A systematic review entitled "Avoiding Wrong Site Surgery" was published in *Spine* in April 2010 by John DeVine, MD,* Norman Chutkan, MD,† Daniel C. Norvell, PhD,‡ and Joseph R. Dettori, PhD‡(from the *Orthopedic Service, Department of Surgery, Eisenhower Army Medical Center, Ft. Gordon, GA; †Department of Orthopaedic Surgery, Medical College of Georgia, Augusta, GA; and ‡Spectrum Research Inc., Tacoma, WA). The review was supported by AOSpine North America. Analytic support for the review was provided by Spectrum Research, Inc. with funding from AOSpine North America. The authors state "no benefits in any form have been or will be received from a commercial party related directly or indirectly to the subject of this manuscript."

The authors' primary focus was to identify the spine studies, but other surgical reports were included if the authors determined they contributed to answering the review objectives due to the limited literature on this topic.

The objectives of the review were to answer the following questions:

1. What is the incidence or frequency of wrong site surgery?
2. What are the causes of wrong site surgery?
3. What preoperative measures are effective in preventing wrong site surgery?

A systematic search was conducted in MEDLINE, EMBASE, the Cochrane Collaboration Library, and the Food and Drug Administration and JC websites for literature published from 1990 through December 2008. Results were limited to humans and to articles published in the English language. Reference lists of key articles were also systematically checked. The authors identified 65 articles or reports from the literature search reporting on wrong site surgery. From these potential articles or reports, 19 were selected to undergo full text review. After full text review, eight additional exclusions were made, leaving 11 studies for inclusion. Of these, five were used to assess the frequency of wrong site surgery.

The authors stated, "[t]his systematic review has limitations based primarily on the lack of quality and quantity research in this area. It is probably not feasible to perform a prospective, randomized trial to generate level I evidence that these procedures, among others as outlined by JC and NASS, are effective in decreasing the incidence of these adverse events. As Gibbs has pointed out that continued adherence to the Universal Protocol guidelines over a longer period of time is probably required before a decrease in incidence can be measured."

This review assessed studies through December 2008. Since that time, additional studies have been reported in the literature that would likely influence the grading of the body of evidence.

1c.11 System Used for Grading the Body of Evidence: **GRADE**

1c.12 If other, identify and describe the grading scale with definitions:

1c.13 Grade Assigned to the Body of Evidence: The authors concluded, "[t]he overall strength of the evidence to establish an incidence or rate of wrong site surgery is 'very low', that is, any estimate of effect is very uncertain. The overall strength of the evidence to establish the causes of wrong site surgery is 'low', that is, further research is very likely to have an important impact on our confidence in the estimate of effect and is likely to change the estimate. The overall strength of the evidence to establish the efficacy of preoperative measures including checklists for preventing wrong site surgery is 'very low'."

1c.14 Summary of Controversy/Contradictory Evidence: No controversy or contradictory evidence reported.

1c.15 Citations for Evidence other than Guidelines(Guidelines addressed below):

Blanco M, Clarke JR, Martindell D. Wrong site surgery near misses and actual occurrences. AORN J. 2009 Aug;90(2):215-8, 221-2.

Canale ST. Wrong-site surgery: a preventable complication. Clin Orthop Reat Res. 2005;433:26- 29.

Carayon P, Schultz K, Hundt AS. Righting wrong site surgery. Jt Comm J Qual Saf. 2004;30(7):405-410.

Clarke JR, Johnston J, Finley ED. Getting surgery right. Ann Surg. 2007; 246(3):395-403.

Cohen SP, Hayek SM, Datta S, Bajwa ZH, Larkin TM, Griffith S, Hobelmann G, Christo PJ, White R. Incidence and Root Cause Analysis of Wrong-site Pain Management Procedures: A Multicenter Study Anesthesiology. 2010 Mar;112(3):711-8.

Devine J, Chutkan N, Norvell DC, Dettori JR. Avoiding wrong site surgery: a systematic review. Spine. 2010 Apr 20;35(9 Suppl):S28-36

Elghrably I, Fraser SG. An observational study of laterality errors in a sample of clinical records. Eye. 2008;22(3):340-343.

Garnerin P, Ares M, Huchet A, Clergue F. Verifying patient identity and site of surgery: improving compliance with protocol by audit and feedback. Qual Saf Health Care. 2008;17(6):454-458.

Haynes AB, Weiser TG, Berry WR, et al. A surgical safety checklist to reduce morbidity and mortality in a global population. N Engl J Med. 2009:491-499.

Jhavar BS, Mitsis D, Duggal N. Wrong-sided and wrong-level neurosurgery: a national survey. J Neurosurg Spine. 2007;7(5):467-472.

Joint Commission. Joint Commission Sentinel Event Statistics. <http://www.jointcommission.org/sentinelevents/statistics>. Accessed August 9, 2011.

Kwaan MR, Studdert DM, Zinner MJ, Gawande AA. Incidence, patterns, and prevention of wrong-site surgery. Arch Surg. 2006;141(4):353-357.

Makary MA, Mukherjee A, Sexton JB, et al. Operating room briefings and wrong-site surgery. J Am Coll Surg. 2007;204(2):236-243.

Meinberg EG, Stern PJ. Incidence of wrong-site surgery among hand surgeons. J Bone Joint Surg Am. 2003 Feb;85-A(2):193-7.

