1. Each group must first select the measures they wish to collect at www.abgreporting.com.
2. Once measure selection has been completed, refer to the table below for the list of observations that must be collected for each of your selected measures.
3. To report observations, use the database ID#s shown below and make the appropriate entries in the upload spreadsheet. See footnote below for instructions on observation entry procedure.
4. ABG collects some observations by phase (OR, PACU, Postop). The phase refers to when the observation is made, NOT when the event occurred.
5. Database ID#s below 1000 should be placed in the Event ID#s columns. Database ID#s above 1000 should be placed in the Measure Event#s column.

Go to Database ID#s

ABG QCDR MEASURES LIST 2016

ABG Measure #	Measure Title	Measure Desription	Required Observation(s)	Observation Subcategories (if any)	Definitions	Database ID#*	Measure Responses Required	NQS Domain
1	Intra-operative anesthesia safety	Percentage of patients with no significant anesthesia adverse events in the operating room/procedure room.	No Serious Observations		Selecting this item certifies that no serious observations occurred.	1	None	Effective Clinical Care
			Other serious observation not listed elsewhere		Observation other than nausea or vomiting.	33		
2	Intra-operative Cardiac Arrest Rate	The rate of unplanned cardiac arrest requiring CPR and/or defibrillation for all patients in the operating room/procedure room who have anesthesia.	Cardiac Arrest (w CPR)		Any alteration in cardiac activity requiring CPR and/or unplanned defibrillation within the first 24 hours after the completion of an anesthetic.	14	None	Patient Safety
3	Intra-operative Mortality Rate	The mortality rate for all patients in the operating room/procedure room who have anesthesia.	Death		Death within 24 hours after completion of anesthesia/ in-hospital death.	32	ASA PS 6?	Patient Safety
4	PACU tracheal intubation Rate	The rate of tracheal intubation in the PACU for all patients who have anesthesia in the operating room/procedure room.	Tracheal intubation in PACU		Any patient who requires tracheal intubation in the PACU after receiving anesthesia.	8	None	Patient Safety
5	Composite Procedural Safety for All Vascular Access Procedures	Percentage of adults under anesthesia care in the operating room/procedure room who experience a serious injury from an attempt at securing vascular access of any type (arterial, central venous, peripheral venous) that is recognized in the operating room procedure room.	Pneumothorax	After perithoracic vascular procedure	A new onset of a pneumothorax in the periopertive period following anesthetically performed perithoracic vascular procedures.	73	None	Patient Safety
			Other Vascular Access Event		An event arising from an attempt at securing vascular access (arterial, central venous, or peripheral venous) requiring intervention (not including pneumothorax- For pneumothorax, please use "Pneumothorax after perithoracic vascular procedure").	19		
6	Rate of Unplanned Use of Difficult Airway Equipment and/or Failed Airway	For all patients on whom difficult airway equipment is used in the operating room/procedure room, the rate with which it is used unexpectedly, or a failed airway is encountered	Use of difficult airway equipment	Unspecified	Use of difficult airway equipment- reason not specified.	3	Dificult Airway Equipment Used?	Effective Clinical Care
			Use of difficult airway equipment	Planned	Difficult airway equipment is brought to the room before it is needed and used for any reason (difficult airway, educational, cervical spine instability, etc).	36		
16	Planned use of difficult airway equipment	For all patients on whom difficult airway equipment is used in the operating room/procedure room, the rate with which it's use is planned ahead of time for either therapeutic or educational purposes.	Use of difficult airway equipment	Unplanned	Difficult airway equipment is brought to the room after induction and used when difficult airway is encountered unexpectedly.	37		
			Use of difficult airway equipment	**Unable to intubate**	Unable to achieve translaryngeal tracheal intubation.	4		
			Use of difficult airway equipment	Surgical airway required	Res ipsa loquitur.	38		
7	Immediate Adult Post-Operative Pain Management	The percentage of patients 18 or older admitted to the PACU after an anesthetic with a maximum pain score <7/10 within 15 minutes of arrival.	Pain score 0-6 on arrival to PACU		Using 0-10 scale, measured within 15 minutes of arrival.	1001	Pain Score on arrival to PACU	Person and Caregiver-Centered Experience and Outcomes
			Pain score 7-10 on arrival to PACU		Using 0-10 scale, measured within 15 minutes of arrival.	1002		
			Patient unable to report pain score on arrival to PACU			1003		
			Patient not transferred to PACU			1017		
8	Use of Checklist or Protocol for Transfer of Care in Phase I recovery From Anesthesia Provider to PACU or ICU	Percentage of patients, regardless of age, who are under the care of an anesthesia practitioner and in phase one recovery, in which a checklist or protocol is used to handoff care to non-anesthesia providers.	Checklist/Protocol used for transfer to non-anesthesia provider			1004	Checklist/Protocol Used?	Communication and Care Coordination
			Checklist/Protocol NOT used for transfer to non-anesthesia provider			1005		
9	OR Fire	Number of anesthetic cases in an operating room/procedure room in which there is an OR fire of any type (excluding airway fires) regardless of whether patient is injured.	OR fire/burn	Unspecified	Fire in OR, location not specified.	50	None	Patient Safety
			OR fire/burn	Surface burn	Any fire on patient surface.	51		
			OR fire/burn	OR fire	Fire in OR, not contacting patient.	53		
22	Intraoperative Airway Fire	Number of patients that have a fire in their airway in the operating room/procedure room.	OR fire/burn	Airway fire	Any fire in patient airway.	52		
10	Day of Surgery Case Cancellation Rate	Percentage of patients who have a scheduled surgical case cancelled on the day of surgery for any reason	Case Cancelled Day of Surgery	Unspecified	A procedure/surgery that is cancelled on the day of surgery, reason unspecified.	2	None	Efficiency and Cost Reduction
			Case Cancelled Day of Surgery	System Reasons	Case cancelled on day of surgery due to system reasons such as surgeon unavailable/previous long case, equipment not available, etc.	63		
			Case Cancelled Day of Surgery	Medical Reasons	Case cancelled on day of surgery due to medical or surgical factor, such as surgery no longer indicated or patient illness.	64		
			Case Cancelled Day of Surgery	Patient Reasons	Case cancelled on day of surgery due to patient failure to follow directions or other economic, social, or religious reasons.	65		

11	Anaphylaxis During Anesthesia Care in the Operating Room	Rate of severe hypersensitivity reactions among all patients who have anesthesia that is recognized in the operating room/procedure room.	Anaphylaxis		Immediate sensitivity response after exposure to specific antigen; results in life-threatening respiratory distress; usually followed by vascular collapse, shock, urticaria, angioedema and pruritus.	79	None	Patient Safety
12	Anesthesia: Patient Experience Survey	Percentage of patients who are provided with a patient survey to provide feedback about their anesthesia experience	Patient survey provided			1006	Patient Survey Provided?	Person and Caregiver-Centered Experience and Outcomes
			Patient survey NOT provided			1007		
			Patient/Parent unable to complete survey			1008		
13	Malignant Hyperthermia	Number of patients receiveing general anesthesia who experience a suspected malignant hyperthermia episode in the operating room/procedure room or PACU requiring treatment with Dantrolene.	Malignant Hyperthermia		Suspected MH following induction of general anesthesia requiring treatment with Dantrolene.	78	General Anesthesia?	Patient Safety
14	Corneal Abrasion	Percentage of patients having an anesthetic in the operating room/procedure room who experience any ocular surface injury requiring evaluation, follow up, or treatment prior to discharge from PACU	Corneal Abrasion		Any ocular surface injury requiring evaluation, follow up, or treatment.	80	None	Patient Safety
15	Dental Injury	Percentage of patients who have general anesthesia and have an unintended change in dental status that is identified prior to PACU discharge	Dental injury		Unintended change in the patient's perioperative dental status.	6	General Anesthesia?	Patient Safety
17	Medication errors during surgery	Percentage of anesthesia cases in which a wrong drug or dose is given in the operating room/procedure room.	Medication error		Wrong drug or dose given to the patient.	47	None	Patient Safety
18	Pre-operative Attestation of documentation of current medications in the medical record	Percentage of cases in which an anesthesia provider attests to reviewing the current medication list in the medical record preoperatively.	Preop medication review attested			1009	Preop Medication Review?	Communication and Care Coordination
			Preop medication review NOT attested			1010		
			Preop medication review omitted for medical or patient reasons			1011		
19	Unplanned hospital admission post-op, including 23 hr stay	Percentage of outpatients who have a procedure in the operating room/procedure room, and are admitted to the hospital from the PACU that were originally scheduled to go home	Unplanned Hospital Admission (and 23 hr stays)		Patient admitted to the hospital from the PACU that was originally scheduled to go home.	11	Patient Source Type?	Efficiency and Cost Reduction
20	Unplanned transfer ASC to hospital	Percentage of patients admitted to a hospital directly from an ambulatory care center	Unplanned ICU Admission		A patient admitted to the ICU within 24 hours of anesthesia care when the need for ICU care is determined after the induction of anesthesia.	10		
21	Pre-operative OSA assessment	Percentage of patients who undergo a procedure in the operating room/procedure room that have a pre-operative assessment for Obstructive Sleep Apnea (OSA)	Preoperative OSA assesment done			1014	OSA Assessment Done?	Effective Clinical Care
			Preoperative OSA assesment NOT done			1015		
			Medical reason for no preoperative OSA assesment			1016		
23	Intraoperative patient fall	Percentage of cases in which a fall occurs during patient care in the operating room/procedure room, ie during transfer from stretcher to OR table.	Patient Fall		Patient fall while under anesthesia care.	49	None	Patient Safety
24	Time out error-surgical	Percentage of cases in which an error occurs in the operating room/procedure room for surgical site, side, patient, procedure or implant	Time out error- surgical		Incorrect surgical site, side, patient, procedure, implant	55	None	Patient Safety
25	Time out error-regional block	Percentage of cases in which a error occurs during a regional block for side, site, patient or procedure. For blocks performed in preop, OR or PACU that are performed in association with a surgical case in the operating room/procedure room.	Time out error- regional block		Incorrect regional block site, side, patient, procedure	56	Regional block perfomed?	Patient Safety
26	Myocardial Ischemia requiring intervention during the operative period	Percentage of cases in the operating room/procedure room with a scenario felt to be indicative of myocardial ischemia requiring intervention after physician evaluation	Myocardial Ischemia req intervention		Any scenario felt to be indicative of myocardial ischemia that requires intervention after physician evaluation.	12	None	Patient Safety
27	Dysrhythmia requiring intervention during the operative period	Percentage of cases in the operating room/procedure room with an unexpected cardiac dysrhythmia that requires intervention other than anesthetics. Does not include beta blockade for HR<100.	Dysrhythmia requiring intervention		Arrhythmia that requires intervention with anti-arrhythmics other than anesthetics. Does not include beta blockade for cases for HR < 100.	62	None	Patient Safety

* Observations are reported by entering Database ID#s in Upload spreadsheets. Spreadsheet templates can be obtained on ABG reporting website. Database ID#s below 1000 should be reported in one of the EventID#s columns (based on phase of care item was collected in). Database ID#s above 1000 should be reported in MeasureEvent#s column. Multiple entries should be separated by commas. For users of QCDR app: QCDRapp makes all database entries automatically, so no upload of Database ID#s is necessary.