



Maine Quality Forum
a Service of Dirigo Health

VALIDATION MANUAL

October 2006

MAINE QUALITY FORUM
SAFETY STAR VALIDATION MANUAL

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Overview of Validation Process

The purpose of the validation process is to confirm that Safety Star applicants are meeting Maine Quality Forum thresholds for the 28 specific safe practices. (See Appendix A for a complete list of these practices). The Maine Quality Forum uses a peer validation process to confirm each applicant's adherence with Safety Star standards. The Validation Team (VT) responsible for the validation process is comprised of volunteer Quality Improvement professionals from within Maine's hospital system. Each Safety Star application will be verified with a site visit.

Timeline:

- Maine Quality Forum receives completed application.
- Maine Quality Forum verifies receipt of the application within 30 calendar days of receipt and queues it for VT (selection of team from the pool of Quality Improvement professionals).
- Maine Quality Forum and VT meet to conduct review the application and establish Site Visit Team (SVT) for site visit
- Validation process is completed within 90 calendar days of Maine Quality Forum's initial response to application.
 - SVT conducts site visit, using reference tools (see Appendices B, C and D) to complete Validation Forms (see Appendix E) for each Safety Star practice.
 - SVT submits Site Visit Report (see Appendix F) to Maine Quality Forum.
- Maine Quality Forum reviews Site Visit Report and notifies applicant of award decision within 10 business days of receiving the report.
- Maine Quality Forum publicly announces Safety Star Award recipients at time and place intended to generate the most favorable publicity.

Validating Safety Star Practices:

To verify most Safety Star practices, VT members will conduct policy and record reviews during site visits.

Policy Review: a review of written policy, along with observation and interviews to determine if a policy reflects recognized best practice, and is commonly acknowledged, understood and practiced across all organizational levels.

The number of interviews conducted in conjunction with a policy review will be appropriate to hospital staffing at the time of site visit to assure adequate transfer of information.

Record Review: a review of 30 randomly selected patient records

- The SVT will pull 30 patient records and use them for every practice to be validated with record review.

These reviews will ensure that:

- a) An appropriate protocol for a specific practice is in place.
- b) Hospital employees understand the protocol.
- c) Hospital employees follow the established protocol.

In order to validate some practices, VT members will also need to refer to guidelines provided by organizations. The Joint Commission on Accreditation of Healthcare Organizations' Official "Do Not Use" List (see Appendix B) and the Institute for Safe Medication Practices' list of suggested abbreviations (see Appendix C) are reference tools for validating practice 7. Appendix B of the Maine Quality Forum Nursing Sensitive Indicators Manual (available online at <http://mhdo.maine.gov/imhdo/qualitydata.aspx>) includes an American Nurses Association unit indicator list for hospital acquired pressure ulcers; this unit indicator list (see Appendix D) is a reference tool for validating practice 16.

Site Visits

After the Maine Quality Forum responds to an application, it will meet with the Validation Team (VT) to conduct a group review of the application and determine which members will be a part of the team that will conduct the site visit for the application. (A VT member from an applying hospital will recuse him/herself from the group review of the application).

A minimum of five VT members must be present for each group review and SVT selection meeting.

At least two VT members and one representative from the Maine Quality Forum will comprise each Site Visit Team (SVT).

The SVT will include at least one member from an institution of size and complexity comparable to that of the applicant and at least one member from a dissimilar institution.

The information that the SVT gathers during the site visit will be guided by two sources: the Safety Star application itself and Validation Forms (see Appendix E). Safety Star applications will contain information about any supporting documents the applicant has for each practice threshold, where site teams can find those documents, and identify the appropriate contact person for obtaining the documents.

During the site visit, the SVT will complete a Validation Form for every safe practice. The Validation Forms pinpoint the specific information SVT members must find to validate each Safety Star practice.

On the day of the site visit, the applicant must make sure all supporting documentation noted in the application is available for SVT review. The applicant must ensure that the SVT can review records in a way that assures patient privacy. Additionally, hospital unit managers should be made aware of the site visit.

Day of Site Visit

- SVT meets and greets hospital representatives.
- SVT conducts site visit.
- SVT meets briefly and reviews site visit.

- SVT meets with hospital representatives and shares general impressions of visit.

After the site visit, the SVT will complete a Site Visit Report (see Appendix F), which has two parts: a summary of the site visit and the Validation Forms (one for each Safety Star practice), which represent the SVT's pooled observations from the site visit.

Reapplication Process

The Safety Star reapplication process allows applicants to address specific deficiencies cited during site visits and reapply for the Award. Applicants who fail to meet thresholds on three or fewer safety practices may opt to implement changes to improve the practices they missed and reapply for the Safety Star six months after they receive the initial award decision.

The reapplication process timeline conforms to the regular application timeline with the following differences:

- The same group of members who conducted the initial site visit will conduct a reapplication site visit.
- Only those practice thresholds initially missed will be validated during the reapplication site visit.

Intent to Reapply:

Following a non-award determination, a hospital has 60 calendar days to notify Maine Quality Forum of its intent to reapply. Hospitals that do not submit this notification within 60 calendar days of the non-award determination must submit another application.

Reapplication site visits must occur 6-9 months after the original award determination.

The reapplication process is completed within 270 calendar days of the applicant's receipt of original award determination.