Michaels RK, Makary MA, Dahab Y, et al. Achieving the National Quality Forum's "Never Events": prevention of wrong site, wrong procedure, and wrong patient operations. Ann Surg. 2007;245(4):526-532.

Mody MG, Nourbakhsh A, Stahl DL, Gibbs M, Alfawareh M, Garges KJ. The prevalence of wrong level surgery among spine surgeons. Spine.2008;33(2):194-198.

Mulloy DF, Hughes RG. Wrong-site surgery: A preventable medical error. In: Patient Safety and Quality: An Evidence-Based

Handbook for Nurses. Vol 2. Rockville, MD: Agency for Healthcare Research and Quality; 2008:381-395.

Neily J, Mills PD, Eldridge N, Carney BT, Pfeffer D, Turner JR, Young-Xu Y, Gunnar W, Bagian JP. Incorrect Surgical Procedures Within and Outside of the Operating Room: A Follow-up Report. Arch Surg. 2011 Jul 18. [Epub ahead of print]

Neily J, Mills PD, Eldridge N, et al. Incorrect surgical procedures within and outside of the operating room. Arch Surg. 2009;144(11):1028-1034.

Nixon HC, Wheeler P. Wrong-site lower extremity peripheral nerve block: process changes to improve patient safety. Int Anesthesiol Clin. 2011 Spring;49(2):116-24.

Schweitzer KM Jr, Brimmo O, May R, Parekh SG. Incidence of wrong-site surgery among foot and ankle surgeons. Foot Ankle Spec. 2011 Feb;4(1):10-3

Seiden SC, Barach P. Wrong-side/wrong-site, wrong-procedure, and wrong-patient adverse events: are they preventable? Arch Surg. 2006;141(9):931-939.

Shah RK, Arjmand E, Roberson DW, Deutsch E, Derkay C. Variation in surgical time-out and site marking within pediatric otolaryngology. Arch Otolaryngol Head Neck Surg. 2011 Jan;137(1):69-73.

Shah RK, Nussenbaum B, Kienstra M, Glenn M, Brereton J, Patel MM, Nielsen D, Roberson DW. Wrong-site sinus surgery in otolaryngology. Otolaryngol Head Neck Surg. 2010 Jul;143(1):37-41.

Stahel PF, Sabel AL, Victoroff MS, Varnell J, Lembitz A, Boyle DJ, Clarke TJ, Smith WR, Mehler PS. Wrong-site and wrong-patient procedures in the universal protocol era: analysis of a prospective database of physician self-reported occurrences. Arch Surg. 2010 Oct;145(10):978-84.

Stanton MA, Tong-Ngork S, Liguori GA, Edmonds CR. A new approach to preanesthetic site verification after 2 cases of wrong site peripheral nerve blocks. Reg Anesth Pain Med. 2008;33(2):174-177.

Waterman AD, Gallagher TH, Garbutt J, Waterman BM, Fraser V, Burroughs TE. Brief report: Hospitalized patients' attitudes about and participation in error prevention. J Gen Intern Med. 2006;21(4):367-370.

Wong DA, Herndon JH, Canale ST, Brooks RL, Hunt TR, Epps HR, Fountain SS, Albanese SA, Johanson NA. Medical errors in orthopaedics. Results of an AAOS member survey. J Bone Joint Surg Am. 2009 Mar 1;91(3):547-57.

Zohar E, Noga Y, Davidson E, Kantor M, Fredman B. Perioperative patient safety: Correct patient, correct surgery, correct side--a multifaceted, cross-organizational, interventional study. Anesth Analg. 2007;105(2):443-447.

State of Florida; Agency for Health Care Administration, Division of Health Quality Assurance. 2010 Risk Management Statistical Reports: Hospital and Ambulatory Surgical Centers. <http://ahca.myflorida.com/SCHS/risk/statistics2010.shtml>. Accessed August 9, 2011.

State of Indiana: Indiana State Department of Health Indiana. Indiana Medical Error Reporting System: Final Report for 2009. http://www.in.gov/isdh/files/2009_MERS_Report.pdf. Accessed August 9, 2011.

State of Minnesota: Minnesota Department of Health Web. Adverse Health Events in Minnesota: January 2011. <http://www.health.state.mn.us/patientsafety/ae/2011ahereport.pdf>. Accessed August 9, 2011.

Commonwealth of Pennsylvania: Patient Safety Authority. 2010 Annual Report. April 28, 2011. http://patientsafetyauthority.org/PatientSafetyAuthority/Documents/2010_Annual_Report.pdf. Accessed August 9, 2011.

1c.16 Quote verbatim, the specific guideline recommendation (Including guideline # and/or page #):

The Joint Commission has incorporated the Universal Protocol into the National Patient Safety Goal chapter of its various accreditation manuals. The following is taken from pages 6-7 of the 2011 National Patient Safety Goals chapter of The Joint

Commission's accreditation manual for Ambulatory Health Care, effective July 1, 2011.

UP.01.01.01

Conduct a preprocedure verification process.

Elements of Performance for UP.01.01.01

1. Implement a preprocedure process to verify the correct procedure, for the correct patient, at the correct site.

Note: The patient is involved in the verification process when possible.

