DRAFT - Quality Improvement Assessment Questions
Vein Center: Ambulatory Phlebectomy

Answer the questions below by reviewing the medical records for a given procedure. It is recommended that any discrepancies noted in the assessment be reviewed and shared with all pertinent staff members. The assessment is provided to assist the facility in furthering its ongoing Quality Improvement (QI) process.

For the purposes of Quality Improvement (QI), annual medical record self-assessment must be sufficient to ensure the achievement of continuous actions that lead to measurable improvement in the procedures performed in the facility. To attain maximum benefit to the facility no less than 5% of the annual volume must be reviewed. However, for facilities with lower procedure volumes, 30 cases must be reviewed.

Note: Although the case may be in compliance with the IAC Standards based on your assessment, there may be opportunity for improvement.

I. Procedure appropriateness

Did the clinical data support the decision to perform the procedure?  ○ Yes  ○ Cannot determine; need more information

Comments:

II. Technical performance of the procedure

1. Was the procedure completed as expected?  ○ Yes  ○ No

Part C, 2.1.2.1C

2. If the procedure was not completed as expected was the failure to perform the procedure clearly documented?  ○ Yes  ○ No  ○ N/A

Part C, 2.1.2.2C

3. Was venous mapping performed and documented prior to the start of the procedure?  ○ Yes  ○ No  ○ N/A

Part B, 1.7.1.5B

Comments:

III. Patient safety

1. Was the time out procedure documented to confirm correct patient identification?  ○ Yes  ○ No

Part B, 1.3.1.2B

2. Was the appropriate pharmacologic and anesthetic agent name, dosage, concentration and amount used documented?  ○ Yes  ○ No

Part B, 1.7.1.3B

3. Were any patient safety adverse events documented?  ○ Yes  ○ No  ○ N/A

Comments:

IV. Medical records completeness and timeliness

1. Was a complete clinical evaluation performed and documented prior to being considered for treatment?  ○ Yes  ○ No

Part B, 1.2.1.1B

2. Was a complete diagnostic venous duplex exam for reflux completed prior to the procedure?  ○ Yes  ○ No  ○ N/A

Part B, 1.2.1.1B
3. Was a procedure specific informed consent form signed and dated by the patient and the physician prior to the procedure? [Part B, 1.3.1.1.B]
   - Yes
   - No

   - Yes
   - No

5. Was the use of ultrasound guidance documented? [Part B, 1.7.3.1Bi]
   - Yes
   - No
   - N/A

6. Were the location of the varicosities documented? [Part B, 1.7.3.1Bii]
   - Yes
   - No

7. Were the number of incisions/stabs documented? [Part B, 1.7.3.1Biii]
   - Yes
   - No

8. Were post procedure instructions given to the patient? [Part B, 1.5.1B]
   - Yes
   - No

9. Were all the patient records completed and signed within two weeks of the date of the procedure? [Part C, 2.1.4.1C]
   - Yes
   - No

   Could the medical record completeness and timeliness for this case have been improved?
   - Yes
   - No

Comments:

<table>
<thead>
<tr>
<th>V. Procedure Outcomes</th>
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<tbody>
<tr>
<td>1. Was hemostatic compression documented post procedure? [Part B, 1.7.2.1B]</td>
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| - Yes
| - No |

| 2. Did this patient have any complications/adverse events reported before, during or after the procedure prior to discharge? [Part B, 1.4.1.2B] |
| - Yes
| - No |

| 3. Was a follow-up note included in the medical record? |
| - Yes
| - No |

| 4. Were any complications/adverse events reported within 30 days post-procedure? [Part B, 1.5.2B] |
| - Yes
| - No |

Comments: