Outpatient Facility Standards
What is Necessary for Satisfactory Outcomes?

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KEYWORDS

• Patient safety • Standards composition and oversight • Educational training • Quality assurance • Inspectors • Facilities

KEY POINTS

- Patient safety is the mission of the American Association for Accreditation of Ambulatory Surgery Facilities, Inc (AAAASF).
- Well-crafted standards are at the foundation of attaining successful standards outcomes.
- Without expert inspection practices and administrative processes supporting these standards, they are powerless to protect patients.
- This 2 part approach is used by AAAASF to ensure 100% compliance of all surgical standards.

PART 1: SURGICAL ENVIRONMENT
Stratification of Facilities Based on Administered Anesthesia

Facilities are often classified on the level of the anesthetic care offered. One classification would stratify the facilities as: Class 1, Local, Regional and Topical Anesthesia; Class 2, Parenteral Sedation (not including propofol); Class 3, Parenteral Sedation Including Propofol; and Class 4, General Anesthesia. In the case of Class 3 and Class 4, an anesthesiologist or certified registered nurse anesthetist (CRNA) would be required to administer the anesthetic.

In Class 2, a qualified physician could supervise the administration of a parenteral sedation.[1]

Operating Suite (Physical Plant)

An operating suite should include an operating room (OR), scrub area, clean area, dirty area, and a recovery room. The operating suite needs to be physically separate from the general office.

The OR should be a separate and distinct area in the suite, dedicated specifically for surgical use. All major surgery is to be performed in the OR. To maintain the sterile atmosphere, unauthorized individuals should be deterred from entering the OR. The OR should be adequately ventilated and temperature controlled for safety reasons. Hypothermia is known to increase risk of arrhythmias and infection.

The available square footage in the OR must be adequate to hold all of the personnel, equipment, sterile supplies, and medications necessary to perform the surgical procedure. It should be sufficient to accommodate emergency situations and the personnel necessary to evacuate a patient in the case of an unforeseen event. Efficiency and sterility dictate that personnel leaving the operating room to obtain supplies should be kept to a minimum, and that the storage space in the OR should allow for easy identification and inventory of the supplies.

Surfaces in the OR, such as the countertops, ceiling surface, and floors, should be smooth, easily washable, and free of particular material that might cause contamination. There must not be any tears, breaks, or cracks in these surfaces that could

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harbor bacteria. Any seams should be sealed with an impermeable sealant other than silicone.

The recovery-area space allocated in the suite should be sufficient to accommodate the necessary personnel, equipment, and monitoring devices necessary for a safe recovery. This area needs to be stocked with readily accessible equipment and medications for routine recoveries, as well as emergencies. Similar to the OR, the postanesthesia care unit (PACU) should be easy to clean and free from fire hazards. Space available for sterilizing instruments should be segregated into a dirty area where contaminated instruments are cleaned, and a clean area for packaging and sterilization. Separation between dirty and clean areas may be accomplished by a wall, distance, or time. The same area may be used for both purposes if, and only if, it is the documented policy of the facility to clean and disinfect the dirty utility area before assembly of packages for sterilization occurs.

Fire in an operating suite can be disastrous. Proper preparation and avoidance of problems may mitigate the devastating effects including injury and loss of life. The facility must be equipped with heat sensors and/or smoke detectors and an adequate number of appropriately placed fire extinguishers that are inspected annually. Fire-exit signs are posted and adequate emergency lighting is available. A smoke-filled room can become dark very quickly, and appropriate lighting is critical. All safety regulations of the Occupational Safety and Health Administration (OSHA) should be followed to help decrease the risk of fire. Appropriate fire precautions must be in place when using a cautery or a laser during the administration of oxygen.

Fire safety mandates that the operating suite contain sufficient number of electrical outlets that are labeled and grounded. There must be a source of emergency power, such as a generator or battery-powered inverter, with the capacity to operate anesthesia, surgical equipment, and lighting for an amount of time that is consistent with procedures performed. The generated power should be available seamlessly within 30 seconds of the power failure. Pertinent safeguards require that essential equipment should be connected to the emergency power source during surgery and recovery, thus preventing a situation whereby personnel are frantically looking for backup power outlets during an outage or, worse, in a smoke-filled room. The backup power equipment should be checked on a monthly basis and a log kept of the checks.

Equipment

Boxes 1–3 list the basic equipment that should be contained in the operating room and PACU. The equipment requirement may vary somewhat depending on the type of anesthesia administered in the facility.

Box 1
Operating room equipment

1. Adequate washable operating room table or chair
2. Adequate ceiling lighting
3. Electrocardiography monitor with pulse read-out
4. Pulse oximeter
5. Blood pressure monitoring equipment
6. Standard defibrillator, or an automated external defibrillator unit
7. Sequential compressive devices
8. Electrocautery with a grounding plate or disposable pad

The specifications, that is, the manufacturer's recommendations for the equipment's operation, maintenance, and cleaning, should be kept in an organized file available to all staff. Safety standards demand that only inspected equipment is permitted to be used in the suite. All equipment should be inspected at least annually by a biomedical technician. Detailed records of the equipment inspections should be kept. Some equipment, such as sterilizers, should be checked weekly with spore tests or an equivalent, and the records maintained. Automated external defibrillators and

Box 2
Anesthesia equipment

1. Laryngoscope
2. Appropriately sized oral airways, nasopharyngeal airways, and laryngeal mask airways
3. Endotracheal tubes
4. Endotracheal stylet
5. Positive pressure ventilation device (eg, Ambu bag)
6. Source of O_2
7. Source of suction
8. CO_2 monitor
9. Anesthesia machine
    i. Mechanical ventilator with disconnect device
    ii. Purge system
    iii. Inspired gas oxygen monitor

Box 3
Recovery room equipment

1. A reliable source and amount of oxygen, regulators, tubing, and masks
2. Adequate and reliable source of suction
3. Self-inflating (Ambu) bags, capable of delivering positive pressure ventilation with at least 90% oxygen concentration
4. Adequate illumination for patients, machines, and monitoring equipment
5. Sufficient available electrical outlets, labeled and grounded to suit the equipment and connected to emergency power supplies where appropriate
6. Emergency cart available with defibrillator, necessary drugs, and other cardiopulmonary resuscitation equipment
7. Separate pulse oximeter available for each patient

defibrillators should also be checked weekly and a performance log kept. Any repairs should be performed and documented by a biomedical technician.

Instrument Sterilization

The facility is required to have at least one autoclave that uses high-pressure steam. A gas sterilizer is an acceptable addition, and must be vented properly. High-level disinfectants, such as Cidex, may only be used for nonautoclavable equipment by which contact will be made with mucous membranes or other body surfaces that are not sterile. Protocols for proper handling and sterilization of equipment should be present in the Policy and Procedure manual (for an example of a high-level disinfection protocol, see **Box 4**).[2] If the sterilizer produces monitoring records, they should be logged. If no monitoring record is produced, best practices may include production of a sterilizing log noting each load that is sterilized by whom, the date, the cycle that it was sterilized on, and so forth.

Storage of sterile supplies should be away from potentially contaminated areas; sterile packages should be labeled to indicate date of sterilization and, if necessary, when the sterility should expire. Sterile supplies should be packaged and sealed to prevent accidental opening and, if more than 1 sterilizer is available in the facility, the package should be labeled as to which sterilizer was used, in the case of a positive spore test. Sterile and clean supplies should not be stored in the same space. Sterile packages should not be stored above a steam autoclave, to prevent contamination.

Box 4
Processing an endoscope

- The location of the manual rinsing and cleaning of endoscopes before high-level disinfection may be performed in the procedure room away from the patient
- Specific steps must be in place to minimize spraying and aerosolizing of the bio-burden
- Processing of the scopes must be in the location that meets requisite standards of air exchange ratios and vapor particle standards
- Necessary protective equipment for personnel must be available
- Scope-cleaning functions should be limited to properly trained personnel
- If there is not a separate room (see previous standard) being used for processing of the scopes, the protocol must include steps directing that the contaminated equipment will be cleaned and placed in the reprocessor before bringing the next patient into the room. In addition, the clean scope coming out of the reprocessor is to be removed only when the room is clean and free of dirty instruments
- Cross-contamination should be avoided no matter where cleaning and processing takes place. There must always be some distinct type of separation of clean and dirty areas in any location
- Clean (reprocessed) endoscopes should be stored in a closed cabinet exclusively dedicated to scope storage, to avoid contamination before use
- High-level disinfection is used only for nonautoclavable endoscopic equipment, and in areas that are categorized as semicritical where contact will be made with mucous membrane or other body surfaces that are not sterile
- At all times the manufacturer's recommendations for use should be followed

Cleaning the Facility

The entire operating suite should be cleaned and disinfected according to an established schedule created specifically to prevent cross-contamination. Blood and body-fluid spills are cleaned using an intermediate-level disinfectant (sporicidal, bactericidal, fungicidal, and virucidal).

If the cleaning personnel are not part of the staff, they should sign a HIPAA (Health Insurance Portability and Accountability Act 1996) compliant confidentiality agreement in the event that any patient information is visible.

Medical wastes are stored in OSHA-acceptable containers and separated for special collection. Disposable sharps are kept in a puncture-resistant container close to the area where they are used. Finally, all garments, scrub suits, linen, blankets, and so forth do not leave the facility to be washed at home, but are cleaned by an OSHA-compliant laundry; or, if the laundry is processed on premises, a protocol geared to rid the laundry of pathogens is followed.

Medication, Intravenous Fluids, Gases

All medications present must be in date and readily identifiable. It is critical that all personnel know the location of medications, especially emergency medications. An emergency cart with a defibrillator, necessary drugs, other cardiopulmonary resuscitation equipment (such as a source of suction and intravenous setup), and the Advanced Cardiopulmonary Life Support (ACLS) algorithms resides in the suite.

All controlled substances are to be secured and locked under supervised access. A bound or secured-computer narcotic inventory and control record is required. This record must be dated and include the patient's name or ID number, and be verified by 2 licensed members of the OR team at least weekly as well as on the day any of these agents are administered.

It is required that intravenous fluid is present in every facility, even if just local or topical anesthetics are used. If the facility presents an unusual situation in having a means to obtain and administer, there must be a protocol for the blood to be typed, cross-matched, checked, and verified. Dextran, a blood substitute, should be present in the facility, or the facility should have a means of obtaining it on a timely basis.

If potential triggering agents are present in the facility, an appropriate malignant hyperthermia emergency protocol and setup must be available. Even if succinylcholine is present and is only to be used in dire circumstances such as for bronchospasm, this setup is required. An alternative to the drug of choice (succinylcholine) is the nondepolarizing and nontriggering agent, rocuronium.

A reliable source and amount of oxygen should be present, and must include a regulator as well as the tubing and mask. Other essential equipment for a facility that would be Class 2 or greater (see later discussion) would include a laryngeal mask airway or endotracheal tube necessary to deliver the oxygen. A self-inflating Ambu bag capable of delivering positive pressure ventilation with 90% oxygen concentration, and a separate pulse oximeter for each patient, are essential.

All explosive and combustible materials are stored and handled in a safe manner according to state, local, and/or National Fire Protection Association codes. Compressed-gas cylinders should be chained to the wall or placed in an appropriate carrier.

OR Suite Staff: Medical Director, Practitioners, Personnel

A Medical Director, specifically a physician (MD or DO), is a necessity. The Medical Director must actively participate in the management of the facility. The Medical Director must be currently licensed in the state where the facility is located. The team should include a nurse and anesthesiologist or CRNA when dissociative anesthesia, intravenous sedation with propofol, or general anesthesia is performed. Determining who is appropriately credentialed and qualified to perform procedures in the facility is an arduous task, as any physician who has obtained hospital privileges can attest. The required steps are practically impossible for a smaller facility to accomplish. Each facility cannot have its own criteria for credentialing. One solution to the credentialing dilemma is to require the practitioner be credentialed by an acute care hospital for privileges consistent with privileges requested of the facility.

In addition, following the American Medical Association core principle #7, it is essential that every individual who performs procedures in the facility needs to be "…currently board certified/qualified by one of the boards recognized by the American Board of Medical specialties, American Osteopathic Association, or a board with equivalent standards approved by the state medical board."[3] The procedures that the practitioner performs must be "generally recognized by that certifying board as falling within the scope of training and practice of the physician providing the care."[3] Appropriate board certification of podiatrists or oral surgeons must also be required.

The proof of acceptable credentials is evidenced by the practitioner's demonstration that he or she holds or has held unrestricted core privileges in his or her specialty at a licensed care hospital. The loss of hospital privileges may not be caused by a lack of clinical competence, ethical issues, and so forth; rather, the only acceptable reason for the loss of hospital privileges is economic credentialing by the care facility. If the

practitioner has not maintained privileges, arrangements must be in place assuring that another practitioner of the same specialty with privileges at the local acute care hospital will assume care of the patient in the event of unforeseen hospital transfer of the patient.

Continued maintenance of privileges requires that each physician, podiatrist, or oral and maxillofacial surgeon submits to the facility a copy of his or her current appropriate state license. Any actions affecting the practitioner, Medical Director, or any other member of the team must be reported to the governing body within a reasonable specified time period.

The personnel who work in the OR suite must meet acceptable standards as defined by their professional governing bodies, where applicable. Every employee should have a file that contains documentation (as outlined in **Box 5**). Be aware that according to OSHA regulations, these files should be kept for 30 years. There should be a written manual containing job descriptions, confidentiality policies, vacation policies, payment procedures, and so forth. Every employee should become familiar with the policies contained in this manual.

There is a regularly employed and licensed registered nurse, physician (other than the operating surgeon), or physician's assistant designated as the person responsible for patient care in all areas of the suite. All operating suite personnel are under the immediate supervision of this individual.

The OR personnel must be knowledgable in treating cardiopulmonary and anaphylactic emergencies. The OR personnel are familiar with operation and location of equipment, medication, and procedures used in the treatment of such emergencies. At least one member of the OR team, preferably the surgeon or the anesthesia provider, must hold current ACLS certification. Everyone else should possess at least a current Basic Cardiopulmonary Life Support certification (see **Box 4**).

The safety of all OR suite personnel is essential. There is a written policy for personal protective equipment for specific tasks in the facility such as instrument cleaning, disposal of biological waste, and surgery. Badge testing is required if a gas sterilizer, x-ray equipment, or high-level disinfectant is used in the facility. A Facility Safety Manual should provide employees with information about hazardous chemicals used and methods to minimize exposure to them. Material safety data sheets on all potentially hazardous substances found in the facility should be located in this manual.

Box 5
Required personnel documentation

- Personnel records should contain:
  - Resumé of training and experience
  - Current certification or license if required by the state
  - Date of employment
  - Description of duties
  - Record of continuing education
  - Inoculations or refusals
- Proof of training:
  - Hazard safety training
  - Blood-borne pathogens
  - Universal precautions
  - Other safety training such as operation of a fire extinguisher
  - At least Basic Cardiopulmonary Life Support certification, or Advanced Cardiac Life Support (ACLS)
  - ACLS for one member in each operating room and recovery room team is required

Anesthesia: Anesthesiologist/CRNA

In facilities where dissociative anesthesia with propofol, spinal or epidural blocks, or general anesthesia is administered, an anesthesiologist or CRNA must provide the anesthetic care. These individuals must be qualified for such patient care, their credentials verified, and the documentation kept on file. These persons must be responsible for the monitoring of all life-support systems and ensure that all anesthesia equipment is in proper working order.

If responsible for supervising anesthesia or providing anesthesia, the qualified physician or CRNA must be present in the operating suite throughout the anesthetic. If sedation is being supervised by the operating surgeon, he or she must have knowledge of anesthetics and resuscitative techniques. Podiatrists and oral surgeons must use an anesthesiologist or a supervising physician to administer anesthesia other than local.

A physician is responsible for determining the medical status of the patient, and must examine the patient immediately before surgery. The anesthesia care provider must verify that an anesthesia care plan has been developed and documented. The patient must be informed of such a plan and receive preoperative instruction by the anesthesia provider supervising the anesthetic.

During the procedure, besides administering medication the individual responsible for the anesthetic care should monitor and record the patient's vital signs on a frequent basis. Appropriate fluids should be administered, oxygenation maintained, and temperature monitored, especially if clinically significant changes in body temperature are expected. Forced air warmers, blanket warmers, or other devices should be used to maintain patient temperature. Sequential compression devices should be used for cases other than local anesthesia and of longer duration.

Anesthesia personnel should be familiar with the facility's emergency protocol for cardiopulmonary emergencies and other internal and external disasters. These individuals should be trained and knowledgable about the facility's protocols for safe and timely transfer of a patient to an alternative care facility when extended or emergency services are required.