2. Identify the items that must be available for the procedure and use a standardized list to verify their availability. At a minimum, these items include the following:

- Relevant documentation (for example, history and physical, signed procedure consent form, nursing assessment, and preanesthesia assessment)
- Labeled diagnostic and radiology test results (for example, radiology images and scans, or pathology and biopsy reports) that are properly displayed
- Any required blood products, implants, devices, and/or special equipment for the procedure

Note: The expectation of this element of performance is that the standardized list is available and is used consistently during the preprocedure verification. It is not necessary to document that the standardized list was used for each patient.

3. Match the items that are to be available in the procedure area to the patient.

UP.01.02.01

Mark the procedure site.

Elements of Performance for UP.01.02.01

1. Identify those procedures that require marking of the incision or insertion site. At a minimum, sites are marked when there is more than one possible location for the procedure and when performing the procedure in a different location would negatively affect quality or safety. Note: For spinal procedures, in addition to preoperative skin marking of the general spinal region, special intraoperative imaging techniques may be used for locating and marking the exact vertebral level.

2. Mark the procedure site before the procedure is performed and, if possible, with the patient involved.

3. The procedure site is marked by a licensed independent practitioner who is ultimately accountable for the procedure and will be present when the procedure is performed. In limited circumstances, the licensed independent practitioner may delegate site marking to an individual who is permitted by the organization to participate in the procedure and has the following qualifications:

- An individual in a medical postgraduate education program who is being supervised by the licensed independent practitioner performing the procedure; who is familiar with the patient; and who will be present when the procedure is performed
- A licensed individual who performs duties requiring a collaborative agreement or supervisory agreement with the licensed independent practitioner performing the procedure (that is, an advanced practice registered nurse [APRN] or physician assistant [PA]); who is familiar with the patient; and who will be present when the procedure is performed.

Note: The organization's leaders define the limited circumstances (if any) in which site marking may be delegated to an individual meeting these qualifications.

4. The method of marking the site and the type of mark is unambiguous and is used consistently throughout the organization.

Note: The mark is made at or near the procedure site and is sufficiently permanent to be visible after skin preparation and draping. Adhesive markers are not the sole means of marking the site.

5. A written, alternative process is in place for patients who refuse site marking or when it is technically or anatomically impossible or impractical to mark the site (for example, mucosal surfaces or perineum).

Note: Examples of other situations that involve alternative processes include:

- Minimal access procedures treating a lateralized internal organ, whether percutaneous or through a natural orifice
- Teeth
- Premature infants, for whom the mark may cause a permanent tattoo

UP.01.03.01

A time-out is performed before the procedure.

Elements of Performance for UP.01.03.01

1. Conduct a time-out immediately before starting the invasive procedure or making the incision.

2. The time-out has the following characteristics:

- It is standardized, as defined by the organization.
- It is initiated by a designated member of the team.
- It involves the immediate members of the procedure team, including the individual performing the procedure, the anesthesia providers, the circulating nurse, the operating room technician, and other active participants who will be participating in the procedure from the beginning.

3. When two or more procedures are being performed on the same patient, and the person performing the procedure changes, perform a time-out before each procedure is initiated.

4. During the time-out, the team members agree, at a minimum, on the following:

- Correct patient identity
- The correct site
- The procedure to be done

5. Document the completion of the time-out.

Note: The organization determines the amount and type of documentation.

1c.17 Clinical Practice Guideline Citation: The Joint Commission, Ambulatory Health Care: 2011 National Patient Safety Goals.

1c.18 National Guideline Clearinghouse or other URL:

http://www.jointcommission.org/assets/1/6/NPSG_EPs_Scoring_AHC_20110707.pdf

1c.19 Grading of Strength of Guideline Recommendation. Has the recommendation been graded? No

1c.20 If guideline recommendation graded, identify the entity that graded the evidence including balance of representation and any disclosures regarding bias:

1c.21 System Used for Grading the Strength of Guideline Recommendation: Other

1c.22 If other, identify and describe the grading scale with definitions: Not graded

1c.23 Grade Assigned to the Recommendation: Not graded

1c.24 Rationale for Using this Guideline Over Others: The Joint Commission's "Universal Protocol" for eliminating wrong site, wrong procedure, wrong person surgery is widely accepted - approximately 51 professional associations and organizations endorsed the original version. It was recently updated in 2010 "to address patient safety issues while allowing organizations flexibility in applying the requirements within existing work processes".

Other guidelines, recommendations and position statements that address wrong site surgery include, but are not limited to, the following:

American Academy of Ophthalmology. Recommendations of American Academy of Ophthalmology Wrong-Site Task Force. http://one.aaof.org/ce/practiceguidelines/patient_content.aspx?cid=d0db838c-2847-4535-baca-aebab3011217. Accessed August 9, 2011.

American Academy of Orthopaedic Surgeons. Wrong-Site Surgery. Information Statement 1015. <http://www.aaos.org/about/papers/advistmt/1015.asp>. Accessed August 9, 2011.

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

American College of Surgeons. [ST-41] Statement on ensuring correct patient, correct site, and correct procedure surgery. http://www.facs.org/fellows_info/statements/st-41.html. Accessed August 9, 2011.

AORN. AORN Position Statement on Preventing Wrong-Patient, Wrong-Site, Wrong-Procedure Events. <http://www.aorn.org/PracticeResources/AORNPositionStatements/PositionCorrectSiteSurgery/>. Accessed August 9, 2011.

Best practices for preventing wrong site, wrong person, and wrong procedure errors in perioperative settings. *AORN J.* 2006;84:(suppl 1):S13-S29.

Institute for Clinical Systems Improvement (ICSI). Perioperative protocol. Health care protocol. Bloomington (MN): Institute for Clinical Systems Improvement (ICSI); Oct 2010.

Institute for Clinical Systems Improvement (ICSI). Safe site invasive procedure -- non-operating room. Bloomington (MN): Institute for Clinical Systems Improvement (ICSI); Aug 2010.

World Health Organization. WHO Guidelines for Safe Surgery 2009.
http://whqlibdoc.who.int/publications/2009/9789241598552_eng.pdf. Accessed August 9, 2011.

Based on the NQF descriptions for rating the evidence, what was the **developer's assessment** of the quantity, quality, and consistency of the body of evidence?

1c.25 Quantity: **Moderate** 1c.26 Quality: **Moderate** 1c.27 Consistency: **Moderate**

Was the threshold criterion, *Importance to Measure and Report*, met?

(1a & 1b must be rated moderate or high and 1c yes) Yes No

Provide rationale based on specific subcriteria:

For a new measure if the Committee votes NO, then STOP.

For a measure undergoing endorsement maintenance, if the Committee votes NO because of 1b. (no opportunity for improvement), it may be considered for continued endorsement and all criteria need to be evaluated.

2. RELIABILITY & VALIDITY - SCIENTIFIC ACCEPTABILITY OF MEASURE PROPERTIES

Extent to which the measure, as specified, produces consistent (reliable) and credible (valid) results about the quality of care when implemented. (**evaluation criteria**)

Measure testing must demonstrate adequate reliability and validity in order to be recommended for endorsement. Testing may be conducted for data elements and/or the computed measure score. Testing information and results should be entered in the appropriate field. Supplemental materials may be referenced or attached in item 2.1. See [guidance on measure testing](#).

S.1 Measure Web Page (*In the future, NQF will require measure stewards to provide a URL link to a web page where current detailed specifications can be obtained*). Do you have a web page where current detailed specifications for this measure can be obtained? **Yes**

S.2 If yes, provide web page URL: <http://ascquality.org/documents/ASCQualityCollaborationImplementationGuide.pdf>

2a. RELIABILITY. Precise Specifications and Reliability Testing: H M L I

2a1. Precise Measure Specifications. (*The measure specifications precise and unambiguous.*)

2a1.1 Numerator Statement (*Brief, narrative description of the measure focus or what is being measured about the target population, e.g., cases from the target population with the target process, condition, event, or outcome*):

ASC admissions experiencing a wrong site, wrong side, wrong patient, wrong procedure, or wrong implant

2a1.2 Numerator Time Window (*The time period in which the target process, condition, event, or outcome is eligible for inclusion*):

In-facility, prior to discharge

2a1.3 Numerator Details (*All information required to identify and calculate the cases from the target population with the target process, condition, event, or outcome such as definitions, codes with descriptors, and/or specific data collection items/responses*):

DEFINITIONS:

Admission: completion of registration upon entry into the facility

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

2a1.4 Denominator Statement (*Brief, narrative description of the target population being measured*):

All ASC admissions

2a1.5 Target Population Category (*Check all the populations for which the measure is specified and tested if any*): **Adult/Elderly Care, Children's Health**

2a1.6 Denominator Time Window (*The time period in which cases are eligible for inclusion*):

In-facility, prior to discharge

2a1.7 Denominator Details (All information required to identify and calculate the target population/denominator such as definitions, codes with descriptors, and/or specific data collection items/responses):

DEFINITION:

Admission: completion of registration upon entry into the facility

2a1.8 Denominator Exclusions (Brief narrative description of exclusions from the target population):

None

2a1.9 Denominator Exclusion Details (All information required to identify and calculate exclusions from the denominator such as definitions, codes with descriptors, and/or specific data collection items/responses):

Not applicable

2a1.10 Stratification Details/Variables (All information required to stratify the measure results including the stratification variables, codes with descriptors, definitions, and/or specific data collection items/responses):

The measure is not stratified

2a1.11 Risk Adjustment Type (Select type. Provide specifications for risk stratification in 2a1.10 and for statistical model in 2a1.13): No risk adjustment or risk stratification **2a1.12 If "Other," please describe:**

2a1.13 Statistical Risk Model and Variables (Name the statistical method - e.g., logistic regression and list all the risk factor variables. Note - risk model development should be addressed in 2b4.):

Not applicable

2a1.14-16 Detailed Risk Model Available at Web page URL (or attachment). Include coefficients, equations, codes with descriptors, definitions, and/or specific data collection items/responses. Attach documents only if they are not available on a webpage and keep attached file to 5 MB or less. NQF strongly prefers you make documents available at a Web page URL. Please supply login/password if needed:

2a1.17-18. Type of Score: Rate/proportion

2a1.19 Interpretation of Score (Classifies interpretation of score according to whether better quality is associated with a higher score, a lower score, a score falling within a defined interval, or a passing score): Better quality = Lower score

2a1.20 Calculation Algorithm/Measure Logic(Describe the calculation of the measure score as an ordered sequence of steps including identifying the target population; exclusions; cases meeting the target process, condition, event, or outcome; aggregating data; risk adjustment; etc.):

The number of admissions experiencing a wrong site, wrong side, wrong patient, wrong procedure, or wrong implant event is divided by the number of ASC admissions during the reporting period, yielding the rate of wrong site, wrong side, wrong patient, wrong procedure, and wrong implant events for the reporting period.

