

Improving Quality and Safety in Office Based Surgery and Anesthesia

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“Wild Wild West of Healthcare”

- Lack of uniform regulation of office based practice
- Increasing number and variety of cases
- Increasing complexity of cases and patients
- Sedation by anesthesia and non-anesthesia personnel
- Widely publicized fatalities and malpractice claims


The Institute for Safety in Office Based Surgery

- Non profit organization established 2009
- Purpose:
 - promote patient safety in office-based surgery
 - design tools for advanced detection and prevention of adverse events
 - encourage collaboration across all subspecialties
 - improve physician and patient education
 - generate evidence based standard of care for safer office based practice



Objectives

- A review of the current literature on office based surgical safety
- Understand the necessity and role that team training contributes to a safe office environment
- Measuring quality and safety - 2016 updates
- Current research: outcome data analysis from the NACOR (AQI), The Doctor's Company
- The Patient Checklist



ENTERTAINMENT WEEKLY

Melissa Rivers Files Lawsuit In Mother Joan Rivers' Death

WATCH: Melissa Rivers Files Malpractice Lawsuit

NEW YORK (AP) — While Joan Rivers lay sedated in a Manhattan clinic, her doctors performed unauthorized medical procedures, snuffed a saline with the comedian and failed to act as her vital signs deteriorated, according to a malpractice lawsuit filed Monday by her daughter, Melissa.

The 81-year-old comedian and star of "Fashion Police" on E! died Sept. 4, days after she went in for a routine endoscopy at Verdelle Endoscopy on Manhattan's Upper East Side and stopped breathing.

The lawsuit filed in Manhattan State Supreme Court paints a picture of a careless, cocky staff of doctors who ran roughshod over Rivers while she was unconscious, and it suggests that she died because of their incompetence. The suit seeks unspecified damages.

“It is my goal to make sure that this kind of horrific medical treatment never happens again.” Rivers

Office-Based Anesthesia: Safety and Outcomes

Fred E. Shapiro, DO,* Nathan Punwani, MD,† Noah M. Rosenberg, MD,‡ Arnaldo Valedon, MD,§
Rebecca Twersky, MD, MPH,|| and Richard D. Urman, MD, MBA¶ (Anesth Analg 2014;119:276-85)

The increasing volume of office-based medical and surgical procedures has fostered the emergence of office-based anesthesia (OBA), a subspecialty within ambulatory anesthesia. The growth of OBA has been facilitated by numerous trends, including innovations in medical and surgical procedures and greater convenience for patients and providers. **There is a lack of randomized controlled trials** to determine how office-based procedures and anesthesia affect patient morbidity and mortality. As a result, studies on this topic are retrospective in nature. Some of the early literature broaches concerns about the safety of office-based procedures and anesthesia. However, more recent data have shown that care in ambulatory settings is comparable to hospitals and ambulatory surgery centers, especially when offices are accredited and their proceduralists are board-certified. **Enhance quality of care by engaging in proper procedure and patient selection, provider credentialing, facility accreditation, and incorporating patient safety checklists and professional society guidelines into practice.** Strategies for minimizing patient complications and mortality in OBA, and future developments that could impact the field. (Anesth Analg 2014;119:276-85)

ASA CLOSED CLAIM PROJECT

Injury and Liability with MAC cases

Bhananker, SM, et al., Anesthesiology 2006; 104:228-34.

Office-Based Anesthesia: Safety and Outcomes

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Recent Studies on the Safety of Office-Based Anesthesia and Procedures

Study	Key Findings
Vila et al. 2003	2 years of adverse events reported to Florida Board; 10-fold relative risk in office compared with ASC
Fleisher et al. 2004	564,267 outpatient surgeries, Medicare population 1-week mortality rates: in the office - 0.035%, ASC - 0.025%, in the hospital - 0.05%. Inpatient admission rate within 7 days of outpatient surgery: in the office - 0.91%, ASC - 0.84%, in the hospital - 2.1%
Bhananker et al. 2006	>40% of MAC claims involved death or permanent brain damage, similar to general anesthesia claims. Respiratory depression: 21% of MAC claims. 46% preventable by better monitoring, eg capnography, improved vigilance, or audible alarms. On-the-patient operating room fires from electrocautery, supplemental oxygen during facial surgery: burn injuries in 17% of MAC cases.
Starling et al. 2012	Six years of adverse event reporting Alabama: 3 deaths, 49 procedure-related complications and hospital transfers, board-certified physicians. Cosmetic procedures = 42% of hospital transfers and no deaths. 86% of hospital transfers associated with a cosmetic procedure involved general anesthesia. Liposuction = no deaths and 2 hospital transfers Ten years of Florida data: 46 deaths and 263 procedure-related complications and hospital transfers. Cosmetic procedures were liable for half the deaths and hospital transfers. 67% of deaths and 74% of hospital transfers associated with a cosmetic procedure involved general anesthesia. Liposuction, liposuction with abdominoplasty or other cosmetic procedure = 10 deaths and 34 hospital transfers. 93% of offices reporting an adverse event had board-certified physicians, 98% with hospital privileges.
Soltani et al. 2013	22,000 adverse events, 5.5 million plastic surgery procedures, IBQAP AAAASF accredited. Complication rate 0.4%, 94 deaths (0.0017% death rate); 40 cases pulmonary embolism. Office based abdominoplasty 5.5x risk associated with pulmonary embolism/VTE.

