

Top Allegations & Risk Concerns for ASC

Today's Program Speaker

Today's speaker is Viviane Jesequel, RN, HCRM, Senior Clinical Risk Management Consultant, Medical Protective
(Viviane.Jesequel@medpro.com)

Viviane provides comprehensive risk management services to healthcare systems, hospitals, clinics, and physicians in Florida, Alabama, Mississippi and Puerto Rico. She has more than 25 years of experience in the healthcare industry and has achieved an understanding of the challenges and opportunities facing both clinicians and hospitals.

Viviane has been actively involved in healthcare risk and quality management for many years. In previous positions, she provided services to hospitals, nursing homes, physicians, and other allied health professionals.

Viviane's expertise includes consulting with clients regarding patient safety and quality/performance improvement, identifying and evaluating potential liability exposures, and developing solutions to reduce or eliminate loss severity.

Viviane earned her RN degree from Mount Saint Mary College in New York. She also earned a bachelor of science degree in business administration from Mount Saint Mary College, and she is licensed as a healthcare risk manager by the state of Florida.



Today's Program Speaker

Also speaking is Robert D. Henry, a shareholder at Ringer, Henry, Buckley and Seacord P.A. in Orlando, Florida. (bhenry@ringerhenry.com)

For over thirty years, Bob has represented physicians, physician groups, hospitals and other health care providers in medical malpractice actions and Department of Health administrative actions. He has been invited to discuss medical malpractice issues for medical malpractice insurance carriers, before local organizations and at the national medical malpractice seminar of the Defense Research Institute. Bob has also



presented the civil case law update at the annual business meeting of the Florida Conference of Circuit Judges. He is a Certified Circuit Court Mediator. He received his law degree at the University of Florida in 1981 and has specialized in the defense of medical malpractice cases since that time. Bob has an AV Preeminent rating by Martindale-Hubbel and has been recognized many times as a Florida Super Lawyer and one of Florida's Legal Elite attorneys.

Bob has handled many cases involving Ambulatory Surgical Care Centers, with a number of them currently pending.



Objectives

At the conclusion of this program, you should be able to:

- Identify the top allegations in the ambulatory surgical setting.
- Identify contributing risk factors for the pre-operative, peri-operative and post-operative period.
- Implement risk strategies to improve patient safety.
- Identify risk issues related to case studies in the Ambulatory Surgery Centers.