Protocols, Policies, and Procedures

PACU

After the procedure is completed the patient is transferred to the PACU, where he or she will recover from the anesthetic. During this monitored trip the patient needs to be accompanied by a member of the anesthesia team who is knowledgable about the patient's condition. It will be necessary for the accompanying staff to provide the necessary information to the PACU personnel. The patient is evaluated in the PACU, and vital functions are supported as needed until the patient stabilizes. Initially, recovery room staff must evaluate the patient and record a set of vital signs. Observation and monitoring in the PACU must be by methods appropriate to the patient's condition and include ventilation, circulation, temperature, and mentation. A physician, CRNA, physician assistant, or registered nurse should directly supervise the recovery room care. The responsible individual must be currently licensed by the appropriate state, certified in ACLS, and immediately available until the patient has left the PACU.

The course of events in the PACU, similar to that in the OR, needs to be documented, starting with the patient's time of arrival. The recovery-room record should reflect the recovery course with entries of medications given to the patient, nursing notes, vital signs, and fluid administration.

For discharge from the PACU to occur, approved and standardized criteria need to be met. The determination that discharge criteria have been achieved must be performed and documented by a physician, based on input from the PACU personnel. Written instructions including procedures for emergency situations must be given to an adult who is responsible for the patient's care and transportation and to the patient. Personnel will assist in discharging the patient from the PACU, accomplished by wheelchair or gurney as needed.

Other policies and protocols

Plans of action should be in place for the following: cardiopulmonary resuscitation; malignant hyperthermia; security emergencies such as an intruder in the facility; an unruly patient or visitor; a threat to the staff or patients; fire; unplanned return to the operating room; a surgeon, anesthesiologist, or CRNA becoming incapacitated; and power-failure emergencies. Best practices would also include a deep vein thrombosis/emboli protocol.

Drills

The purpose of a drill is to convert a set of actions into a coherent plan that is practiced, so that when and if an emergent or threatening event occurs appropriate action ensues, rather than chaos. The tasks required should be detailed with regard to the specific action required, how to accomplish the task, and which team member should be assigned to perform the task. Drills should include, but not be limited to, fire drills, emergency evacuation of the facility, and malignant hyperthermia and cardiopulmonary resuscitation.

Patient's bill of rights

A copy of the patient's rights is prominently displayed, or a copy is provided to each patient. It is important that the Bill of Rights is adhered to by all facility personnel.

Documentation: Medical Records

Medical records are to be kept in the facility. The record should include an intake sheet completed by the patient providing most of his or her medical history and demographics. A history and physical examination commensurate with the procedure to be performed, a preoperative anesthesia evaluation with an anesthesia care plan, and informed consent should be contained in the chart. All laboratory results must be present and reviewed. The review should be initialed and dated by the surgeon at the time of evaluation. All other reports, such as pathology reports and medical clearance reports, must be reviewed and initialed. A written operative report, anesthesia record, and recovery record should be present. Best practice would also include an OR record. Finally, postoperative notes should be present.

Quality Assessment and Quality Improvement

The facility has a written quality improvement program in place, which should include surveys of projects that monitor and evaluate patient care, evaluate methods to improve patient care, identify and correct deficiencies within the facility, and alert the Medical Director to identify and resolve problems. To monitor performance, a review of a set number of random cases and any operative sequelae occurring within 30 days of the surgery should be performed on a regular basis. Peer review must be conducted by a recognized peer-review organization or a physician, podiatrist, or oral and maxillofacial surgeon other than the operating surgeon.

Each Unanticipated Operative Sequelae chart review must include the following information, in addition to the operation performed: identification of the problem, immediate treatment or disposition of the case, outcome, reason for problem, and assessment of efficacy of treatment.

PART 2: MAINTENANCE AND OVERSIGHT

Maintenance of Standards

The first part of this article describes the necessary components of the surgical environment required to produce safe outcomes. The mechanism of regulating such environmental necessities is best accomplished by the generation of a set of standards that precisely and concisely describe these requirements. Compliance with these standards engenders safety, and the facility's sustained adherence to the requirements is essential to continued success. In addition, following these standards must allow for the creation of a facility that has the potential for safe outcomes.

Accrediting Organization

To ensure the provision, implementation, and maintenance of the standard, an independent organization is required, whose purpose is to provide accreditation to facilities that are in compliance. The test for compliance is an inspection. The methods used to implement standards should be predominantly educational.