ASA Closed Claims Analysis: MAC Cases

- **Respiratory depression**-most common mechanism (21%)
- 46% deemed preventable by:
 - better monitoring eg. capnography
 - improved vigilance
 - audible alarms

Vila et al.

Arch Surg 2003;138:991-995 - Tampa, Florida

- Study to compare outcome to determine patient safety between offices and ambulatory surgicenter (ASC)
- All adverse incidents reviewed (April 2000 – April 2002)
- Approximately 10-fold increased risk of adverse incident and death in an office based setting

The risk and safety of anesthesia at remote locations: the US closed claims analysis

Metzner, Julia; Posner, Karen L; Domino, Karen B

Current Opinion in Anaesthesiology
Issue: Volume 22(4), August 2009, p 502-508

We analyzed claims from 1990 and later in the American Society of Anesthesiologists Closed Claims database to assess patterns of injury and liability associated with claims from anesthesia in remote locations (n = 87) compared with claims from operating room procedures (n = 3287).

Recent findings: Compared with operating room claims, remote location claims involved older and sicker patients (P < 0.01), with 50% of remote location claims involving monitored anesthesia care. The proportion of claims for death was significantly higher for remote location claims (44 vs. 8% for operating room claims), P < 0.001. The most common specific location claims were for monitored anesthesia care (32 vs. 8% for operating room claims).

...anesthesia at remote locations poses a significant risk for the patient, particularly related to oversedation and inadequate oxygenation/ventilation during monitored anesthesia care.

Similar anesthesia and monitoring standards and guidelines should be used in all anesthesia care areas.

The risk and safety of anesthesia at remote locations: the US closed claims analysis.

Metzner, Julia; Posner, Karen; Domino, Karen

Current Opinion in Anaesthesiology. 2009, August; 502-508.

Table 5 . Characteristics of remote location claims associated with over 1000 deaths (n = 26)

Characteristic	n (%)
Aged 70 years or older (n = 26)	7 (27%)
ASA physical status 3-5 (n = 26)	14 (54%)
Obese (n = 18)	10 (56%)
Location (n = 26)	
Cardiology	4 (15%)
Gastrointestinal suite	15 (58%)
Lithotripsy	3 (12%)
Radiology	4 (15%)
Sedative agents (n = 22)	
Propofol and benzodiazepines/opioids/ketamine	12 (55%)
Propofol alone	5 (23%)
Benzodiazepine, opioid, or both	3 (14%)
Methohexital	2 (9%)
Monitoring in use (n = 26)	
Pulse oximetry only	18 (69%)
Both pulse oximetry and capnograph	4 (15%)
Neither	4 (15%)
Preventable by better monitoring (n = 24)	15 (62%)
Death or permanent brain damage (n = 26)	24 (92%)
Substandard care (n = 22)	19 (86%)
Payment to plaintiff	
Payment made (n = 26)	19 (73%)
Median (range) of payments (n = 19)	\$460 000 (\$47 600-7 082 500)

ASA, American Society of Anesthesiologists. Percentages are based on claims without missing data. Denominators are listed in parentheses. Payments were adjusted to 2007 dollars using the Consumer Price Index.



ASA Closed Claim Project: 14 cases prior to 1996
Severity of Injury

Office-based

Ambulatory

- Death: 64%
- Temporary injury: 21%

- Death: 21%
- Temporary injury: 62%

Complications of Non-Operating Room Procedures: Outcomes From the National Anesthesia Clinical Outcomes Registry
Chang B. et al. J Patient Saf 2015;00: 00-00

	OR	Non-OR
Patients > age 50	55.56%	61.92%
MAC use	10.89%	20.15%
Sedation	0.57%	2.05%
Minor Complications:		
postop nausea + vomiting		
Inadequate pain control		
Hemodynamic instability		
Major complications:		
Serious hemodynamic instability (P=0.0001)	0.12%	0.10%
Upgrade of care (P<0.0001)	0.25%	0.10%
Overall Mortality (P<0.0001)	0.04%	0.02%

Non-OR Cardiology Mortality: 0.05%
Non-OR Radiology Mortality: 0.05%

ASA Closed Claim Project : 1996-2011

- Patient description: 64 office claims (718)
 - Middle-aged (median = 45 years)
 - Female (65%)
 - ASA I-II (79%)
 - Elective surgery
 - plastic 45% vs 18%
 - eye 16% vs 10%