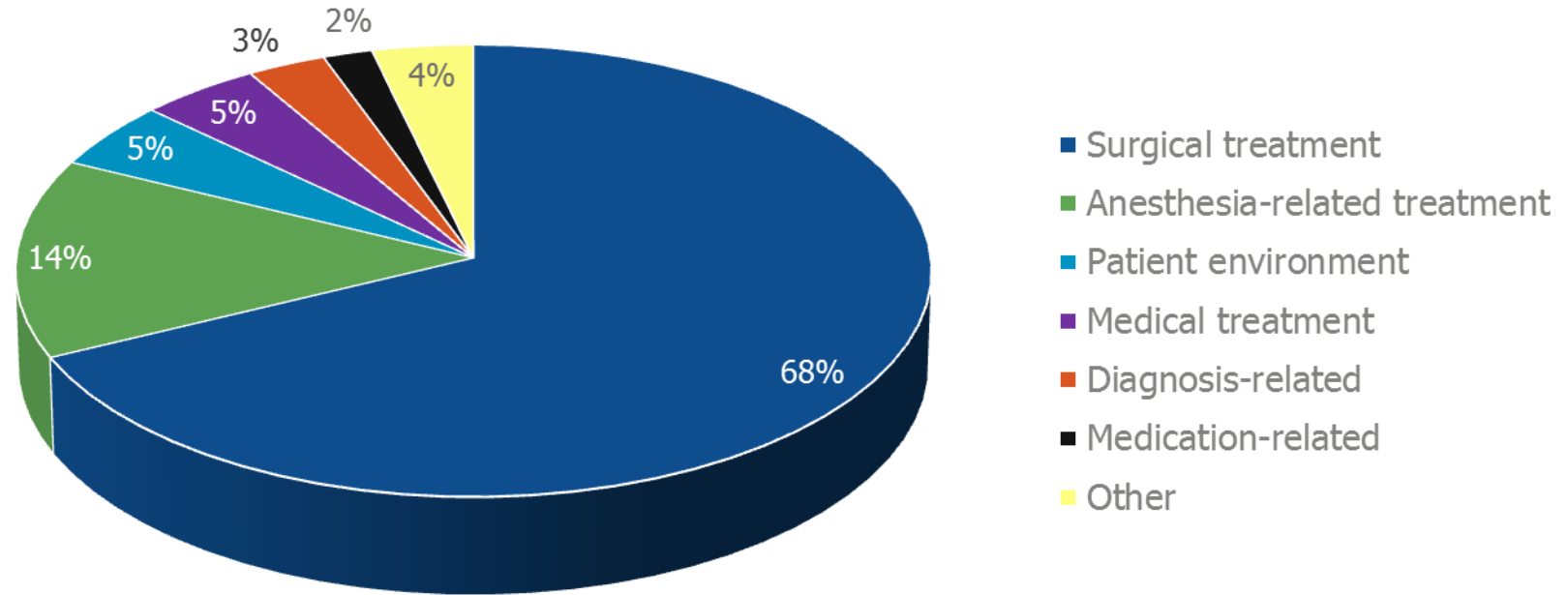


Ambulatory Surgery Centers Making the News !

- Anesthesiologist Accused of Failing to Respond While Woman, 29, Slipped Away
- Jury awards \$543K in lawsuit against outpatient surgery center- alleged post-op infection following arthroscopic knee surgery
- Doctors and staff trash sedated patient during colonoscopy — and it ends up costing her \$500K
- \$9.1M awarded to family of 17-year-old boy who died following elective tonsillectomy for treatment of OSA.
- Joan Rivers' Daughter Sues Medical Clinic Over Comedian's Death
- Case Settles for \$6.2M - 9-year-old boy who allegedly suffered extensive and permanent brain damage after surgery to remove his tonsils and adenoids - alleged that hospital staff failed to make note of his severe sleep apnea when prepping him for surgery.



