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DECEMBER '23

Ambulatory Anesthesia Care:
Strategies to Mitigate Risk and Improve Patient Safety

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INTRODUCTION

The Centers for Medicare and Medicaid Services (CMS) defines an ambulatory surgical center (ASC) as "any distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization and in which the expected duration of services would not exceed 24 hours following an admission."[1] Although some ASCs were operational in the early 1970s, it wasn't until 1982 that Medicare first approved payment to ASCs for roughly 200 procedures.[2] Convenience, efficiency, and cost savings for both patients and clinicians likely contributed to the continued growth and utilization of ASCs over time. Medicare now approves payment for over 3,500 ASC procedures. According to the March 2023 ASC Services: Status Report, the number of ASC facilities and volume of services provided to Medicare beneficiaries continued to increase in 2021. A shift was also apparent from lower to higher-complexity surgical services.[2,3] With complex spine procedures and total joint replacements moving into this arena, the advancement of minimally invasive products and surgical techniques has undoubtedly made this shift possible.[4] Some projections forecast continued surgical volume growth in the ASC setting of an estimated 25% over the next decade.[5]

Without the parallel evolution of anesthesia care in the ambulatory setting, ASC facility growth and utilization would not be possible. The need to determine guidelines for delivering ambulatory anesthesia care was first established in 1973 by the American Society of Anesthesiologists (ASA), and in 1984 the Society for Ambulatory Anesthesia (SAMBA) was formed.[2,6] Aligned in their mission to provide safe perioperative anesthesia care, the evidence-based guidelines set forth by ASA and SAMBA help to set the standard of care for ambulatory anesthesia clinicians. Along with risk management considerations, some of these guidelines will be referenced in this article. They are meant to both aid clinicians in assessing gaps in their practice and implementing strategies to improve patient safety throughout the delivery of ambulatory anesthesia care.

Claim Trends:
Examination Gives Insight into Liability Risks

Liability risks related to the anesthesia specialty may be better understood by examining closed claim trends from the Medical Professional Liability (MPL) Association Data Sharing Project, a national medical liability claims database. Trends were published in their 2022 MPL Specialty Snapshot—Surgical Edition, which analyzed 889 anesthesia claims and lawsuits closed between 2017 and 2019. Notably, this revealed that anesthesia claims resulted in the highest average indemnity payments compared to all other specialties.[7] Cardiac arrest was the most common and costly patient outcome associated with these claims, and 26% of all anesthesia claim incidents involved a patient death.[7]

This data emphasizes the importance of both anesthesia emergency prevention and response to reduce liability risk and improve patient safety. While anesthesia emergencies can be difficult to manage regardless of the care setting, the case examples in this article highlight additional challenges and considerations unique to the delivery of ambulatory anesthesia care.

Anesthesia Assessment:

Patient Safety in the ASC Setting Starts Here

The following case illustrates the importance of conducting a thorough anesthesia assessment to confirm that the ASC setting is appropriate for the patient. Further, it illustrates the importance of having a transfer agreement in place to ensure patients can receive a higher level of care without delay. As with most claims, poor documentation throughout the delivery of care left many aspects of the anesthesiologist's decision-making unclear, thus complicating defensibility.

CASE ONE

Allegation: Negligent anesthesia management for Lap-Band surgery resulted in postoperative cardiopulmonary arrest and death.

A patient presented to an ASC for elective laparoscopic gastric band (Lap-Band) system insertion with possible hiatal hernia repair. His preop anesthesia assessment was completed by the anesthesiologist on the morning of surgery. Obesity (with a body mass index—BMI—of 55) and previous abdominal surgery were documented as his pertinent past medical history. No abnormalities were noted on preoperative pulmonary and cardiac exams. Vital signs
were within normal limits. The anesthesiologist assigned the patient as a Mallampati Class III and an ASA Class III. An electrocardiogram (EKG) indicating sinus rhythm was included in the anesthesia record, but there was no date or time to indicate when it was recorded.