ASA CLOSED CLAIM PROJECT

Liability with Office-Based Cases

ASA Office-based Claims: 1996-2011

- Inadequate oxygenation: (17% vs 6%)
- Death 27%, perm disabling 17% (similar)
- Substandard care: 52% (vs 37%)
- OBA claims- payment: 72% (vs 56%)
- Payment similar: (\$ 135,800 vs \$ 211,500)

Determining the Safety of Office-Based Surgery: What 10 Years of Florida Data and 6 Years of Alabama Data Reveal

JOHN STARLING III, MD,* MAYA K. THOSANI, MD,* AND BRETT M. COLDIRON, MD, FACP††
Dermatol Surg 2012;38:171-177

Adverse Event Reporting in Alabama and Florida

Alabama (6 years of data)	Florida (10 years of data)
Medical offices: 3 deaths and 49 procedure-related complications and hospital transfers. All occurred in the offices of board-certified physicians.	Medical offices: 46 deaths and 263 procedure-related complications and hospital transfers.
Cosmetic procedures: 42% of hospital transfers and no deaths. 86% of hospital transfers caused by a cosmetic procedure involved the use general anesthesia.	Cosmetic procedures: at least half of the deaths and hospital transfers. 67% percent of deaths and 74% of hospital transfers associated with a cosmetic procedure involved general anesthesia.
Liposuction: no deaths and 2 hospital transfers.	Liposuction and liposuction with abdominoplasty or other cosmetic procedure: 10 deaths and 34 hospital transfers. 93% of offices reporting an adverse event had physicians with board certification, and 98% of them had physicians with hospital privileges



USA TODAY INVESTIGATION

These women died after having liposuction.

September 14, 2011
 By Jayne O'Donnell



Maria Shortall

Kellee Lee-Howard

"... levels of training vary so widely that some doctors are performing cosmetic procedures **after only a weekend** observing other doctors."

Their doctor, like many in the booming cosmetic surgery field, wasn't board-certified – but **there was no law to stop him.**

Outpatient Surgery and Sequelae An Analysis of the AAAASF Internet-based Quality Assurance and Peer Review Database

Ali M. Soltani, MD¹, Geoffrey R. Keyes, MD^{1,2,3,*}, Robert Singer, MD^{1,4}, Lawrence Reed, MD¹, Peter B. Fodor, MD⁵ *Clin Plastic Surg* 40 (2013) 465-473

Summary:

- 5.5 million plastic surgery cases
- 22,000 sequelae (0.4% incidence)
- 94 deaths 2001-12 (0.0017%)
- Risk in plastic surgery=1/41,726
- PE most common 40 deaths
- Abdominoplasty incidence 0.925%
- Abdominoplasty 5.5 risk of VTE vs other

ThursdayStyles

The New York Times

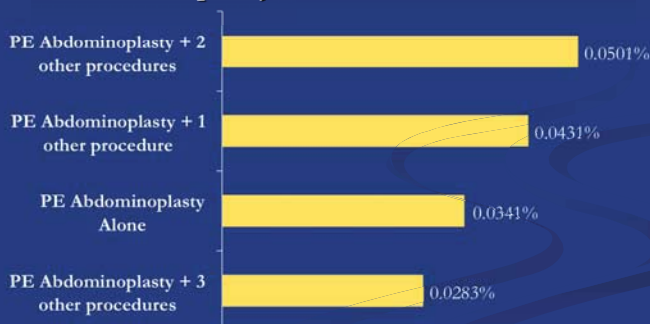
THURSDAY, NOVEMBER 5, 2009

- 37 y/o RN goes to MedSpa for liposuction.
- MD performing was **trained in Occupational Medicine.**
- Took **3-day course in liposuction.**
- Lidocaine and propofol administered.
- Patient became unconscious, seizes and dies.

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Abdominoplasty and Associated PE Rates



Clayman, MA, Seagle BM.
Plast. Reconstr. Surg 2006; 118: 777-785.

- What does board-certified mean?
- Are practitioners doing something other than what their board certification qualifies them to do?

Safety by Educating the Public

Clayman MA, et al.

Ann Plast Surg. 2007; 58: 288–291

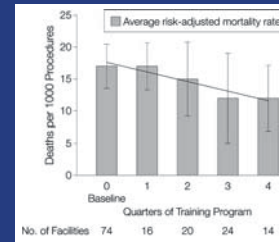
Suggestions:

- **Physicians** critically read any medical literature that are read by the public or touted in media.
- **Patients** should research education, training, certification of person performing the procedure.
- **Patients should ask:** Do they have surgical privileges to perform the same procedure in an accredited hospital?