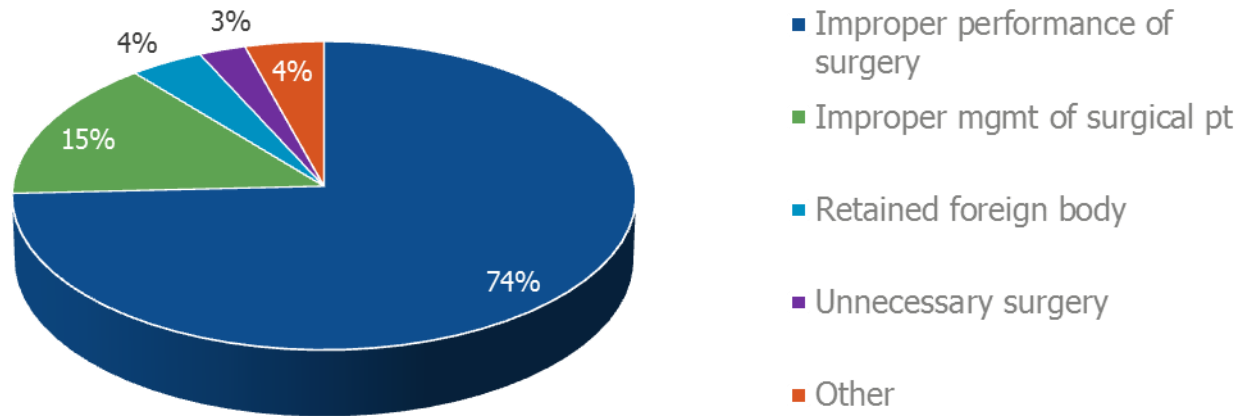
Allegation categories



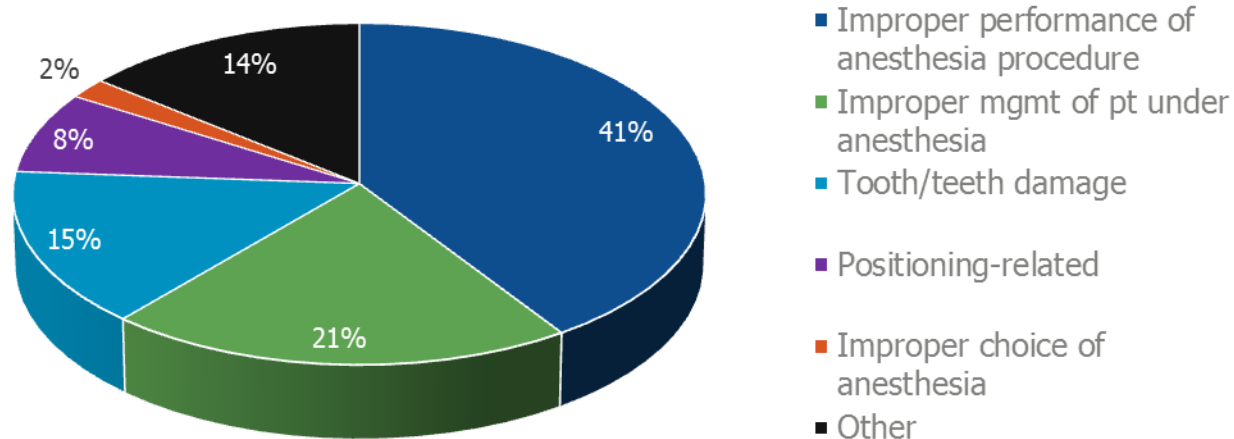
There can be multiple allegations assigned to each case, but only one major allegation. The allegations grouping is designed to classify logically major allegations.



