CULTURE OF SAFETY	Safety and Quality Improvement projects as part of the daily work
	A good system for self-reporting of adverse events by anesthesiologists
	Departmental peer review and safety combined in the same committee
	Quality nurse assigned to anesthesiology or perioperative area
	System to find and deal with patients who linger in the PACU
	Use of EMR to find patients who visit the ER within 24 hours of anesthesia
	Preoperative check of all existing IVs
	A periodic meeting of surgeons, nurses and anesthesiologists
	Separation of clean and dirty areas in the anesthesia work space
	Availability of Pedi Crisis checklists on computers in the OR
	Simulate use of Pedi Crisis checklist with OR team
	Consistent hand-washing before and after patient care
UNIVERSAL PROTOCOL	A morning meeting or “huddle” that includes anesthesiology, surgery, and nursing to discuss cases and operational issues for the day.
	Involvement of the anesthesiologists in sign in of patient prior to induction
	Perform sign-in with parents present
	Time out done with Challenge-response format
	Consistent time out prior to anesthesia blocks
HANDOFFS	Preoperative report generated from EMR including important information for anesthesiologists
	Use of scripts during handoffs, having PACU nurse fill out the form
	Attending to attending communication during handoff of ICU patients with a written summary
MEDICATION MANAGEMENT (adapted from the APSF recommendations for medication safety)	High alert drugs (such as phenylephrine and epinephrine) should be available in standardized concentrations/diluents prepared by pharmacy in a ready-to-use (bolus or infusion) form that is appropriate for both adult and pediatric patients
	Infusions should be delivered by an electronically-controlled smart device containing a drug library
	Ready-to-use syringes and infusions should have standardized fully compliant machine–readable labels
	Interdisciplinary and uniform curriculum for medication administration safety to be available to all training programs and facilities
	No concentrated versions of any potentially lethal agents in the operating room
	Required read-back in an environment for extremely high alert drugs such as heparin
	Use of sticker on infusion meds to require 2 person checks
	Standardized placement of drugs within all anesthesia workstations in an institution
	Convenient required method to save all used syringes and drug containers until case concluded
	Standardized infusion libraries/protocols throughout an institution
	Standardized route-specific connectors for tubing (IV, arterial, epidural, enteral)
	Routine provider-prepared medications should be discontinued whenever possible
	Clinical pharmacists should be part of the perioperative/ operating room team
	Standardized pre-prepared medication kits by case type should be used whenever possible
	Interdisciplinary and uniform curriculum for medication administration safety for all anesthesia professionals and pharmacists
	Enhanced training of operating room pharmacists specifically as perioperative consultants
	Deployment of ubiquitous automated dispensing machines in the operating room suite (with communication to central pharmacy and its information management system)
	Establish a “just culture” for reporting errors (including near misses) and discussion of lessons learned
	Establish a culture of education, understanding, and accountability via a required curriculum and CME
	Every anesthetizing location should have a mechanism to identify medications before drawing up or administering them (bar code reader) and a mechanism to provide feedback, decision support, and documentation (automated information system)
	Technology training and device education for all users, possibly requiring formal certification
	Improved and standardized user interfaces on infusion pumps
	Mandatory safety checklists incorporated into all operating room systems
	Use of machine with bar code technology to produce syringe labels at point of use for all practitioner prepared medications