Team Training

- Medical team training, involving teamwork training, ongoing coaching, and checklists to trigger operating room briefings and debriefings, was associated with a **reduction in mortality**.
- **Surgical mortality declined 18%** at hospitals that implemented the Medical Team Training program (n=74), compared with a 7% mortality reduction in the control hospitals (n=34).

Quarters of Risk-Adjusted Surgical Mortality Rate



Neily, J et al. JAMA. 2010; 304(15):1693-1700.

Value-Based Purchasing

- **High quality and cost-effective healthcare**
- Construct incorporates The National Quality Strategy's aims:
 - **patient safety, patient-centered experience and outcomes, improve care coordination, efficiency and cost reduction, population health**



The NEW ENGLAND JOURNAL of MEDICINE

Checklists for Invasive Procedures

The same sign-in, time-out, and sign-out phases are eminently applicable to procedures performed...*outside the OR...* in the endoscopy suite, the cardiac catheter laboratory, and interventional radiology rooms.

These patients are deserving of the same safety considerations that are being afforded to those undergoing an operation...*in the OR...*

The essential objectives listed by the WHO include appropriate consent, appropriate personnel and equipment, correct procedural site, avoidance of known allergies, contingency planning for complications, and optimization of thromboprophylaxis.

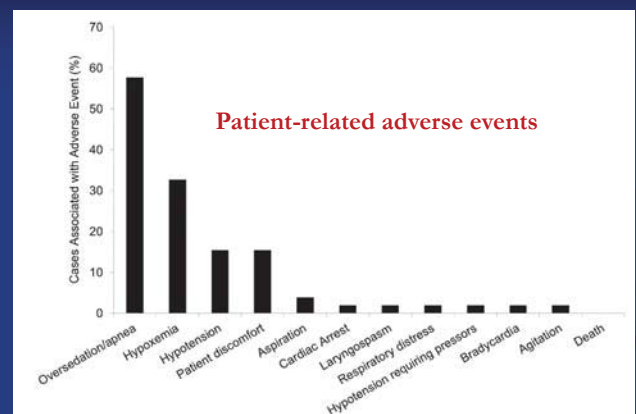
Use of Checklist in ASC

- **January 2012, CMS instituted use of a safe-surgery checklist**
- Efficacy quality improvement and patient safety in tertiary care.
- ASCs free to select the checklist that meets individual needs.
- CMS uses the name "*safe surgery*" checklist, applies to all ASC *procedures*, including those considered to be diagnostic and pain management procedures.
- World Health Organization, Association of the periOperative Registered Nurses (AORN), American College of Gastroenterology, American College of Surgeons, The Institute for Safety in Office-Based Surgery

Analysis of Adverse Events Associated With Adult Moderate Procedural Sedation Outside the Operating Room

Sergey Karunov, MD,* Natalia Sarkisian, PhD,† Rebecca Grummer, DMD,* Wendy L. Gross, MD, MHCM, and Richard D. Urman, MD, MBA*

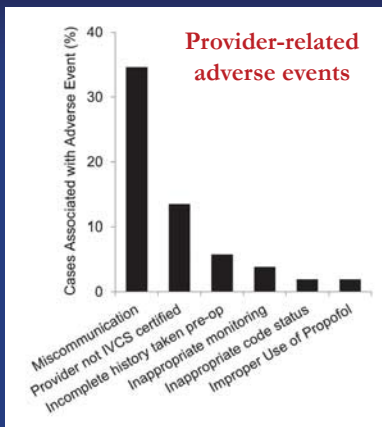
J Patient Saf. 2014 Sep 8.



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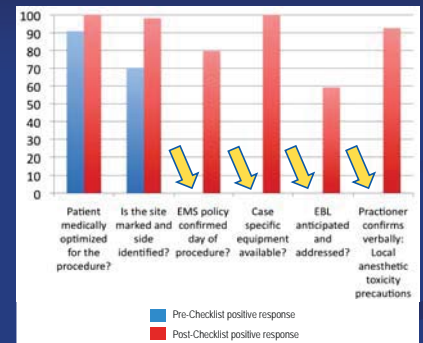


Study Results



- Pre-checklist, **90%** missing documentation of **three or more elements**.
- **15%** of cases had adverse events of which **pain (3.7%)** and **bleeding/bruising (3.2%)** were most common.
- Post-checklist analysis: **90-100% increase in documentation** of several key indicators and practices.