The accrediting organization should have a national recognized presence and reputation for excellence in medical and surgical standards, along with the substantial, dedicated resources to support the necessary high level of service and trained management for the standards programs. A well-trained accreditation staff must be available to process the application and inspection phases of new and renewed facilities. In addition, systems and equipment must be upgraded and ready to store mandatory accreditation documents for annual reference by accreditation staff. Inquiries from state medical boards, national regulatory organizations, and law firms require the ability to provide expedited and accurate responses from the accreditation staff concerning accredited facilities.

Oversight of all of the processes and final decisions ultimately resides with the Board of Directors. This board comprises surgeons, anesthesiologists, CRNAs, nurses, and public members.

Standards

To be functional, there are many characteristics that the standards should possess. Standards must be clear and concise. Every individual reading the standard should derive the same meaning or intent from the standard. There should not be any room for interpretation. Each standard should be objective. To alleviate subjectivity requires that each standard should have "yes" or "no" answers with respect to compliance. Every standard should be specific, addressing a single attribute of the environment.

A committee of individuals who possess significant awareness of surgical processes should be charged to provide the standards' content. The composition of this body should be predominantly surgical clinicians. This committee should meet regularly to review all standards in a rotational framework to ensure all medical standards have received supervision to stay current with clinical standards of practice, equipment, medication improvements, and safety.

Input into the committee should come from many sources. Many of the standards require a perusal of other organizations that produce successful outcomes, such as hospitals. The object of outpatient care is to reduce the cumbersome or nonessential elements to provide a limited scope of care. The committee should work closely with regulatory organizations such as OSHA, the Centers for Disease Control and Prevention, HIPAA, the Association of Perioperative Registered Nurses, and other similar national authorities, along with medical specialty associations, to stay current on new procedures, updates in standards of practice, and alerts on patient safety.

The Inspection

The test for measuring a facility's compliance with the standards is the inspection. In the authors' experience, surgeons seem to make the best examiners. Of course, for larger facilities a team of inspectors is necessary. The team is significantly benefited by nurses and anesthesiologists. The

level of surgical sophistication is high, and helps provide standardization. It is almost comforting to the facility's Medical Director to know that he or she will be dealing with another physician who can manifest a clear understanding of the standards. Despite their background, inspectors will be required to undergo training by the accreditation organization, which may be accomplished through various methods including seminars, webinars, DVDs, and newsletters.

The inspection is, in essence, an "open book test." The standards book is presented to each facility ahead of time. There must not be any confusion over what is necessary and what will be examined. The process of the inspection involves the inspector to read and test each standard. For example, if the standard calls for a policy for a "time-out," the inspector will request to see the written policy requiring a time-out including the content of the time-out. There is the potential that a certain standard may not be applicable to a specific facility. The fact that it does not apply would require that a reason be specified.

After inspection, a list of deficiencies is provided to the facility. Any deficiency found must be rectified within 30 days of the reported inspection. It must be understood that a deficiency left uncorrected could result in decertification.

Oversight of the inspectors is the work of the Quality Assurance committee. Data are collected on all inspectors with the goal of using the data to improve the inspector pool. It is the goal of the entire organization to generate standardization, so that any inspection done by any inspector in any location would yield the same results.

Validation of Standards

A program of reported and collected peer-review information is critical in keeping abreast of patient safety issues and trends. It is required that all facilities submit peer review, including a random review of record and operative sequelae, at least biannually to maintain accreditation. Some sequelae need to be reported more quickly; for example, an operative death must be reported within 5 days of the knowledge of its occurrence.

An organization that requires the timely reporting of unanticipated sequelae is supporting definitive patient safety evidence on behalf of the accredited facilities and their surgical specialties. Accrediting organizations collect patient safety data based on their standards. These collected statistics are then able to validate that facilities' safety rates are acceptable.

Evidence-based medicine has entered into consideration with the development of medical standards providing up-to-date and precise content for the oversight of all standards. A future vision would be to generate data through AAAAF's Internet-Based Quality Assurance and Peer-Review Program (IBQUA) which, by virtue of its large sample size, has the potential to provide better evidence for delivery of safe surgical care through the integration of perioperative care data points with outcomes.[4,5]

SUMMARY

Patient safety should remain at the core of all successful outpatient standards, now and into the future. Quantified surgical safety data, along with the development of new and safer surgical procedures, are combining to create safe surgical standards for the benefit of all. More than 2000 years ago Cicero said: "The safety of the people is the supreme law [salus populi suprema lex]."

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