Anesthesia was initiated with the administration of sevoflurane gas, propofol, fentanyl, dexamethasone, and rocuronium. At approximately 10:00 a.m. intubation was attempted with a Miller blade and 7.0 endotracheal tube. Due to poor visualization of the vocal cords the patient was repositioned, and intubation was eventually successful on the fourth attempt.

The procedure began at 10:05 a.m. The bariatric surgeon performed the laparoscopic gastric banding procedure without complication. The intraoperative anesthesia record revealed the patient's oxygen (O_2) saturation (sat) and end-tidal carbon dioxide ($ETCO_2$) concentrations to be within normal limits throughout the procedure which was completed at 10:40 a.m. The extubation time was not documented, but nursing notes indicate the patient arrived in the post-anesthesia care unit (PACU) at 10:55 a.m. with a dusky appearance and shallow breathing.

At 11:00 a.m. a bag valve mask (Ambu bag) was utilized by the anesthesiologist in PACU to assist with the patient's breathing. O_2 sats were noted to be 85 at the initiation of these efforts, which reportedly continued for about an hour and a half. At 11:30 a.m. anesthesiology notes reflected an O_2 sat of 84, while nursing notes reflected an O_2 sat of 78.

At 11:45 a.m. the anesthesiologist inserted a laryngeal mask airway (LMA), at which time the nurses began to assist respirations with an Ambu bag. At 11:48 a.m. the anesthesiologist suspected the LMA was leaking and replaced it. Nursing notes indicated that pink, frothy sputum was suctioned from the patient's nose and mouth at this time. At 11:50 a.m. intravenous (IV) furosemide was administered, and a Foley catheter was inserted with a resultant 100 cc of amber urine. At 12:00 p.m. O_2 sats remained in the mid-80s prompting administration of IV dexamethasone followed by albuterol.

At 12:30 p.m. the patient was noted to be tachycardic, diaphoretic, and his skin color appeared bluish. The anesthesiologist removed the LMA and reintubated the patient. He was transported back to the operating room (OR) where he was ventilated and attempts to transfer the patient to a higher level of care were initiated. (The anesthesiologist would later testify that he did not have the authority to transfer the patient and relied on the ASC to facilitate it.) The patient remained sedated on the ventilator in the OR under the anesthesiologist's care awaiting transfer for five hours.

At 5:30 p.m. emergency medical services (EMS) arrived, and the ASC staff assisted with the patient's transfer from the bed to the gurney and into the ambulance. Upon loading him into the ambulance his cardiac rhythm converted to asystole, and advanced cardiac life support (ACLS) was initiated by paramedics. The patient was rerouted to the nearest hospital emergency department where life-saving efforts continued. He passed away shortly after arriving at the hospital.

DISCUSSION

Plaintiff and defense experts were unsupportive of multiple aspects of the anesthesiologist's care. Initial criticisms were centered around the lack of documentation of a thorough preoperative evaluation and physical exam, including review of preoperative consultations, to ensure readiness for surgery in an ASC setting. Additionally, review of the surgeon's medical record documentation revealed a more complex medical picture than what was reflected in the anesthesiologist's documentation. Pertinent additional diagnoses included hypertension, obstructive sleep apnea (OSA), hypercholesterolemia, gastroesophageal reflux disease, depression, steatohepatitis, and chronic bronchitis. With a more thorough understanding of the patient's medical picture, experts agreed that the patient's ASA classification would have changed and required a hospital surgical setting.

Additional criticisms were centered around the lack of preparedness. Experts opined the anesthesiologist was unprepared to handle a difficult airway, which affected this patient at multiple stages of care. These stages included the initial intubation, the LMA placement in PACU, and the subsequent intubation when the patient continued to decline. Experts also opined that both the anesthesiologist and center were unprepared to manage patients requiring a higher level of care as there was no transfer agreement in place with any neighboring hospitals. There was also confusion regarding whose responsibility it was to initiate the transfer and ensure that it occurred in a timely manner. Experts agreed that a more active approach should have been taken to transfer the patient to a higher level of care when he met the definition of being critically ill, requiring mechanical ventilation. They opined that EMS should have been called at that point, as the patient's status would have required neighboring hospitals to accept the patient even without a transfer agreement in place.