Percentage of Positive Responses Pre- and Post-Checklist Implementation



Office Surgical Checklist Pilot Study

Safety Checklist for Office-Based Surgery

from the Institute for Safety in Office-Based Surgery (ISOBS)



Introduction	Setting	Operation	Before discharge	Satisfaction
<p>Preoperative encounter with practitioner and patient</p> <p>Patient medically optimized for the procedure?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No, and plan for optimization made. <p>Does patient have DVT risk factors?</p> <input type="checkbox"/> Yes, and prophylaxis plan arranged. <input type="checkbox"/> No <p>Procedure complexity and sedation/analgesia reviewed?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No <p>NPO instructions given?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No <p>Escort and post-procedure plans reviewed?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Emergency equipment check complete (e.g. airway, AED, code cart, MRI kit)?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No, and plan for optimization made. <p>EMS availability confirmed?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No <p>Oxygen source and suction checked?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No <p>Anticipated duration ≤ 6 hours?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No, but personnel, monitoring and equipment available	<p>Patient identity, procedure, and consent confirmed?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No <p>Is the site marked and side identified?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No <p>DVT prophylaxis provided?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No <p>Antibiotic prophylaxis administered within 60 minutes prior to procedure?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No <p>Essential imaging displayed?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No <p>Practitioner confirms verbally:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Local anesthetic toxicity precautions <input type="checkbox"/> Patient monitoring (per institutional protocol). <input type="checkbox"/> Anticipated critical events addressed with team. <input type="checkbox"/> Each member of the team has been addressed by name and is ready to proceed. 	<p>On arrival to recovery area, with practitioner & personnel</p> <p>Assessment for pain?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No <p>Assessment for nausea/vomiting?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No <p>Recovery personnel available?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No <p>Prior to discharge (with personnel and patient)</p> <p>Discharge criteria achieved?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No <p>Patient education and instructions provided?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No <p>Plan for post-discharge follow-up?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No <p>Escort confirmed?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Completed post-procedure, with practitioner and patient</p> <p>Unanticipated events documented?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No <p>Patient satisfaction assessed?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No <p>Provider satisfaction assessed?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No

This checklist is not intended to be comprehensive. Additions and modifications to fit local practice are encouraged. *Adapted from the WHO Surgical Safety Checklist. © 2010 Institute for Safety in Office-Based Surgery (ISOBS), Inc. - All Rights Reserved - www.iso.org

Examining Trends and Outcomes in Ambulatory Surgery: Looking Into the Future

Looking Into the Future

Samir R. Jani, M.D., M.P.H.
Committee on Patient Safety and Education
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AMERICAN SOCIETY OF ANESTHESIOLOGISTS
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Effect of an Office-Based Surgical Safety System on Patient Outcomes

Published December 25, 2012

Noah M. Rosenberg, MD,* Richard D. Urman, MD, MBA,[†] Sean Gallagher, MD,[‡] John Stenglein, MD,[‡] Xiaoxia Liu, MS,[§] and Fred E. Shapiro, DO*

- 28-element perioperative ISOBS checklist
- Customized to an office-based plastic surgery
- 219 cases
- Baseline and post-op adverse outcomes
- post-checklist implementation chart review

Additional Goals:

- To decrease incidence of **adverse outcomes** in the perioperative period
- To **educate** the practitioner and support staff

Initial Results from the National Anesthesia Clinical Outcomes Registry and Overview of Office-Based Anesthesia

Fred E. Shapiro, DO¹, Samir R. Jani, MD, MPH², Xiaoxia Liu, MS³, Richard P. Dutton, MD, MBA⁴, Richard D. Urman, MD, MBA^{1,5,*}

Anesthesiology Clin 32 (2014) 431-444

Table 3
Age distribution of OBA and in non-OBA NACOR cases

Variable	Office Based (N = 84,461) n (%)	NACOR (N = 12,557,021) n (%)
Age group (y)		
<1	121 (0.14)	64,951 (0.52)
1-18	6024 (7.35)	1,302,276 (10.37)
19-49	35,862 (42.46)	4,397,863 (35.02)
50-64	29,362 (34.76)	3,218,552 (25.63)
65-79	10,760 (12.74)	2,682,377 (21.36)
80+	2152 (2.55)	891,002 (7.10)

P = <.0001.

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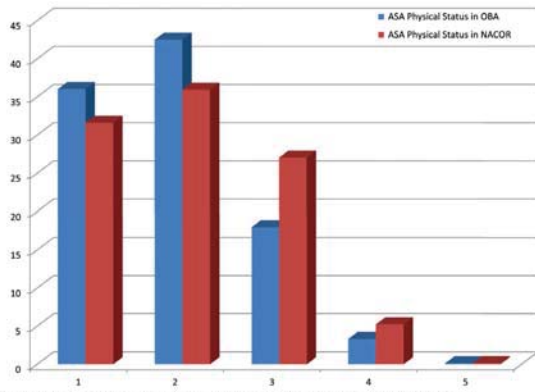


Fig. 1. Distribution of ASA physical status in OBA and non-OBA NACOR cases.