The hospital must submit a Reapplication Form within 150 calendar days from when it received the original award decision. The reapplication site visit is completed within 270 calendar days of applicant's receipt of original award determination. The reapplication site visit will not be scheduled until Maine Quality Forum receives a completed Reapplication Form.

Disqualification:

The following disqualify a hospital from the reapplication process:

- Failure to submit intent to reapply within 60 calendar days of receipt of original award determination.
- Failure to submit Reapplication Form within 150 calendar days of receipt of original award decision.
- Failure to complete the reapplication process within 270 calendar days of receipt of original award determination.
- Failure to schedule a reapplication site visit between 180 and 270 calendar days of receipt of original award determination.

Reconsideration Process

The Safety Star reconsideration process gives applicants who question the award decision delivered to them by the Maine Quality Forum the opportunity to have that decision reviewed.

Timeline:

- Maine Quality Forum receives request for reconsideration.
- Maine Quality Forum responds to request.
- Within 75 calendar days of receipt of a request for reconsideration, the Chair of the Performance Indicator Committee of the Maine Quality Forum Advisory Council reviews all associated documents.
- The Performance Indicator Committee Chair makes reconsideration award decision recommendation to Director of the Maine Quality Forum.
- The Director of the Maine Quality Forum will issue notice of reconsideration decision within 10 business days of Performance Indicator Committee Chair recommendation. The Director of the Maine Quality Form is the final authority. All decisions are final.

Validator Rights and Responsibilities

Compensation:

- Validation Team (VT) membership is voluntary.
- Maine Quality Forum will reimburse members of the VT for mileage and lodging expenses (if a site visit requires an overnight stay). Reimbursement policies, procedures and rates can be found in Chapter 10 of the State Administrative and Accounting Manual (available online at <http://www.maine.gov/osc/pdf/saam%20manual/ch10travel.pdf>).
- To receive reimbursement, VT members must complete a Travel Expense Form (See Appendix G). Tax concerns are the responsibility of VT members.
- Members of the Validation Team may not receive gifts or compensation from hospitals.

Site Visits:

- Validation Team members are Good Samaritans who agree to conduct site visits attentively. Accordingly, team members cannot be held liable for any omissions. By applying, hospitals agree to this rule.
- Each member agrees not to conduct a site visit for his or her employer.
- VT members will self-assess to determine if a conflict of interest is present and recuse themselves if a conflict exists.
- Validators will agree to sign appropriate confidentiality forms and adhere to hospital practices and processes designed to comply with HIPAA requirements.
- Should SVT members observe unethical practices during site visits, they shall be guided by accepted professional ethics regarding their response.

Edit Report

Significant changes made to the Safety Star Validation Manual will be reported on this page.

The October 2006 Safety Star Validation Manual includes the following revisions:

1. A group review of the application has been added to the SVT selection meeting between MQF and the VT. This review will enable VT members to discuss application weaknesses and strengths and help inform the SVT process.
2. Each SVT member is no longer required to complete individual Validation Forms during the site visits. Instead, the SVT will complete the Validation Forms together, and each form will represent the SVT's group findings for that particular practice.
3. Please see the Edit Report of the October 2006 Safety Star Manual for a detailed list of revisions to the text of Safety Star standards, thresholds, and validation criteria that also apply to this Validation Manual.

October 10, 2006

Appendix A: Safety Star Standards

Maine Quality Forum Recognized Provider Safe Practices Worksheet

NQF #	Category	Practice	Threshold
1	Culture	Culture of Safety	At least one institution wide survey by Agency for Healthcare Research and Quality criteria with results reported to staff and governing board.
2	Matching Needs to Capacity	Evidence-based Referral	Policy in place by Medical Executive Committee (MEC) acknowledging the principle of evidence-based referral and listing high risk services that should be sought outside the institution in elective situations.
3	Matching Needs to Capacity	Ensure Adequate Nursing Staff	Evidence that the institution complies with the Department of Health and Human Services, Division of Licensing and Certification
4	Matching Needs to Capacity	Intensivist Care	Not applicable 2006
5	Matching Needs to Capacity	Pharmacists Involved in Medication Use	24-hour pharmacist coverage via on-site pharmacist and/or telepresence. If less than 24-hour pharmacist coverage, a score of "full pie" ("Excellent use of recommended medication safety practices") on the Maine Health Management Coalition Medication Safety Spotlight Survey.
6	Facilitating Information Transfer	Verbal Order Safety	Evidence that the institution has requirement that verbal orders are immediately read back and then noted in the chart by the recipient to confirm read back. Evidence that a sampling has been performed within the last 12 months to ensure compliance with immediate read back and chart notation.
7	Facilitating Information Transfer	Standardized Abbreviations and Dose Designation	Full adoption of National Quality Forum-endorsed "Do Not Use" list. Presence of functioning Quality Improvement (QI) mechanism.
8	Facilitating Information Transfer	Care Summaries not Prepared From Memory	Structure to provide clinician access to necessary records at time of dictation. Presence of functioning QI program based on sampling, documenting completeness and accuracy of dictated summaries.
9	Facilitating Information Transfer	Accurate Information Flow Across Providers	Evidence of medication reconciliation surveillance at admission, discharge or intramural transfers. Evidence of a system of verification and a QI process focused on the presence of and accuracy of verification. The presence of such a system meets this threshold.
10	Facilitating Information Transfer	Patient Understanding of Treatment	Staff training module outlining informed consent. Evidence of preprocedure discussion with patient demonstrating understanding of proposed procedure.
11	Facilitating Information Transfer	Life-Sustaining Treatment Preferences Charted	Patient preferences for life sustaining treatment on all charts. Evidence of reporting of all codes performed against preferences to MEC and Board Quality Committee.
12	Facilitating Information Transfer	Computerized Prescriber Order Entry	Not applicable 2006
13	Facilitating Information Transfer	Accurate X-Ray Labeling	Standardized protocols in place for correct labeling. Mislabeling incidents reported to MEC and Board Quality Committee. Presence of systems that make mislabeling extraordinarily rare.
14	Facilitating Information Transfer	Prevent Wrong Site/Wrong Patient Surgery	Protocol adopted, with measurement of compliance at reasonable intervals. Episode of wrong site, wrong patient, wrong surgery within the last 12 months disqualifies applicant.