2a1.21-23 Calculation Algorithm/Measure Logic Diagram URL or attachment:

2a1.24 Sampling (Survey) Methodology. If measure is based on a sample (or survey), provide instructions for obtaining the sample, conducting the survey and guidance on minimum sample size (response rate):

The measure is not based on a sample.

2a1.25 Data Source (Check all the sources for which the measure is specified and tested). If other, please describe:

Paper Records

2a1.26 Data Source/Data Collection Instrument (*Identify the specific data source/data collection instrument, e.g. name of database, clinical registry, collection instrument, etc.*): ASC medical records, as well as incident/occurrence reports, and variance reports may serve as data sources. No specific collection instrument is required although the ASC Quality Collaboration has developed a sample data collection instrument that may be used as desired. Facilities may use any collection instrument that allows tracking of all wrong site, wrong side, wrong patient, wrong procedure, and wrong implant events.

2a1.27-29 Data Source/data Collection Instrument Reference Web Page URL or Attachment: URL
<http://ascquality.org/documents/ASCQualityCollaborationImplementationGuide.pdf>
 Not needed

2a1.30-32 Data Dictionary/Code Table Web Page URL or Attachment:
 URL
<http://ascquality.org/documents/ASCQualityCollaborationImplementationGuide.pdf>
 Not needed

2a1.33 Level of Analysis (*Check the levels of analysis for which the measure is specified and tested*): Facility

2a1.34-35 Care Setting (*Check all the settings for which the measure is specified and tested*): Ambulatory Care : Ambulatory Surgery Center (ASC)

2a2. Reliability Testing. (*Reliability testing was conducted with appropriate method, scope, and adequate demonstration of reliability.*)

2a2.1 Data/Sample (*Description of the data or sample including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included*):
 A convenience sample of 21 ambulatory surgery centers was selected for a retrospective chart audit comparing the reported values for the measure versus the values identified from the medical record. The centers were located in eight different states throughout the US. Services from April 1, 2010 to September 30, 2010 were reviewed in the course of the reliability testing.

2a2.2 Analytic Method (*Describe method of reliability testing & rationale*):
 The numerator All Ambulatory Surgery Center (ASC) admissions experiencing a wrong site, wrong side, wrong patient, wrong procedure or wrong implant) and denominator (number of ASC admissions) values were compared for all 21 centers in the sample.

2a2.3 Testing Results (*Reliability statistics, assessment of adequacy in the context of norms for the test conducted*):
 The error rates at all 21 of the ASCs (100%) were zero for both the numerator and denominator. The results show an excellent level of reliability with an overall 100% accuracy rate. One center was removed from this portion of the testing due to missing data.

2b. VALIDITY. Validity, Testing, including all Threats to Validity: H M L I

2b1.1 Describe how the measure specifications (*measure focus, target population, and exclusions*) **are consistent with the evidence cited in support of the measure focus** (*criterion 1c*) **and identify any differences from the evidence:**
 The measure specifications include all the potential "wrong" scenarios indicated by the evidence. The measure also evaluates all patients due to the relative infrequency of these events.

2b2. Validity Testing. (*Validity testing was conducted with appropriate method, scope, and adequate demonstration of validity.*)

2b2.1 Data/Sample (*Description of the data or sample including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included*):
 Validity was measured via a formal consensus process. A questionnaire that included ratings of the various characteristics of the measure was distributed to 8 clinicians (RNs), who currently work in ambulatory surgery centers or have responsibility for multiple surgery centers, two have credentials in quality and the others are involved in quality in their current positions. Responses were received from 7 of the panel members.

2b2.2 Analytic Method (*Describe method of validity testing and rationale; if face validity, describe systematic assessment*):
 Validity was measured via a formal consensus process. All seven respondents responded with a 5/5 rating for the question most related to content validity for this measure. Due to the high level of consensus on the primary validity question, multiple rounds of

Delphi-type evaluations were not necessary. These results demonstrate a high level of agreement around the validity of the measure.

2b2.3 Testing Results (Statistical results, assessment of adequacy in the context of norms for the test conducted; if face validity, describe results of systematic assessment):

Each attribute was measured on a 5 point Likert Scale. The attributes related to validity and average scores are listed below:

1. The measure appears to measure what it is intended to. (Median: 5.0/5.0; Mean: 5.0/5.0)
2. The measure is defined in a way that will allow for consistent interpretation of the inclusion and exclusion criteria from center to center. (Median: 5.0/5.0; Mean 4.9/5.0)
3. The data required for the measure are likely to be obtained with reasonable effort. (Median: 5.0/5.0; Mean: 5.0/5.0)
4. The data required for the measure are likely to be obtained with reasonable cost. (Median: 5.0/5.0; Mean: 5.0/5.0)
5. The data required for the measure can be generated during care delivery. (Median: 5.0/5.0; Mean: 5.0/5.0)

POTENTIAL THREATS TO VALIDITY. (All potential threats to validity were appropriately tested with adequate results.)

2b3. Measure Exclusions. (Exclusions were supported by the clinical evidence in 1c or appropriately tested with results demonstrating the need to specify them.)