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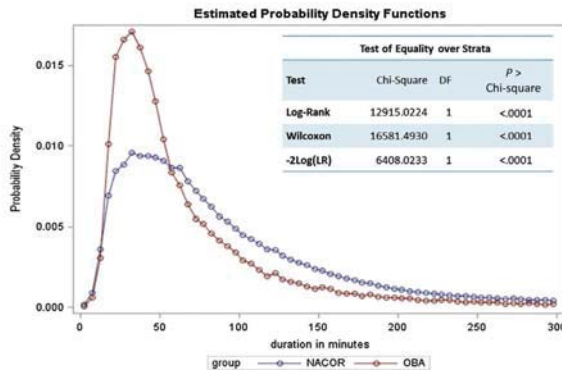


Fig. 2. Distribution of case duration (min) in OBA and non-OBA NACOR cases. DF, degrees of freedom; P, probability; LR, log-rank.

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Anesthesiology Clin 32 (2014) 431-444

Variable	Office Based (N = 44,484) n (%)	NACOR (N = 9,365,286) n (%)
Anesthesia Type		
ESP	1241 (2.83)	853,823 (9.22)
GEN	30,638 (69.91)	6,566,028 (70.93)
LOC	4 (0.01)	10,093 (0.11)
MAC	11,600 (26.47)	1,537,381 (16.61)
OTH	56 (0.13)	96,677 (1.04)
REG	284 (0.65)	192,662 (2.08)

P = <.0001.
Abbreviations: ESP, epidural/spinal; GEN, general anesthesia; LOC, local anesthesia only; OTH, other; REG, regional anesthetic.

A Comparison Between Office and Ambulatory Practices: Analysis from the National Anesthesia Clinical Outcomes Registry

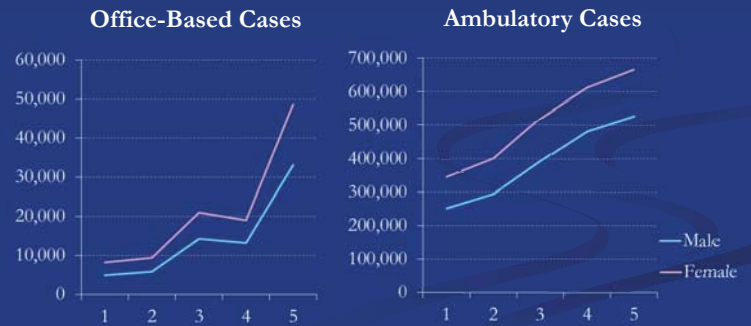
Samir R. Jani, MD, MPH, Fred E. Shapiro, DO, Hubert Kordylewski, James H. Diaz, MD, MPH, Alan D. Kaye, MD, PhD, Richard P. Dutton, MD, MBA, Richard D. Urman, MD, MBA

- Anesthesia Quality Institute (AQI) has collected patient and procedural characteristics on 19,032,432 anesthetics from all healthcare settings since 2010.
- **108,443 office** and **3,647,690 ambulatory** cases were isolated and compared.
- Our findings show that although both settings are often grouped together, there are statistically significant differences in patient demographics, procedure types, and reported adverse events.

A Comparison Between Office and Ambulatory Practices: Analysis from the National Anesthesia Clinical Outcomes Registry

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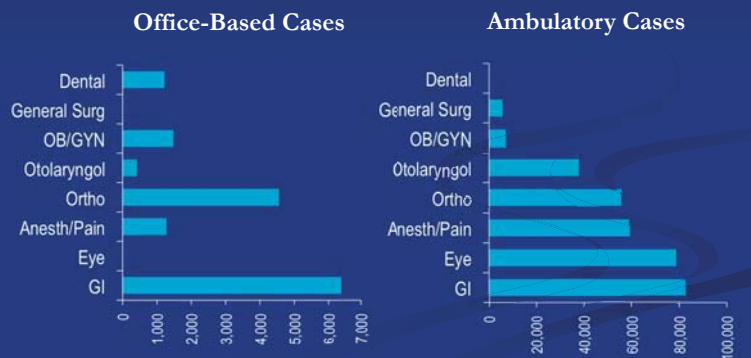
The number of cases is increasing in both categories



A Comparison Between Office and Ambulatory Practices: Analysis from the National Anesthesia Clinical Outcomes Registry

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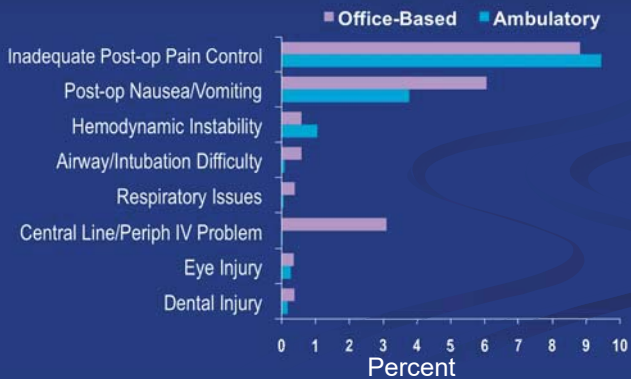
Most active specialties (2013)