Maine Quality Forum Recognized Provider Safe Practices Worksheet

NQF #	Category	Practice	Threshold
15	Process of Care	Beta Blockers Prescribed Before and After Surgery	Protocol adopted, with measurement of compliance at 80% level every 6 months.
16	Process of Care	Continuous Risk Assessment and Prevention of Pressure Ulcer Development	Protocol adopted, with measurement of an internally set, reasonable level of compliance at each unit level annually. (units per American Nurses Association indicator list)
17	Process of Care	Continuous Risk Assessment and Prevention of DVT/VTE (clots in legs to lungs)	Protocol adopted, with measurement of 80% compliance at each unit level annually.
18	Process of Care	Safe and Effective Blood Thinning (anti-thrombotic treatment)	Protocol adopted for inpatient management and discharge planning, with compliance confirmed by sampling annually on each unit. If anticoagulation team then evidence that the team participates in 80% of appropriate cases annually.
19	Process of Care	Continuous Risk Assessment and Prevention of Aspiration	Protocol adopted, with measurement of compliance at 80% level every 6 months.
20	Process of Care	Prevention of Central Catheter Infection	Protocol adopted consistent with best practices and evidence of 90% compliance sampled annually.
21	Process of Care	Risk-based Prevention of Surgical Site Infection	Protocol adopted, with measurement of compliance by reports to Maine Health Data Organization.
22	Process of Care	Risk-based Prevention of Kidney Injury From X-Ray Dye	Protocol adopted, with measurement of 80% compliance semi-annually.
23	Process of Care	Continuous Risk Assessment and Prevention of Malnutrition	Protocol adopted, with measurement of an internally set, reasonable level of compliance semi-annually.
24	Process of Care	Continuous Risk Assessment and Prevention of Tourniquet Complications	Protocol adopted, with measurement of 80% compliance semi-annually.
25	Process of Care	Prevent Person-to-Person Transmission of Infection	Protocol adopted, with annual assessments on a majority of hospital units and responses to assessments that include setting goals for achievement. The presence of assessments and responses to assessments meets this threshold
26	Process of Care	Influenza Vaccination of Healthcare Workers	Vaccinated 80% of required except those who formally refuse.
27	Increasing Medication Safety	Appropriate Workplace for Medication Preparation and Dispensing	Minimum of monthly documentation that indicates a continuous surveillance of compliance by responsible person
28	Increasing Medication Safety	Standardized Medication Labeling and Storage	Self assessment of full compliance.
29	Increasing Medication Safety	Identification and Appropriate Use of "High Alert" Drugs	Self assessment of full compliance.
30	Increasing Medication Safety	Medication Dispensed in Unit Dose	Self assessment of full compliance.

**Appendix B: Joint Commission on Accreditation of Healthcare
Organizations' Official "Do Not Use" List**

Official “Do Not Use” List¹

Do Not Use	Potential Problem	Use Instead
U (unit)	Mistaken for “0” (zero), the number “4” (four) or “cc”	Write "unit"
IU (International Unit)	Mistaken for IV (intravenous) or the number 10 (ten)	Write "International Unit"
Q.D., QD, q.d., qd (daily)	Mistaken for each other	Write "daily"
Q.O.D., QOD, q.o.d, qod (every other day)	Period after the Q mistaken for "I" and the "O" mistaken for "I"	Write "every other day"
Trailing zero (X.0 mg)* Lack of leading zero (.X mg)	Decimal point is missed	Write X mg Write 0.X mg
MS	Can mean morphine sulfate or magnesium sulfate	Write "morphine sulfate" Write "magnesium sulfate"
MSO ₄ and MgSO ₄	Confused for one another	

¹ Applies to all orders and all medication-related documentation that is handwritten (including free-text computer entry) or on pre-printed forms.

***Exception:** A “trailing zero” may be used only where required to demonstrate the level of precision of the value being reported, such as for laboratory results, imaging studies that report size of lesions, or catheter/tube sizes. It may not be used in medication orders or other medication-related documentation.