2b3.1 Data/Sample for analysis of exclusions (Description of the data or sample including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included):

No exclusions

2b3.2 Analytic Method (Describe type of analysis and rationale for examining exclusions, including exclusion related to patient preference):

Not applicable

2b3.3 Results (Provide statistical results for analysis of exclusions, e.g., frequency, variability, sensitivity analyses):

Not applicable

2b4. Risk Adjustment Strategy. (For outcome measures, adjustment for differences in case mix (severity) across measured entities was appropriately tested with adequate results.)

2b4.1 Data/Sample (Description of the data or sample including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included):

This measure is not risk adjusted

2b4.2 Analytic Method (Describe methods and rationale for development and testing of risk model or risk stratification including selection of factors/variables):

Not applicable

2b4.3 Testing Results (Statistical risk model: Provide quantitative assessment of relative contribution of model risk factors; risk model performance metrics including cross-validation discrimination and calibration statistics, calibration curve and risk decile plot, and assessment of adequacy in the context of norms for risk models. Risk stratification: Provide quantitative assessment of relationship of risk factors to the outcome and differences in outcomes among the strata):

Not applicable

2b4.4 If outcome or resource use measure is not risk adjusted, provide rationale and analyses to justify lack of adjustment: Wrong site, wrong side, wrong patient, wrong procedure and wrong implant events should be rare if appropriate protocols are in place. Risk adjustment for patient characteristics would mask any measurement of performance difference. Thus we believe this measure should not be risk adjusted.

2b5. Identification of Meaningful Differences in Performance. (The performance measure scores were appropriately analyzed and discriminated meaningful differences in quality.)

2b5.1 Data/Sample (Describe the data or sample including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included):

Although data for 1,184 ASCs are included in our public reporting of this indicator, many ASCs report at the corporate level and do

NQF #0267 Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant

not report data for individual centers. The database includes center-level rates for this measure for 541 ASCs throughout the US. The statistics reported below include rates for this measure based on the 541 individually-reporting ambulatory surgery centers throughout the US.

2b5.2 Analytic Method (*Describe methods and rationale to identify statistically significant and practically/meaningfully differences in performance*):

An individual ASC's rate for surgeries involving the wrong site, side, patient, procedure or implant may be compared to the standard rate from the ASC Quality website <http://www.ascquality.org/qualityreport.cfm#Wrong>). A statistically significant difference in performance may be detected by using a standard test of proportions as outlined in most standard statistical texts.

2b5.3 Results (*Provide measure performance results/scores, e.g., distribution by quartile, mean, median, SD, etc.; identification of statistically significant and meaningfully differences in performance*):

The rate for surgeries involving the wrong site, side, patient, procedure or implant ranged from a minimum of 0.00% to a maximum of 0.31%. The mean rate was 0.00% (SD: 0.02%), while the median rate was 0.00%. The maximum surgeries involving the wrong site, side, patient, procedure or implant rate of 0.31% demonstrates that there is an opportunity for improvement in this measure.

2b6. Comparability of Multiple Data Sources/Methods. (*If specified for more than one data source, the various approaches result in comparable scores.*)

2b6.1 Data/Sample (*Describe the data or sample including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included*):

This measure is specified for a single data source (paper medical record/flow sheet) as noted in 2a1.25. above.

2b6.2 Analytic Method (*Describe methods and rationale for testing comparability of scores produced by the different data sources specified in the measure*):

Not applicable

2b6.3 Testing Results (*Provide statistical results, e.g., correlation statistics, comparison of rankings; assessment of adequacy in the context of norms for the test conducted*):

Not applicable

2c. Disparities in Care: H M L I NA (*If applicable, the measure specifications allow identification of disparities.*)

2c.1 If measure is stratified for disparities, provide stratified results (*Scores by stratified categories/cohorts*): This measure is not stratified

2c.2 If disparities have been reported/identified (e.g., in 1b), but measure is not specified to detect disparities, please explain:

The data the ASC Quality Collaboration currently receives for this measure is collected at the ASC-level or at the level of the corporate parent of the ASC. Corporate parent data submissions combine data from multiple ASCs. Disparity measures by population group require the collection of patient-level data or collection of the data for individual populations of patients. At this time, the ASC Quality Collaboration does not have access to any patient-level or individual population level data that would allow for analysis of subpopulation disparities based on race, sex and age. However, we understand the importance of subpopulation data and are taking steps that would allow us to collect the necessary data. We are actively pursuing the development of a registry that would allow us to develop subpopulation performance data for this measure and others. Potential registry development vendors have been identified and initial communications regarding the project have already taken place. We plan to select a vendor by the end of 2011, initiate the development of the registry database immediately upon contract acceptance, and have a functioning registry three to six months thereafter.

In addition, a federal quality reporting system has not yet been implemented for ambulatory surgical centers. Based on recent proposals from the CMS, we anticipate the agency will begin implementing an ASC quality reporting system in 2012 and that the measure set for the quality reporting system might include this measure. When the system is implemented and if this measure is included in the measure set, patient level demographic data could be collected in association with ASC data on wrong site, wrong side, wrong patient, wrong procedure and wrong implant events, allowing for the detection of any disparities.

2.1-2.3 Supplemental Testing Methodology Information:

Steering Committee: Overall, was the criterion, *Scientific Acceptability of Measure Properties*, met?