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RISK REDUCTION STRATEGIES

A well-thought-out preoperative evaluation and patient selection process ensures a better understanding of a patient's overall health status, which is vital to properly assess ambulatory surgery candidacy. Policies and procedures supporting these processes and thorough documentation throughout the delivery of anesthesia care strengthen the defensibility of claims and help improve patient safety. Consider the following risk reduction strategies to support your preoperative anesthesia processes in the ambulatory setting:

Patient Selection:

- Develop policies and procedures that define patient selection criteria protocols for the ambulatory setting. Ideally this should be a collaborative effort between the surgical and anesthesia teams.

- Develop clinical pathways to ensure consistency in your approach to determining readiness for surgery. For example, perhaps cardiac events within a certain timeframe require cardiac clearance, or a specific BMI threshold triggers OSA screening.

- Determine exclusionary criteria or contraindications requiring referral to the inpatient surgical setting, based on your center's capabilities. Some examples may include:

  - ▶ Known or suspected difficult intubation

  - ▶ Unstable medical conditions (e.g., poorly controlled diabetes, unstable angina)

  - ▶ 24-hour O_2 requirements

  - ▶ Absence of a responsible adult into whose care the patient can be discharged

- Avoid making exceptions to your policies and procedures regardless of a patient's desire to accept additional risks that may apply to their unique medical picture.

Preoperative Assessment:

- Ensure there is a well-documented preanesthesia evaluation performed or verified by an anesthesiologist within 30 days of surgery.

- Ensure the patient receives preoperative instructions and has an opportunity to ask questions. It is important that patients know how and who to contact should new questions arise, or they forget medication hold instructions.

- On health questionnaires, consider specifically inquiring about medical conditions that may increase risk of complications. If sections are left blank, discuss these further rather than assuming a negative response.

- Ensure preoperative testing, including medical clearances, is ordered, obtained, and reviewed prior to the day of surgery.

- If there are any changes in the patient's preoperative medical history or unexpected physical exam findings on the day of surgery, postpone the procedure. Obtain the necessary tests or records required to ensure it is safe to proceed.

- Understand and follow ASA guidance on the basic standards for preanesthesia care.[8]

Ambulatory Anesthesia Emergencies:
Identification and Response Reduce Impact

The Accreditation Association for Ambulatory Health Care (AAAHC) released an analysis of data from over 2,000 accreditation surveys conducted in 2021 and 2022. Deficiencies in the Emergency Preparedness Standard were the most common deficiencies, occurring in 27% of sites surveyed.[9,10] This Standard requires organizations to run scenario-based drills to ensure preparedness for a variety of emergencies, including those requiring cardiopulmonary resuscitation (CPR).[9] While the stress of an anesthesia emergency can affect clinical performance, successful anesthesia teams plan for emergent events in advance. In doing so they help ensure their staff is prepared with the necessary equipment and skills to provide patients with the best care possible. The following cases highlight what can happen when clinical staff or facilities are not equipped to identify or respond to an anesthesia emergency in a timely manner.

CASE TWO

Allegation: Failure by the anesthesiologist and CRNA to adequately respond to cardiac arrest resulted in the patient's death.

Upon induction of general anesthesia by a certified registered nurse anesthetist (CRNA) in an ASC, a 48-year-old patient was turned prone for plastic surgery. The patient's skin immediately became mottled and there was a sudden loss of $ETCO_2$ suggesting cardiac arrest. It was unclear what caused the cardiac arrest, and resuscitation efforts were unsuccessful.