Additional Abbreviations, Acronyms and Symbols
(For possible future inclusion in the Official “Do Not Use” List)

Do Not Use	Potential Problem	Use Instead
> (greater than) < (less than)	Misinterpreted as the number “7” (seven) or the letter “L” Confused for one another	Write “greater than” Write “less than”
Abbreviations for drug names	Misinterpreted due to similar abbreviations for multiple drugs	Write drug names in full
Apothecary units	Unfamiliar to many practitioners Confused with metric units	Use metric units
@	Mistaken for the number “2” (two)	Write “at”
cc	Mistaken for U (units) when poorly written	Write "ml" or “milliliters”
µg	Mistaken for mg (milligrams) resulting in one thousand-fold overdose	Write "mcg" or “micrograms”

Appendix C: Institute for Safe Medication Practices Suggested Abbreviations

ISMP List of Error-Prone Abbreviations, Symbols, and Dose Designations

It's been over 2 years since we published a list of abbreviations, symbols, and dose designations that have contributed to medication errors. Now, with the 2004 JCAHO National Patient Safety Goals calling for organizational compliance with a list of prohibited "dangerous" abbreviations, acronyms and symbols, we thought an updated list would be useful. Since JCAHO has specified that certain abbreviations must appear on

the organization's list, we've highlighted these items with a double asterisk (**). Also, effective April 1, 2004, each organization must include at least three additional items on their list. However, we hope that you will consider others beyond the minimum JCAHO requirement. Selections can be made from the attached list. These items should be considered for handwritten, preprinted, and electronic forms of communication.

Abbreviations	Intended Meaning	Misinterpretation	Correction
μg	Microgram	Mistaken as "mg"	Use "mcg"
AD, AS, AU	Right ear, left ear, each ear	Mistaken as OD, OS, OU (right eye, left eye, each eye)	Use "right ear," "left ear," or "each ear"
OD, OS, OU	Right eye, left eye, each eye	Mistaken as AD, AS, AU (right ear, left ear, each ear)	Use "right eye," "left eye," or "each eye"
BT	Bedtime	Mistaken as "BID" (twice daily)	Use "bedtime"
cc	Cubic centimeters	Mistaken as "u" (units)	Use "mL"
D/C	Discharge or discontinue	Premature discontinuation of medications if D/C (intended to mean "discharge") has been misinterpreted as "discontinued" when followed by a list of discharge medications	Use "discharge" and "discontinue"
IJ	Injection	Mistaken as "IV" or "intrajugular"	Use "injection"
IN	Intranasal	Mistaken as "IM" or "IV"	Use "intranasal" or "NAS"
HS	Half-strength	Mistaken as bedtime	Use "half-strength" or "bedtime"
hs	At bedtime, hours of sleep	Mistaken as half-strength	
IU**	International unit	Mistaken as IV (intravenous) or 10 (ten)	Use "units"
o.d. or OD	Once daily	Mistaken as "right eye" (OD-oculus dexter), leading to oral liquid medications administered in the eye	Use "daily"
OJ	Orange juice	Mistaken as OD or OS (right or left eye); drugs meant to be diluted in orange juice may be given in the eye	Use "orange juice"
Per os	By mouth, orally	The "os" can be mistaken as "left eye" (OS-oculus sinister)	Use "PO," "by mouth," or "orally"
q.d. or QD**	Every day	Mistaken as q.i.d., especially if the period after the "q" or the tail of the "q" is misunderstood as an "i"	Use "daily"
qhs	Nightly at bedtime	Mistaken as "qhr" or every hour	Use "nightly"
qn	Nightly or at bedtime	Mistaken as "qh" (every hour)	Use "nightly" or "at bedtime"
q.o.d. or QOD**	Every other day	Mistaken as "q.d." (daily) or "q.i.d." (four times daily) if the "o" is poorly written	Use "every other day"
q1d	Daily	Mistaken as q.i.d. (four times daily)	Use "daily"
q6PM, etc.	Every evening at 6 PM	Mistaken as every 6 hours	Use "6 PM nightly" or "6 PM daily"
SC, SQ, sub q	Subcutaneous	SC mistaken as SL (sublingual); SQ mistaken as "5 every;" the "q" in "sub q" has been mistaken as "every" (e.g., a heparin dose ordered "sub q 2 hours before surgery" misunderstood as every 2 hours before surgery)	Use "subcut" or "subcutaneously"
ss	Sliding scale (insulin) or 1/2 (apothecary)	Mistaken as "55"	Spell out "sliding scale;" use "one-half" or "1/2"
SSRI	Sliding scale regular insulin	Mistaken as selective-serotonin reuptake inhibitor	Spell out "sliding scale (insulin)"
SSI	Sliding scale insulin	Mistaken as Strong Solution of Iodine (Lugol's)	
i/d	One daily	Mistaken as "tid"	Use "1 daily"
TIW or tiw	3 times a week	Mistaken as "3 times a day" or "twice in a week"	Use "3 times weekly"
U or u**	Unit	Mistaken as the number 0 or 4, causing a 10-fold overdose or greater (e.g., 4U seen as "40" or 4u seen as "44"); mistaken as "cc" so dose given in volume instead of units (e.g., 4u seen as 4cc)	Use "unit"
Dose Designations and Other Information	Intended Meaning	Misinterpretation	Correction
Trailing zero after decimal point (e.g., 1.0 mg)**	1 mg	Mistaken as 10 mg if the decimal point is not seen	Do not use trailing zeros for doses expressed in whole numbers
No leading zero before a decimal dose (e.g., .5 mg)**	0.5 mg	Mistaken as 5 mg if the decimal point is not seen	Use zero before a decimal point when the dose is less than a whole unit