(Reliability and Validity must be rated moderate or high) Yes No

Provide rationale based on specific subcriteria:

If the Committee votes No, STOP

3. USABILITY

Extent to which intended audiences (e.g., consumers, purchasers, providers, policy makers) can understand the results of the measure and are likely to find them useful for decision making. (**evaluation criteria**)

C.1 Intended Purpose/ Use (Check all the purposes and/or uses for which the measure is intended): Public Reporting, Quality Improvement (Internal to the specific organization), Quality Improvement with Benchmarking (external benchmarking to multiple organizations)

3.1 Current Use (Check all that apply; for any that are checked, provide the specific program information in the following questions): Public Reporting, Quality Improvement with Benchmarking (external benchmarking to multiple organizations), Quality Improvement (Internal to the specific organization)

3a. Usefulness for Public Reporting: H M L I

(The measure is meaningful, understandable and useful for public reporting.)

3a.1. Use in Public Reporting - disclosure of performance results to the public at large (If used in a public reporting program, provide name of program(s), locations, Web page URL(s)). If not publicly reported in a national or community program, state the reason AND plans to achieve public reporting, potential reporting programs or commitments, and timeline, e.g., within 3 years of endorsement: [**For Maintenance** – If not publicly reported, describe progress made toward achieving disclosure of performance results to the public at large and expected date for public reporting; provide rationale why continued endorsement should be considered.]

The ASC Quality Collaboration posts a public report of quality data on six ASC quality measures endorsed by the NQF on a quarterly basis. This quarterly report includes aggregated performance data on the Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant measure. The report for the first quarter of 2011 is available at: <http://www.ascquality.org/qualityreport.cfm>. One thousand one hundred eighty-four (1,184) ASCs submitted wrong site, wrong side, wrong patient, wrong procedure, wrong implant data for the first quarter 2011 report.

3a.2. Provide a rationale for why the measure performance results are meaningful, understandable, and useful for public reporting. If usefulness was demonstrated (e.g., focus group, cognitive testing), describe the data, method, and results: The wrong site, side, patient, procedure, implant rate is similar to measures reported by CMS on the Hospital Compare website. The concept of rates and percentages is commonly used in public reporting of health care and other quality indicators. This measure has an easy to understand numerator and denominator and is easily interpreted by healthcare professionals as well as lay-persons.

3.2 Use for other Accountability Functions (payment, certification, accreditation). If used in a public accountability program, provide name of program(s), locations, Web page URL(s): The Centers for Medicare and Medicaid Services has proposed to include this measure in its ASC Quality Reporting Program. Please see CMS-1525-P, Section XIV.K.3.a.(3). at <http://www.gpo.gov/fdsys/pkg/FR-2011-07-18/pdf/2011-16949.pdf>.

3b. Usefulness for Quality Improvement: H M L I

(The measure is meaningful, understandable and useful for quality improvement.)

3b.1. Use in QI. If used in quality improvement program, provide name of program(s), locations, Web page URL(s): [**For Maintenance** – If not used for QI, indicate the reasons and describe progress toward using performance results for improvement].

This measure is in use in several QI initiatives. For example, the ASC Association includes this metric in its Outcomes Monitoring Project, which is described at <http://www.ascassociation.org/outcomes/>.

It is also in use in various state association quality data collection and reporting projects, including the Texas Ambulatory Surgery Center Association, located at <http://tasc.org/>.

3b.2. Provide rationale for why the measure performance results are meaningful, understandable, and useful for quality improvement. If usefulness was demonstrated (e.g., *QI initiative*), describe the data, method and results:

The wrong site,side,patient,procedure,implant rate is similar to measures reported by CMS on the Hospital Compare website. The concept of rates and percentages is commonly used in public reporting of health care. The definition of the indicator allows individual ASCs to calculate their rate and compare directly with the benchmark rates posted to the ASC Quality website.

Overall, to what extent was the criterion, *Usability*, met? H M L I

Provide rationale based on specific subcriteria:

4. FEASIBILITY

Extent to which the required data are readily available, retrievable without undue burden, and can be implemented for performance measurement. (**evaluation criteria**)

4a. Data Generated as a Byproduct of Care Processes: H M L I

4a.1-2 How are the data elements needed to compute measure scores generated? (Check all that apply).

Data used in the measure are:

generated by and used by healthcare personnel during the provision of care, e.g., blood pressure, lab value, medical condition

4b. Electronic Sources: H M L I

4b.1 Are the data elements needed for the measure as specified available electronically (Elements that are needed to compute measure scores are in defined, computer-readable fields): No data elements are in electronic sources

4b.2 If ALL data elements are not from electronic sources, specify a credible, near-term path to electronic capture, OR provide a rationale for using other than electronic sources: Widespread adoption of electronic health records in ambulatory surgical centers would be needed to achieve electronic capture of data elements.

4c. Susceptibility to Inaccuracies, Errors, or Unintended Consequences: H M L I

4c.1 Identify susceptibility to inaccuracies, errors, or unintended consequences of the measurement identified during testing and/or operational use and strategies to prevent, minimize, or detect. If audited, provide results:

Experience with this measure and feedback from users indicates that it is easy to use and has limited susceptibility to inaccuracies and errors. Reliability is very high. The ASC Quality Collaboration is not aware of any unintended consequences as a result of the use of this measure.

4d. Data Collection Strategy/Implementation: H M L I

A.2 Please check if either of the following apply (regarding proprietary measures): Proprietary measure

4d.1 Describe what you have learned/modified as a result of testing and/or operational use of the measure regarding data collection, availability of data, missing data, timing and frequency of data collection, sampling, patient confidentiality, time and cost of data collection, other feasibility/implementation issues (e.g., fees for use of proprietary measures):

The ASC Quality Collaboration has included "Frequently Asked Questions" in the Implementation Guide for the measure to assist users in their implementation of data collection.