DISCUSSION

There was no explanation for the cause of the patient's demise other than unexplained sudden death in a young patient. All experts were unsupportive of the anesthesia care. Criticisms were centered on the fact that upon starting resuscitation efforts, the medical team discovered the automated external defibrillator was not working properly, so they had to await EMS arrival to deliver a shock. Additionally, CRNA practice in this state did not allow for independent practice. The anesthesiologist was criticized for failure to adequately ensure proper performance of general anesthesia, including intubation and induction, as he was not present.

CASE THREE

Allegation: Failure by the anesthesiologist and CRNA to recognize a hypoxic event during surgery resulted in treatment delay, neurological injury, and death.

After induction with monitored anesthesia care (MAC) in an ASC, the surgeon began hernia repair surgery on a 52-year-old male. During the surgery, the CRNA misinterpreted the abrupt drop in the patient's heart rate as a vasovagal response due to tugging on the spermatic cord. Attempts were made to reposition the O_2 saturation monitor and the surgical drain, which was positioned near the cord. Five minutes passed, and there was no improvement in the patient's status, prompting the CRNA to check the patient's airway. He noted airway obstruction and attempted jaw thrust and chin maneuvers, which failed. The CRNA subsequently attempted Ambu bag ventilation, which also failed, prompting him to call in his supervising anesthesiologist. The patient was ultimately intubated and coded one minute later. ACLS was initiated, and the surgeon placed bilateral chest tubes, suspecting bilateral pneumothorax as the cause of cardiac arrest. The patient's cardiopulmonary status improved, and he was transferred by EMS to the hospital. Computerized tomography scan of the brain was suggestive of a hypoxic brain injury. Magnetic resonance imaging of the brain was completed twice over the next week, and findings were ultimately consistent with brain death.

DISCUSSION

All experts were unsupportive of the anesthesia care. Criticisms were centered on the CRNA not recognizing the signs of a true hypoxic event. While spermatic cord manipulation can affect heart rate, there was an associated decline in blood pressure and respiratory rate, which should have immediately triggered the CRNA to assess the patient's airway. Given the delay, experts also noted that the CRNA failed to appropriately respond to the emergency with advanced airway rescue maneuvers in a timely manner. Additionally the anesthesiologist was criticized for failure to adequately ensure proper performance of MAC anesthesia. He was unaware of the patient's status decline up until the point at which intubation was deemed necessary.

CASE FOUR

Allegation: Negligent postanesthesia care resulted in a hypoxic event, permanent brain injury, and death.

A 54-year-old male patient underwent cervical disc replacement in an ASC. He was the last case scheduled for the day. There were no complications encountered during surgery, and the patient was transferred to the PACU for recovery. After about four hours the patient developed a choking sensation, and the PACU nurse noticed anterior neck swelling. There were no anesthesiologists on site. The operating surgeon was also not on site. The nurse attempted to establish an oral and then a nasal airway which were both unsuccessful. She called for assistance, and a urologist who was on site came to the bedside. He attempted to place an endotracheal tube followed by tracheostomy without success. EMS arrived and were also unable to establish an airway. The patient was pronounced dead upon arrival to the hospital.

DISCUSSION

All experts were unsupportive of the postanesthesia care. Criticisms were centered on negligent medical supervision and care in the PACU by the anesthesiologist, who left the facility prior to the patient's discharge. Experts also opined that there were inadequate center policies assuring the availability of a physician capable of managing complications throughout the patient's recovery in PACU until discharge.

RISK REDUCTION STRATEGIES

These cases highlight how liability allegations involving anesthesia care are often directed at both the supervising/collaborating anesthesiologist and the CRNA. The liability principles in play include direct and vicarious liability, which may coexist in some cases. Anesthesiologists may be held directly liable for failure to properly supervise a CRNA or vicariously liable for the acts or omissions of a CRNA based upon their relationship (employer-employee, for example). These liability principles can be further explored by reviewing previous ProAssurance *Claims Rx* publications including *Direct Liability in Healthcare: Risk Exposure Hiding in Plain Sight*[11] and *Vicarious Liability Risk Management*.[12]

The cases also highlight the importance of assessing anesthesia team competency, training, and comfort level in identifying and responding to anesthesia emergencies. It is also important to assess facility protocols to ensure medical teams have the tools they need to successfully respond to an anesthesia emergency from an equipment, process, and physician support standpoint. Consider the following risk management strategies for anesthesia emergency preparedness to improve patient safety and reduce medical liability.