Dose Designations and Other Information	Intended Meaning	Misinterpretation	Correction
Drug name and dose run together (especially problematic for drug names that end in "L" such as Inderal40 mg; Tegretol300 mg)	Inderal 40 mg Tegretol 300 mg	Mistaken as Inderal 140 mg Mistaken as Tegretol 1300 mg	Place adequate space between the drug name, dose, and unit of measure
Numerical dose and unit of measure run together (e.g., 10mg, 100mL)	10 mg 100 mL	The "m" is sometimes mistaken as a zero or two zeros, risking a 10- to 100-fold overdose	Place adequate space between the dose and unit of measure
Abbreviations such as mg. or mL. with a period following the abbreviation	mg mL	The period is unnecessary and could be mistaken as the number 1 if written poorly	Use mg, mL, etc. without a terminal period
Large doses without properly placed commas (e.g., 100000 units; 1000000 units)	100,000 units 1,000,000 units	100000 has been mistaken as 10,000 or 1,000,000; 1000000 has been mistaken as 100,000	Use commas for dosing units at or above 1,000, or use words such as 100 "thousand" or 1 "million" to improve readability
Drug Name Abbreviations	Intended Meaning	Misinterpretation	Correction
ARA A	vidarabine	Mistaken as cytarabine (ARA C)	Use complete drug name
AZT	zidovudine (Retrovir)	Mistaken as azathioprine or aztreonam	Use complete drug name
CPZ	Compazine (prochlorperazine)	Mistaken as chlorpromazine	Use complete drug name
DPT	Demerol-Phenergan-Thorazine	Mistaken as diphtheria-pertussis-tetanus (vaccine)	Use complete drug name
DTO	Diluted tincture of opium, or deodorized tincture of opium (Paregoric)	Mistaken as tincture of opium	Use complete drug name
HCl	hydrochloric acid or hydrochloride	Mistaken as potassium chloride (The "H" is misinterpreted as "K")	Use complete drug name unless expressed as a salt of a drug
HCT	hydrocortisone	Mistaken as hydrochlorothiazide	Use complete drug name
HCTZ	hydrochlorothiazide	Mistaken as hydrocortisone (seen as HCT250 mg)	Use complete drug name
MgSO4**	magnesium sulfate	Mistaken as morphine sulfate	Use complete drug name
MS, MSO4**	morphine sulfate	Mistaken as magnesium sulfate	Use complete drug name
MTX	methotrexate	Mistaken as mitoxantrone	Use complete drug name
PCA	procainamide	Mistaken as Patient Controlled Analgesia	Use complete drug name
PTU	propylthiouracil	Mistaken as mercaptopurine	Use complete drug name
T3	Tylenol with codeine No. 3	Mistaken as liothyronine	Use complete drug name
TAC	triamcinolone	Mistaken as tetracaine, Adrenalin, cocaine	Use complete drug name
TNK	TNKase	Mistaken as "TPA"	Use complete drug name
ZnSO4	zinc sulfate	Mistaken as morphine sulfate	Use complete drug name
Stemmed Drug Names	Intended Meaning	Misinterpretation	Correction
"Nitro" drip	nitroglycerin infusion	Mistaken as sodium nitroprusside infusion	Use complete drug name
"NorfloX"	norfloxacin	Mistaken as Norflex	Use complete drug name
"IV Vanc"	intravenous vancomycin	Mistaken as Invanz	Use complete drug name
Symbols	Intended Meaning	Misinterpretation	Correction
3	Dram	Symbol for dram mistaken as "3"	Use the metric system
℥	Minim	Symbol for minim mistaken as "mL"	
x3d	For three days	Mistaken as "3 doses"	Use "for three days"
> and <	Greater than and less than	Mistaken as opposite of intended; mistakenly use incorrect symbol; "< 10" mistaken as "40"	Use "greater than" or "less than"
/ (slash mark)	Separates two doses or indicates "per"	Mistaken as the number 1 (e.g., "25 units/10 units" misread as "25 units and 110" units)	Use "per" rather than a slash mark to separate doses
@	At	Mistaken as "2"	Use "at"
&	And	Mistaken as "2"	Use "and"
+	Plus or and	Mistaken as "4"	Use "and"
o	Hour	Mistaken as a zero (e.g., q2 ^o seen as q 20)	Use "hr," "h," or "hour"

** Identified abbreviations above are also included on the JCAHO's "minimum list" of dangerous abbreviations, acronyms and symbols that must be included on an organization's "Do Not Use" list, effective January 1, 2004. An updated list of frequently asked questions about this JCAHO requirement can be found on their website at www.jcaho.org.

Appendix D: American Nurses Association Unit Indicator List

Eligible Unit Type Table

Population and Unit Type Categories	Indicator:
	Hospital- Acquired Pressure Ulcer
Critical Access Hospitals Mixed Acuity	✓
Neonatal	
Level III/IV Critical Care	
Level II Intermediate	
Level I Continuing Care	
Well Baby Nursery	
Mixed Acuity	
Pediatric	
Critical Care-Pediatric	
Step Down	
Medical	
Surgical	
Med-Surg Combined	
Mixed Acuity- Swing Bed Hospital	✓
Adult	
Critical Care-Adult	✓
Step Down	✓
Medical	✓
Surgical	✓
Med-Surg Combined	✓
Obstetrics	
Skilled Nursing Unit	
Mixed Acuity- Swing Bed Hospital	✓
Psychiatric	
Adult	
Adolescent	
Child/Adolescent	
Child	
Geopsych	
Behavioral Health	
Specialty	
Multiple Unit Types	
Other Psychiatric Unit	
Rehab	
Adult	✓
Pediatric	
Mixed Acuity- Swing Bed Hospital	✓
Other	
Ambulatory Care	
Emergency Dept	
Intervention Unit	
Peri-operative	
Other Unit	

Source: American Nurses Association, with local modification to address Critical Access Hospital and qualified Swing Bed Hospital (mixed acuity unit) needs.