Overall, to what extent was the criterion, *Feasibility*, met? H M L I

Provide rationale based on specific subcriteria:

OVERALL SUITABILITY FOR ENDORSEMENT

Does the measure meet all the NQF criteria for endorsement? Yes No

Rationale:

If the Committee votes No, STOP.
If the Committee votes Yes, the final recommendation is contingent on comparison to related and competing measures.

5. COMPARISON TO RELATED AND COMPETING MEASURES

If a measure meets the above criteria and there are endorsed or new related measures (either the same measure focus or the same target population) or competing measures (both the same measure focus and the same target population), the measures are compared to address harmonization and/or selection of the best measure before a final recommendation is made.

5.1 If there are related measures (either same measure focus or target population) or competing measures (both the same measure focus and same target population), list the NQF # and title of all related and/or competing measures:

5a. Harmonization

5a.1 If this measure has EITHER the same measure focus OR the same target population as [NQF-endorsed measure\(s\)](#): Are the measure specifications completely harmonized?

5a.2 If the measure specifications are not completely harmonized, identify the differences, rationale, and impact on interpretability and data collection burden:

5b. Competing Measure(s)

5b.1 If this measure has both the same measure focus and the same target population as NQF-endorsed measure(s): Describe why this measure is superior to competing measures (e.g., a more valid or efficient way to measure quality); OR provide a rationale for the additive value of endorsing an additional measure. (Provide analyses when possible):

CONTACT INFORMATION

Co.1 Measure Steward (Intellectual Property Owner): [Ambulatory Surgical Center Quality Collaboration, 5686 Escondida Blvd S, St. Petersburg, Florida, 33715](#)

Co.2 Point of Contact: [Donna, Slosburg, BSN, LHRM, CASC, donnaslosburg@ascquality.org, 727-867-0072-](#)

Co.3 Measure Developer if different from Measure Steward: [Ambulatory Surgical Center Quality Collaboration, 5686 Escondida Blvd S, St. Petersburg, Florida, 33715](#)

Co.4 Point of Contact: [Donna, Slosburg, BSN, LHRM, CASC, donnaslosburg@ascquality.org, 727-867-0072-](#)

Co.5 Submitter: [Donna, Slosburg, BSN, LHRM, CASC, donnaslosburg@ascquality.org, 727-867-0072-](#), [Ambulatory Surgical Center Quality Collaboration](#)

Co.6 Additional organizations that sponsored/participated in measure development:
[No additional organizations participated in measure development.](#)

Co.7 Public Contact: [Donna, Slosburg, BSN, LHRM, CASC, donnaslosburg@ascquality.org, 727-867-0072-](#), [Ambulatory Surgical Center Quality Collaboration](#)

ADDITIONAL INFORMATION

Workgroup/Expert Panel involved in measure development

Ad.1 Provide a list of sponsoring organizations and workgroup/panel members' names and organizations. Describe the members' role in measure development.

[The ASC Quality Collaboration workgroup members meet via teleconference to develop, critique, and modify candidate measures; to maintain existing measures; and to offer sites willing to participate in testing. No contractors are used.](#)

NQF #0267 Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant

The following is a list of the individuals (and their affiliation at the time of their participation) serving on the workgroup and contributing to this measure:

AAAHC: Naomi Kuznets, PhD
 Ambulatory Surgery Foundation: Debra Stinchcomb, BSN, CASC, David Shapiro, MD, Sarah Martin, RN, BS, CASC and Marian Lowe
 AMSURG: Deby Samuels, Lorri Smith RN, BSN and Linda Brooks-Belli
 AOA/HFAP: Monda Shaver, RN, BSN, CPHIT and Susan Lautner, RN, BSN, MSHL
 AORN: Bev Kirchner BSN, CNOR, CASC and Bonnie Denholm, RN, MS, CNOR
 ASCOA: Ann Geier RN, MS, CNOR, CASC
 ASC Quality Collaboration: Donna Slosburg, BSN, LHRM, CASC
 HCA: Kathy Wilson
 The Joint Commission: Michael Kulczycki and Kathleen Domzalski
 NATIONAL: Rhonda Arnwine, MBA and Terry Hawes, RN, BHA
 Novamed: Cassandra Speier
 NUETERRA: Rachelle Babin RN, BSN
 Surgical Care Affiliates: Kim Wood, MD
 Symbion: Steve Whitmore and Gina Throneberry RN, MBA, CASC
 USPI: David Zarin, MD, Julie Gunderson RN, MM, CPHQ and Clint Chain, RN, BSN

Ad.2 If adapted, provide title of original measure, NQF # if endorsed, and measure steward. Briefly describe the reasons for adapting the original measure and any work with the original measure steward: Not adapted

Measure Developer/Steward Updates and Ongoing Maintenance

Ad.3 Year the measure was first released: 2007

Ad.4 Month and Year of most recent revision: 12, 2010

Ad.5 What is your frequency for review/update of this measure? Annually, or more frequently if indicated

Ad.6 When is the next scheduled review/update for this measure? 12, 2011

Ad.7 Copyright statement: None

Ad.8 Disclaimers:

Ad.9 Additional Information/Comments: None

Date of Submission (MM/DD/YY): 09/13/2011