- Understand and follow CRNA supervisory requirements[13] by state, care model, and practice setting.
- Conduct a risk assessment to identify and plan for a wide range of anesthesia emergencies.
- Assess Basic Life Support (BLS) and ACLS certification status of ASC clinicians upon hire. Consider offering access to American Heart Association accredited courses[14] periodically to ensure no lapses in certification and to support the medical team's overall competence.
- Develop policies and procedures that outline the expected response to anesthesia emergencies.
- Utilize cognitive aids such as the Stanford Emergency Manual for Perioperative Critical Events[15] to promote a standardized response to multiple crises and to review key points in crisis resource management.
- Use emergency carts to enhance your response:[16,17]
  - ▸ Be sure these meet CMS and state board of health requirements, as applicable.
  - ▸ Utilize a checklist to ensure these are organized, and optimize stock with items most useful in the ASC setting. Keep in mind the time and distance to the nearest hospital and the age range of patients you serve.
  - ▸ Implement a monthly monitoring system to ensure crash cart medications do not expire and remain stocked with the necessary quantities of medication and equipment throughout the year.
  - ▸ Equip carts with up-to-date and laminated ACLS protocols.
  - ▸ Locate carts in multiple locations for easy access to both OR and PACU clinicians.
  - ▸ Obtain medications with longer expiration dates and in premixed, ready-to-use doses to minimize time and error associated with preparation.
- Be sure to adequately train staff and run drills to maximize response to a variety of emergencies. Retrain staff when deficiencies are noted.
- Provide group simulation-based training to improve skills and team performance.
- Regularly test equipment to ensure it is in working order and to ensure staff competence.
- Establish a transfer agreement with a local hospital that can meet the needs of your patient's potential complications.
  - ▸ CMS: Sample Transfer Agreement[18]
- Clearly communicate expectations to promote a culture of patient safety.
- Ensure adequate and timely documentation when an anesthesia emergency is encountered. This should include the actions taken in response, hand-off communication to EMS and accepting hospital, and education/instructions given to patient and family.

Ambulatory Anesthesia Care:
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CONCLUSION

ASC surgical volume and scope continue to grow. While anesthesia risks exist regardless of the surgical setting, planning for emergent situations is crucial to reducing their impact when encountered in the ASC. The case examples in this article highlight the importance of anesthesia emergency prevention. These cases offer key considerations regarding your patient selection process, including how to properly assess ambulatory surgery candidacy. The cases also illustrate the unfortunate outcomes that may result when specialized equipment is unavailable and teams are not prepared to manage anesthesia emergencies in the ASC.

As demonstrated in this article, experts are generally called upon to evaluate an insured's position in a claim and opine if there was a deviation in the standard of care that contributed to the patient's injuries. It is important to appreciate that the standards expected to be met in the delivery of anesthesia care to patients do not vary based on care setting. Understanding and communicating the standards expected to be followed by the center, and by all anesthesia providers involved in patient care there, can help improve patient safety. Consider utilizing specialty society guidelines, such as those from ASA and SAMBA, to support efforts in developing your center's anesthesia policies and procedures. Proof that these standards were met can assist in the defense of a claim:

ASA - Statement on Ambulatory Anesthesia and Surgery[19]

ASA - Basic Standards for Preanesthesia Care[20]

ASA - Standards for Basic Anesthetic Monitoring[21]

ASA - Standards for Postanesthesia Care[22]

SAMBA - Clinical Practice Guidelines[23] (membership required)

ENDNOTES

The documents referenced in this article, along with many other risk management resource documents and past editions of *Claims Rx*, are available by calling Risk Management at 844-223-9648 or by email at RiskAdvisor@ProAssurance.com.

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