A Comparison Between Office and Ambulatory Practices: Analysis from the National Anesthesia Clinical Outcomes Registry

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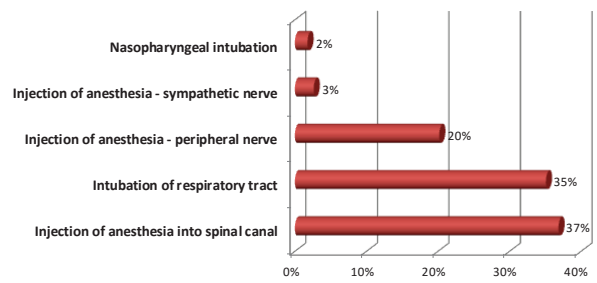
NACOR Reported Outcomes (2010-14 combined)



Analysis of patient injury based on anesthesiology closed claims data from a major malpractice insurer

Ranum, et al., J Healthcare Risk Management 2014; 34(2): 31-42.

Procedures Related to Allegation, "Improper Performance of Anesthesia Procedure"



Analysis of patient injury based on anesthesiology closed claims data from a major malpractice insurer

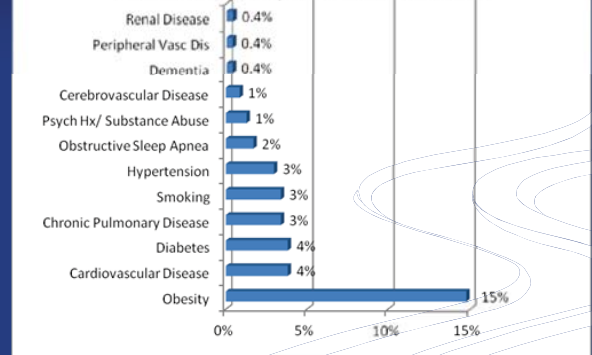
Darrell Ranum, JD, CPHRM, Haobo Ma, MD, Fred E. Shapiro, DO, Beverly Chang, MD, and Richard D. Urman, MD, MBA
J Healthcare Risk Management 2014; 34(2): 31-42.

- Methods:** Review of anesthesia closed claims data as reported by The Doctors Company, 2007 - 2012. Each claim underwent a review by physician and nurse experts. Each injury was classified into 1 of 9 severity levels. Potential association between injury and patient comorbidity also examined.
- Results:** 607 claims analyzed. Most frequent injuries: teeth damage (20.8%), death (18.3%), nerve damage (13.5%), organ damage (12.7%), pain (10.9%), and arrest (10.7%). Obesity was contributing factor in the most number of claims. Injury-to-claim rates were highest in hospitals with fewer than 100 beds, while ambulatory surgery centers had the lowest death-to-claim rate (12%). Average indemnity for an anesthesia claim was \$309,066, compared to \$291,000 for all physician specialties.

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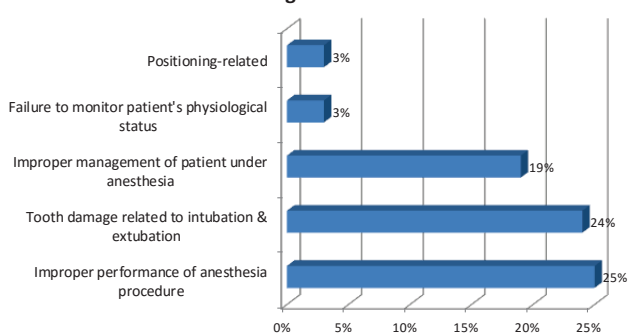
Comorbidities that Impacted the Outcome of Care



Analysis of patient injury based on anesthesiology closed claims data from a major malpractice insurer

Ranum, et al., J Healthcare Risk Management (in press)

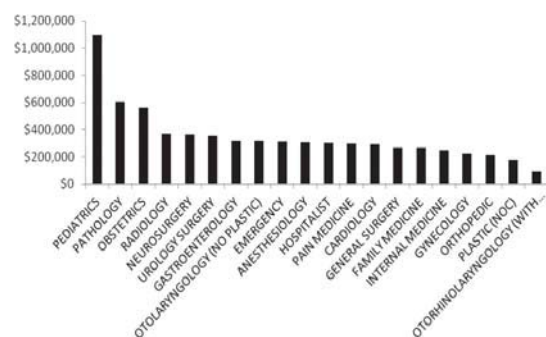
Five Most Common Allegations in Anesthesia Claims



Analysis of patient injury based on anesthesiology closed claims data from a major malpractice insurer

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Average indemnity by specialty



PATIENT-CENTERED CARE: *Improving Patient Safety in Anesthesia Through Patient Engagement*

Annals of the American Society of Anesthesiologists

Volume 79, Number 5, May 2015

“Patient engagement at the level of direct anesthesia care includes a number of elements such as education, risk assessment, intervention, patient questions and, ultimately, shared decision-making. By engaging patients early, we can promote better outcomes by identifying risks, educating patients and encouraging healthful decision-making.”