Allegation categories: Surgical & Anesthesia-related treatment



Surgical treatment – allegation sub-categories

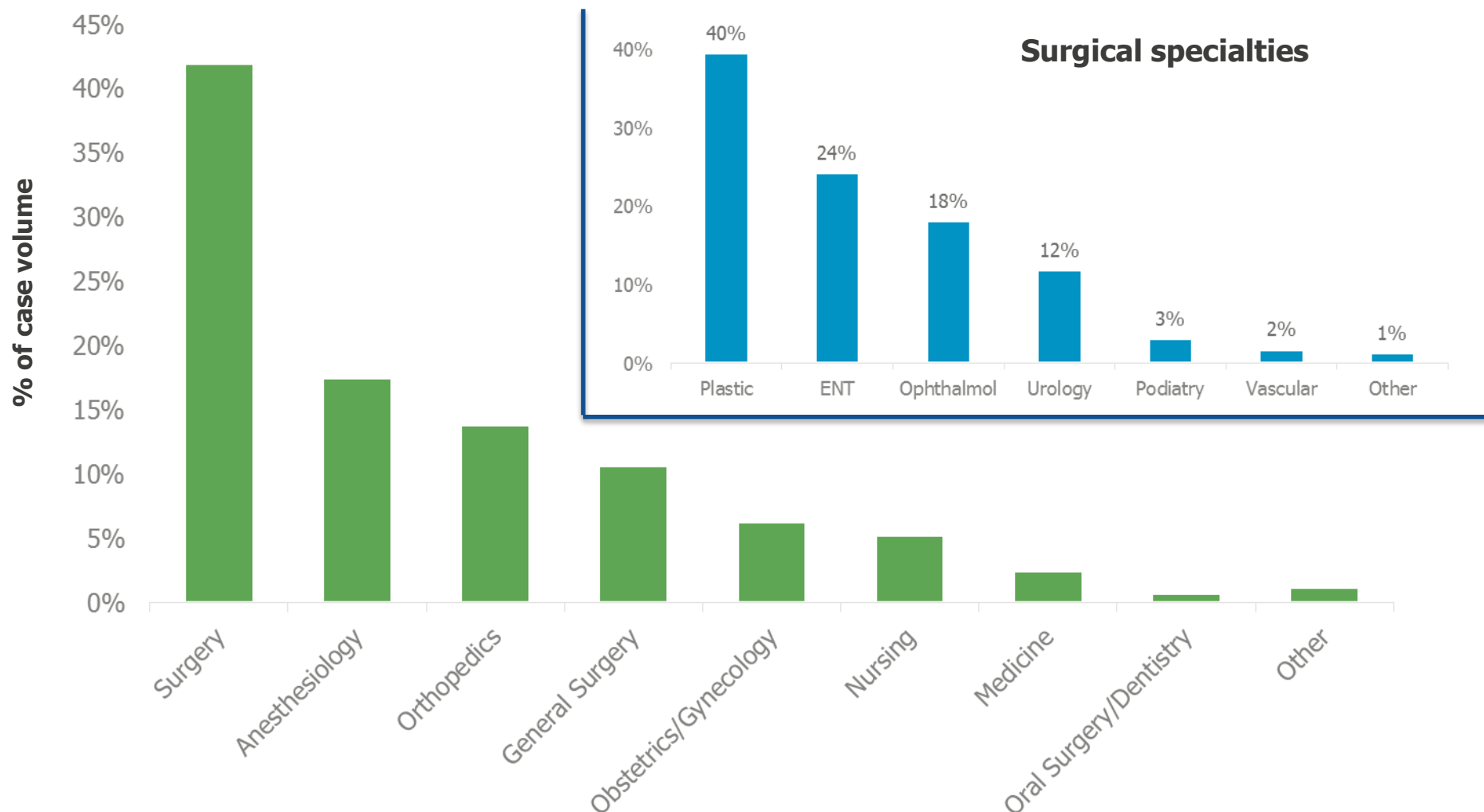


Anesthesia-related treatment – allegation sub-categories