Appendix E: Validation Forms

**MAINE QUALITY FORUM SAFETY STAR PROGRAM
VALIDATION FORM**

Practice: 1. Culture of Safety

Validation Checklist	Yes	No
Evidence of Agency for Healthcare Research and Quality (AHRQ) survey results in staff meeting minutes	<input type="checkbox"/>	<input type="checkbox"/>
Evidence of AHRQ survey results in board meeting minutes	<input type="checkbox"/>	<input type="checkbox"/>
Evidence of AHRQ survey result dissemination to staff (e.g. newsletter)	<input type="checkbox"/>	<input type="checkbox"/>
Standard Met	<input type="checkbox"/>	<input type="checkbox"/>

Observational Notes:

Areas of Concern:

Date: _____

Hospital Name: _____

Validator: _____

**MAINE QUALITY FORUM SAFETY STAR PROGRAM
VALIDATION FORM**

Practice: 2. Evidence-based Referral

Validation Checklist	Yes	No
Presence of written policy	<input type="checkbox"/>	<input type="checkbox"/>
Evidence of record review for all outlier procedures	<input type="checkbox"/>	<input type="checkbox"/>
Evidence of Medical Executive Committee review for all outlier procedures	<input type="checkbox"/>	<input type="checkbox"/>
Standard Met	<input type="checkbox"/>	<input type="checkbox"/>

Observational Notes:

Areas of Concern:

Date: _____

Hospital Name: _____

Validator: _____

**MAINE QUALITY FORUM SAFETY STAR PROGRAM
VALIDATION FORM**

Practice: 3. Ensure Adequate Nursing Staff

Validation Checklist	Yes	No
License without present statement of deficiency related to adequate nursing staffing	<input type="checkbox"/>	<input type="checkbox"/>
Standard Met	<input type="checkbox"/>	<input type="checkbox"/>

Observational Notes:

Areas of Concern:

Date: _____

Hospital Name: _____

Validator: _____

**MAINE QUALITY FORUM SAFETY STAR PROGRAM
VALIDATION FORM**

Practice: 6. Verbal Order Safety

Validation Checklist	Yes	No
Presence of written policy for verbal orders to be immediately read back with notation of read back entered in the chart by recipient	<input type="checkbox"/>	<input type="checkbox"/>
Evidence of compliance audit within past 12 months	<input type="checkbox"/>	<input type="checkbox"/>
Audit shows compliance with policy at an internally established, reasonable level (x %)	<input type="checkbox"/>	<input type="checkbox"/>
Verbal order verification record found in x % of 30 randomly selected patient records	<input type="checkbox"/>	<input type="checkbox"/>
Standard Met	<input type="checkbox"/>	<input type="checkbox"/>

Observational Notes:

Areas of Concern:

Date: _____

Hospital Name: _____

Validator: _____

**MAINE QUALITY FORUM SAFETY STAR PROGRAM
VALIDATION FORM**

Practice: 7. Standardized Abbreviations and Dose Designation

Validation Checklist	Yes	No
Presence of written policy	<input type="checkbox"/>	<input type="checkbox"/>
Evidence that orders are audited	<input type="checkbox"/>	<input type="checkbox"/>
Use of non-standardized abbreviations is documented	<input type="checkbox"/>	<input type="checkbox"/>
Presence of remediation plan	<input type="checkbox"/>	<input type="checkbox"/>
Standard Met	<input type="checkbox"/>	<input type="checkbox"/>

Observational Notes:

Areas of Concern:

Date: _____

Hospital Name: _____

Validator: _____

**MAINE QUALITY FORUM SAFETY STAR PROGRAM
VALIDATION FORM**

Practice: 8. Care Summaries not Prepared From Memory

Validation Checklist	Yes	No
Evidence of protocol to provide clinicians access to necessary records at time of dictation	<input type="checkbox"/>	<input type="checkbox"/>
Evidence of compliance audit	<input type="checkbox"/>	<input type="checkbox"/>
Presence of remediation plan	<input type="checkbox"/>	<input type="checkbox"/>
Care summaries match charts in 30 randomly selected patient records	<input type="checkbox"/>	<input type="checkbox"/>
Coders interviewed note and report discrepancies between charts and care summaries	<input type="checkbox"/>	<input type="checkbox"/>
Standard Met	<input type="checkbox"/>	<input type="checkbox"/>

Observational Notes:

Areas of Concern:

Date: _____

Hospital Name: _____

Validator: _____

**MAINE QUALITY FORUM SAFETY STAR PROGRAM
VALIDATION FORM**

Practice: 9. Accurate Information Flow Across Providers

Validation Checklist	Yes	No
Presence of written policy that includes comprehensive plan for guidelines, timelines, staff assignments, and audit system	<input type="checkbox"/>	<input type="checkbox"/>
Evidence of medication reconciliation at admission, or at discharge, or for intramural transfers	<input type="checkbox"/>	<input type="checkbox"/>
Presence of a system of verification and QI process focused on the presence of and accuracy of verification	<input type="checkbox"/>	<input type="checkbox"/>
Standard Met	<input type="checkbox"/>	<input type="checkbox"/>

