

Hospitals Report Surgical Fires to ECRI Institute PSO

Best Practices Disseminated

Despite the elimination of flammable anesthetics in the 1970s, surgical fires continue to occur on a regular basis. While very rare (~600 per year out of more than 50 million surgeries), fires are often disastrous or even fatal--and completely preventable. Vigilance by the surgical team is the best defense.

The Patient Safety and Quality Improvement Act of 2005 established a framework for healthcare providers to voluntarily report information to Patient Safety Organizations (PSOs). PSOs are expected to compare data of similar cases among similar providers to better identify underlying causes of patient safety problems. PSOs gather lessons learned and provide resources and education to those who participate in the PSO.

Based on these goals, ECRI Institute PSO analyzed the adverse event reports received and determined that surgical fire prevention and management was a topic that should be addressed. It disseminated best practices for surgical fire prevention via an advisory and two webinars.

The information presented was based on new clinical recommendations on preventing and managing surgical fires. The published guidance was developed by ECRI Institute and the Anesthesia Patient Safety Foundation (APSF). Over 200 PSO members attended the webinar. The attendees included surgical staff (surgeons, anesthesiologists/CRNAs, OR nurses, surgical techs), OR administrators, risk managers, clinical engineers, and facilities engineers.

Additional fire safety resources are available for free through ECRI Institute's new Surgical Fires Prevention Web site: www.ecri.org/surgical_fires.

How Can We Help You?

Whether you have questions about the final rule or want to learn more about ECRI Institute PSO and/or support for other PSOs, we would be happy to hear from you. Please contact ECRI Institute at psa@ecri.org or call (610) 825-6000, ext. 5558.