Primary responsible service

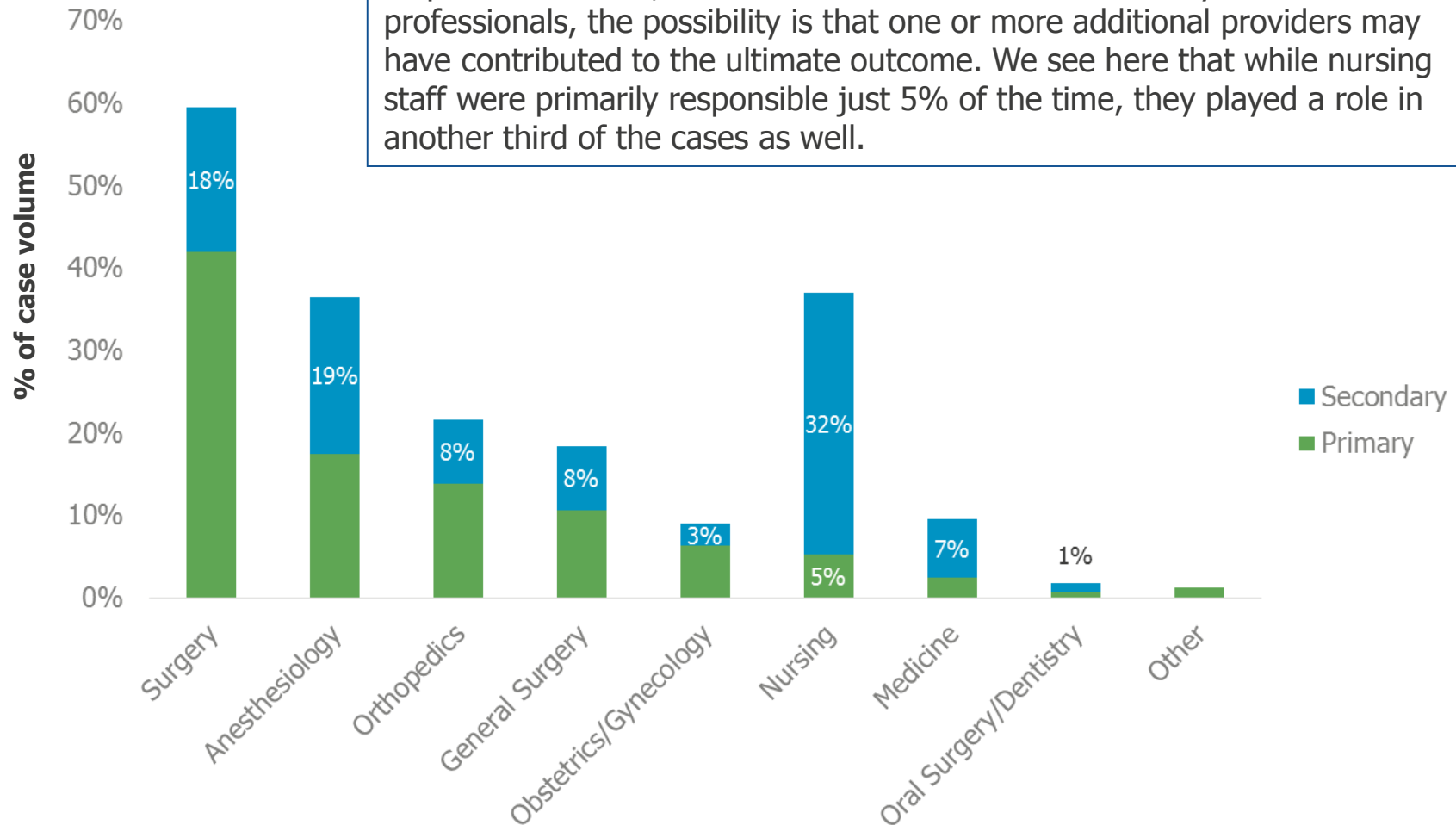
The primary responsible service is that service determined to be most responsible for the resultant allegation(s) of the case.