Annals of the American Society of Anesthesiologists

Volume 79, Number 5, May 2015

AMERICAN SOCIETY OF ANESTHESIOLOGISTS
May 2015 79 (5):10-12

A Survey Analysis of an Ambulatory Surgical Checklist Designed for Use by Patients

Rohesh J. Fernando MD^a, Fred E. Shapiro DO^c, Richard D. Urman MD, MBA^{e*}

- Surveyed 35 patients and 52 providers
- 94% of patients and 83% of providers thought the checklist would be beneficial for patients.
- 37% of providers indicated potential barriers to checklist implementation:
 - fear of confusing the patient
 - making patients doubt the care they were receiving
 - taking too much time
 - lack of resources

The Patient's Checklist for Ambulatory Procedures

from the Institute for Safety in Office-Based Surgery (ISOSIS)

Inquire	The procedure	Have I explored all treatment options regarding my condition? - Yes - No Is my procedure typically done in the ambulatory office facility or the hospital? - Yes - No Who will be giving me sedation/anesthesia and watching my vital signs during the procedure? - Yes - No What is my doctor board-certified in? - Yes - No Ask my doctor: How many times recently have you performed my type of procedure? - Yes - No I know about my doctor's reputation
Stable	My medical conditions	Are my medical conditions stable enough to have this procedure? - Yes - No
Office	The facility	Is the facility accredited and licensed as required by my state's regulations? - Yes - No
Best	The best place for my procedure	Is this ambulatory facility the right place for my procedure versus a hospital? - Yes - No
Suited	Dealing with emergencies	Is this facility prepared for an unexpected emergency, such as drugs, equipment and training? - Yes - No If I need additional medical care, whom will I be transferred? - Yes - No
Plan	Plan for my recovery after the procedure	Who will monitor my recovery and supervise my discharge home? - Yes - No Will I be given discharge instructions and contact information in case I have questions? - Yes - No
Communication	Follow up after the procedure	Who should I follow-up with after my visit? - Yes - No Who do I call if I have a problem after the procedure? - Yes - No

This checklist is not intended to be comprehensive. Additional modifications to fit local practice are encouraged. *Adapted from the WHO Surgical Safety Checklist. © Institute for Safety in Office-based Surgery, 2013.

The Patient Checklist

Is my doctor qualified to perform the same procedure/surgery in the office, ambulatory surgery center (ASC), or a hospital?
 Yes No

Which medical professional will be giving me sedation/anesthesia and Is my health in the best state possible to minimize any risks related to this procedure and anesthesia? If not, what can I do to improve my condition?
 Yes No

Are there any additional techniques or procedures that could decrease my risk?
Is the facility accredited and licensed as required by the state regulations?
Considering my planned procedure and medical history, which is the best facility where my procedure is to be performed prepared for an emergency?
Immediately following the procedure, do I know who will monitor and manage my recovery, who will address my needs, and who will supervise my discharge?
 Yes No

Will I be given written instructions regarding:
 A follow-up appointment after my procedure?
 When to resume my daily medications?
Have I communicated my questions and overall satisfaction to the office staff and the medical professional who provides my sedation/anesthesia?
 Yes No

My medical condition
The facility
The best
Plan for my recovery after the procedure
Follow up after the procedure

This checklist is not intended to be comprehensive. Additional modifications to fit local practice are encouraged. *Adapted from the WHO Surgical Safety Checklist. © 2013 Institute for Safety in Office-based Surgery (ISOSIS), Inc. All Rights Reserved. www.isosis.org

CONCEPTS FOR THE DEVELOPMENT OF A CUSTOMIZABLE CHECKLIST FOR PATIENT USE

Rohesh J. Fernando MD^a, Fred E. Shapiro DO^c, Noah M. Rosenberg, MD^b Angela M. Bader MD, MPH^d, Richard D. Urman MD, MBA^{e*}

A SURVEY ANALYSIS OF AN AMBULATORY SURGICAL CHECKLIST DESIGNED FOR USE BY PATIENT'S

Rohesh J. Fernando MD^a, Fred E. Shapiro DO^c, Richard D. Urman MD, MBA^{e*}



Outpatient Surgery

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Home > News > May, 2015

Melissa Rivers: Joan's Death was "100% Preventable"
She cites egregious alleged failures in interview.

Published: May 4, 2015

Category: Outpatient Surgery News and Trends > General Surgical News and Reports

The death of Joan Rivers was "100% preventable," her daughter, Melissa, tells an interviewer on the "Today Show" in paying attention to the vital signs?" crash cart?"

"[Her] death was 100% preventable... How about paying attention to the vital signs? How about having a properly equipped crash cart?" - Melissa Rivers

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