Observational Notes:

Areas of Concern:

Date: _____

Hospital Name: _____

Validator: _____

**MAINE QUALITY FORUM SAFETY STAR PROGRAM
VALIDATION FORM**

Practice: 13. Accurate X-Ray Labeling

Validation Checklist	Yes	No
Presence of written policy	<input type="checkbox"/>	<input type="checkbox"/>
X-rays accurately labeled in 30 randomly selected patient records	<input type="checkbox"/>	<input type="checkbox"/>
Evidence that mislabeling is reviewed	<input type="checkbox"/>	<input type="checkbox"/>
Standard Met	<input type="checkbox"/>	<input type="checkbox"/>

Observational Notes:

Areas of Concern:

Date: _____

Hospital Name: _____

Validator: _____

**MAINE QUALITY FORUM SAFETY STAR PROGRAM
VALIDATION FORM**

Practice: 14. Prevent Wrong Site/Wrong Patient Surgery

Validation Checklist	Yes	No
Presence of written policy	<input type="checkbox"/>	<input type="checkbox"/>
Evidence that policy is followed in 30 randomly selected patient records in high risk areas (e.g. OR, ER, Invasive Imaging suites)	<input type="checkbox"/>	<input type="checkbox"/>
No wrong site, wrong patient, wrong surgery in past 12 months	<input type="checkbox"/>	<input type="checkbox"/>
Standard Met	<input type="checkbox"/>	<input type="checkbox"/>

Observational Notes:

Areas of Concern:

Date: _____

Hospital Name: _____

Validator: _____

**MAINE QUALITY FORUM SAFETY STAR PROGRAM
VALIDATION FORM**

Practice: 15. Beta Blockers Prescribed Before and After Surgery

Validation Checklist	Yes	No
Evidence of protocol for assessing patients and administering beta blockers	<input type="checkbox"/>	<input type="checkbox"/>
Evidence of 6-month compliance audits	<input type="checkbox"/>	<input type="checkbox"/>
Audits show at least 80% of eligible patients are assessed and given beta blockers	<input type="checkbox"/>	<input type="checkbox"/>
Standard Met	<input type="checkbox"/>	<input type="checkbox"/>

Observational Notes:

Areas of Concern:

Date: _____

Hospital Name: _____

Validator: _____

**MAINE QUALITY FORUM SAFETY STAR PROGRAM
VALIDATION FORM**

Practice: 17. Continuous Risk Assessment and Prevention of DVT/VTE (clots in legs to lungs)

Validation Checklist	Yes	No
Presence of written policy	<input type="checkbox"/>	<input type="checkbox"/>
Evidence of annual unit-based compliance audit	<input type="checkbox"/>	<input type="checkbox"/>
Audits show compliance with policy at 80% or higher	<input type="checkbox"/>	<input type="checkbox"/>
DVT/VTE Risk assessments and prevention plans found in 80% of 30 randomly selected patient records	<input type="checkbox"/>	<input type="checkbox"/>
Standard Met	<input type="checkbox"/>	<input type="checkbox"/>

Observational Notes:

Areas of Concern:

Date: _____

Hospital Name: _____

Validator: _____

**MAINE QUALITY FORUM SAFETY STAR PROGRAM
VALIDATION FORM**

Practice: 18. Safe and Effective Blood Thinning (anti-thrombotic treatment)

Validation Checklist	Yes	No
Presence of written policy	<input type="checkbox"/>	<input type="checkbox"/>
Evidence of annual unit-based compliance audit	<input type="checkbox"/>	<input type="checkbox"/>
Presence of anticoagulation team	<input type="checkbox"/>	<input type="checkbox"/>
If YES: Evidence of its participation in at least 80% of appropriate cases annually	<input type="checkbox"/>	<input type="checkbox"/>
Standard Met	<input type="checkbox"/>	<input type="checkbox"/>

Observational Notes:

Areas of Concern:

Date: _____

Hospital Name: _____

Validator: _____

**MAINE QUALITY FORUM SAFETY STAR PROGRAM
VALIDATION FORM**

Practice: 19. Continuous Risk Assessment and Prevention of Aspiration

Validation Checklist	Yes	No
Presence of written policy	<input type="checkbox"/>	<input type="checkbox"/>
Evidence of 6-month compliance audits	<input type="checkbox"/>	<input type="checkbox"/>
Audits show compliance with policy at 80% or higher	<input type="checkbox"/>	<input type="checkbox"/>
Standard Met	<input type="checkbox"/>	<input type="checkbox"/>

Observational Notes:

Areas of Concern:

Date: _____

Hospital Name: _____

Validator: _____

**MAINE QUALITY FORUM SAFETY STAR PROGRAM
VALIDATION FORM**

Practice: 21. Risk-based Prevention of Surgical Site Infection

Validation Checklist	Yes	No
Evidence of protocol for surgical site infection prevention	<input type="checkbox"/>	<input type="checkbox"/>
Evidence of reporting of compliance to Maine Health Data Organization	<input type="checkbox"/>	<input type="checkbox"/>
Standard Met	<input type="checkbox"/>	<input type="checkbox"/>

Observational Notes:

Areas of Concern:

Date: _____

Hospital Name: _____

Validator: _____

**MAINE QUALITY FORUM SAFETY STAR PROGRAM
VALIDATION FORM**

Practice: 22. Risk-based Prevention of Kidney Injury From X-Ray Dye

Validation Checklist	Yes	No
Presence of written policy	<input type="checkbox"/>	<input type="checkbox"/>
Evidence of semi-annual compliance audit	<input type="checkbox"/>	<input type="checkbox"/>
Audits show compliance with policy at 80% or higher	<input type="checkbox"/>	<input type="checkbox"/>
Standard Met	<input type="checkbox"/>	<input type="checkbox"/>

Observational Notes:

Areas of Concern:

Date: _____

Hospital Name: _____

Validator: _____

**MAINE QUALITY FORUM SAFETY STAR PROGRAM
VALIDATION FORM**

Practice: 23. Continuous Risk Assessment and Prevention of Malnutrition

Validation Checklist	Yes	No
Malnutrition screening and treatment plan protocol is in place	<input type="checkbox"/>	<input type="checkbox"/>
Evidence of semi-annual compliance audit	<input type="checkbox"/>	<input type="checkbox"/>
Audit shows compliance with policy at an internally established, reasonable level (x %)	<input type="checkbox"/>	<input type="checkbox"/>
Evidence of malnutrition screening and treatment plan follow through found in x % of 30 randomly selected patient records	<input type="checkbox"/>	<input type="checkbox"/>
Standard Met	<input type="checkbox"/>	<input type="checkbox"/>

Observational Notes:

Areas of Concern:

Date: _____

Hospital Name: _____

Validator: _____

**MAINE QUALITY FORUM SAFETY STAR PROGRAM
VALIDATION FORM**

Practice: 25. Prevent Person-to-Person Transmission of Infection

Validation Checklist	Yes	No
Presence of written policy that includes the measuring and reporting of progress	<input type="checkbox"/>	<input type="checkbox"/>
Evidence of periodic assessments	<input type="checkbox"/>	<input type="checkbox"/>
Evidence of responses to measurements	<input type="checkbox"/>	<input type="checkbox"/>
Evidence that goals for achievement are set	<input type="checkbox"/>	<input type="checkbox"/>
Standard Met	<input type="checkbox"/>	<input type="checkbox"/>

Observational Notes:

Areas of Concern:

Date: _____

Hospital Name: _____

Validator: _____

**MAINE QUALITY FORUM SAFETY STAR PROGRAM
VALIDATION FORM**

Practice: 26. Influenza Vaccination of Healthcare Workers

Validation Checklist	Yes	No
Influenza vaccination protocol for healthcare workers is in place	<input type="checkbox"/>	<input type="checkbox"/>
Documentation of healthcare workers who have and have not been vaccinated	<input type="checkbox"/>	<input type="checkbox"/>
Evidence that at least 80% of healthcare workers who have agreed to vaccination have received it	<input type="checkbox"/>	<input type="checkbox"/>
Standard Met	<input type="checkbox"/>	<input type="checkbox"/>

Observational Notes:

Areas of Concern:

Date: _____

Hospital Name: _____

Validator: _____

**MAINE QUALITY FORUM SAFETY STAR PROGRAM
VALIDATION FORM**

Practice: 27. Appropriate Workplace for Medication Preparation and Dispensing

Validation Checklist	Yes	No
Med rooms are observed to be clean, orderly, well-lit and quiet	<input type="checkbox"/>	<input type="checkbox"/>
Evidence of monthly (or more frequent) documentation of med rooms	<input type="checkbox"/>	<input type="checkbox"/>
Evidence of med room problem documentation, action plan and follow-up that resolves the issue prior to the next regular check.	<input type="checkbox"/>	<input type="checkbox"/>
Standard Met	<input type="checkbox"/>	<input type="checkbox"/>

Observational Notes:

Areas of Concern:

Date: _____

Hospital Name: _____

Validator: _____

**MAINE QUALITY FORUM SAFETY STAR PROGRAM
VALIDATION FORM**

Practice: 29. Identification and Appropriate Use of "High Alert" Drugs

Validation Checklist	Yes	No
Evidence of protocol for identification and appropriate use of high alert drugs	<input type="checkbox"/>	<input type="checkbox"/>
Presence of list of high alert drugs	<input type="checkbox"/>	<input type="checkbox"/>
Evidence of compliance audit	<input type="checkbox"/>	<input type="checkbox"/>
Audits show full compliance with protocol	<input type="checkbox"/>	<input type="checkbox"/>
High alert drug list has no obvious, unexplainable omissions	<input type="checkbox"/>	<input type="checkbox"/>
High alert drug identification is observed	<input type="checkbox"/>	<input type="checkbox"/>
Standard Met	<input type="checkbox"/>	<input type="checkbox"/>

Observational Notes:

Areas of Concern:

Date: _____

Hospital Name: _____

Validator: _____

Appendix F: Safety Star Site Visit Report Form



MAINE QUALITY FORUM SAFETY STAR PROGRAM SITE VISIT REPORT

Part A: Executive Summary

Date:

Recommend Safety Star Award: Y N

Site Visit Team Summary Statement:

Practice Recommended for State-Wide Dissemination:

Specific Deficiencies:

Recommendations for Remediation:

Site Visit Team Members:

Part B: Validation Forms: Please attach the Site Visit Team's Validation Forms here.

Appendix G: Travel Expense Form