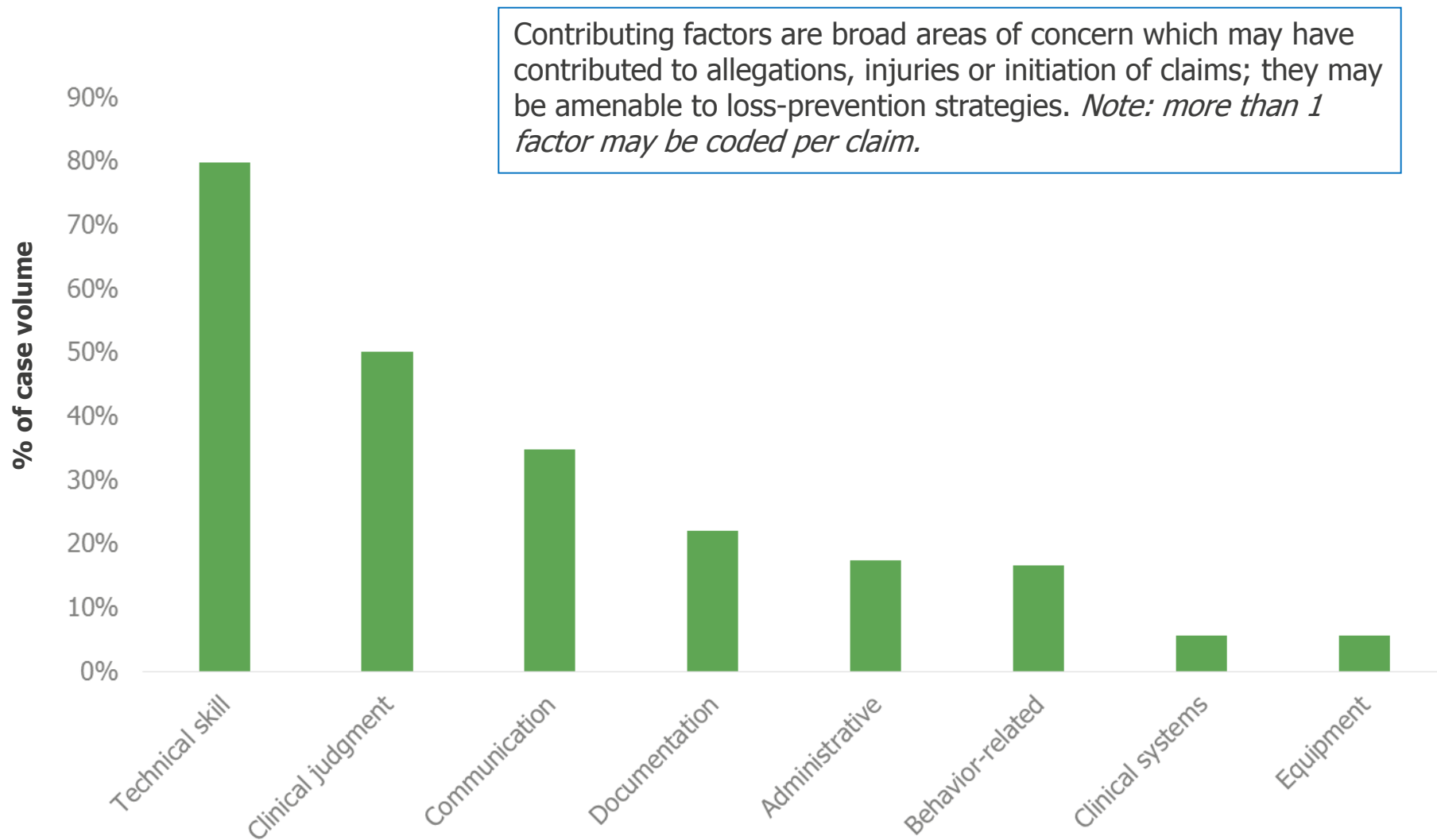
Data source: MedPro Group claims, closed dates 2003-2014; ambulatory surgery location; any totals not = to 100% are result of rounding

Secondary responsible service

Within any one case, there is always a determination of one primary responsible service, but because healthcare is delivered by a team of professionals, the possibility is that one or more additional providers may have contributed to the ultimate outcome. We see here that while nursing staff were primarily responsible just 5% of the time, they played a role in another third of the cases as well.



Top contributing factors



Frequent Risk Issues in ASCs

- Failure to perform adequate pre-surgical assessment
- Failure to provide timely intervention during a procedure
- Performing surgery on the wrong part /patient
- Failure to follow policy and procedure
- Negligent use of surgical equipment
- Electrocautery device ignited oxygen
- Retained foreign body
- Disruptive behavior in the OR
- Cell phone issues – pictures, texting, games



Risk Considerations

- Pre –op & Surgical Clearance
- Health literacy
- Thorough documentation
- Ensure clinical staff meet competencies
- Make sure physicians are credentialed and privileged
- Pick RIGHT procedure for RIGHT location for RIGHT patient!



Informed Consent Process

- Informed consent is an education process that helps develop a *partnership* between the provider and the patient.
- Informed consent is the responsibility of the provider and cannot be delegated.
- A signed form may not comprise an informed consent.



Informed Consent Process

- Explanation of the procedure in layman's language (radiograph = X-ray, etc.)
- Use of translators/interpreters
- Use of educational materials (pamphlets, brochures, drawings, videos, etc.) used to reinforce the education provided by the dentist
- Role of staff in the informed consent process



Communication and Health Literacy



Top Infection Control Risks in ASCs

Cause of transmissions:

- Reuse of syringes on multiple patients
- Reuse of single dose vials on multiple patients
- Failure to store and prepare medications under aseptic conditions
- Poor hand hygiene and glove use
- Shared use of fingerstick devices; glucometers without cleaning between patients
- Inadequate sterilization of instruments



Risk Management Strategies – OSA CHECKLIST

CHECKLIST

Obstructive Sleep Apnea Screening



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The checklist below is intended to be used as a step-by-step organizational assessment of the identification, monitoring, and care of patients diagnosed with, or at risk for, obstructive sleep apnea (OSA). If your organization does not have a written policy and procedure for OSA screening and has not implemented an OSA screening tool and clinical pathway, a multidisciplinary committee for program development and oversight is recommended.

	Yes	No
Does your organization have a written policy that requires patient screening (either all inpatients or patients receiving anesthesia or opioids) for the risk or diagnosis of OSA?	☐	☐
Does your organization have a written procedure that describes how the policy is executed?	☐	☐
Does the procedure:		
• Clearly define who is responsible for OSA screening?	☐	☐
• Specifically state which OSA screening tool should be used to identify patients who are diagnosed with, or at risk for, OSA?	☐	☐
• Define the scope of screening — i.e., all inpatient admissions or patients receiving anesthesia or opioids?	☐	☐
• Explain the method for communicating screening results?	☐	☐
• List the necessary screening equipment, such as pulse oximetry, capnometry, and continuous positive airway pressure (CPAP)?	☐	☐
• Clarify the need for patient discharge instructions?	☐	☐
• Include a plan for staff education?	☐	☐
• Describe the process for quality monitoring?	☐	☐

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Obstructive Sleep Apnea
2

	Yes	No
your OSA clinical pathway include implementing the following interventions when appropriate:		
Assessment of inpatient vs. outpatient status based on the patient's condition?	☐	☐
Anesthesia techniques that minimize risk?	☐	☐
Complete reversal neuromuscular blockade at end of the procedure?	☐	☐
Safe extubation postoperatively?	☐	☐
Avoidance of the supine position (if possible)?	☐	☐
Minimizing the use of analgesics (e.g., opiates and sedatives)?	☐	☐
Appropriate monitoring?	☐	☐
Patient and family education regarding postdischarge risks and further evaluation and management?	☐	☐
Utilization of CPAP (e.g., having patients bring in their masks and tubing)?	☐	☐
Elevating the head of bed >30 degrees or lateral position?	☐	☐
Patient monitoring with pulse oximetry (maintain 92 percent or greater) or capnometry?	☐	☐
Assessing and documenting periods of apnea greater than 10 seconds during patient sleep?	☐	☐
Utilization of OSA identification bands?	☐	☐
your organization have a multidisciplinary committee responsible monitoring the quality of OSA screening implementation and use events associated with OSA?	☐	☐

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Ambulatory Surgery Case Studies



Case Studies:

Outpatient Endoscopy: Cardiac Arrest

Gastroenterologist puts in note that he wants cardiac clearance

Note re need for cardiac clearance is in the outpatient record

No clearance given

Cardiologist says No! (But when?)

Failure to ensure cardiac clearance.

Plastic Surgery: Surgeon/Medical Director Says No to Surgery

Another surgeon schedules patient at Surgery Center

First surgeon is Medical Director

Patient arrests and dies

Potential claim that Surgery Center is responsible because
Medical Director should have said no to surgery



Case Studies:

Epidural Injection: Spinal Cord Infarct

Doctor leases Surgery Center

Facility, equipment and staff (Two half days/week)

Potential claim against Surgery Center as lessor

Plastic Surgery: Saphenous Vein Cut Down

Can't start an IV which is necessary before procedure

Doctor offers cut down; has experience

Patient agrees; but already given pre op medication

Patient gets infection at site; claims nerve injury

Consent issues



Case Studies:

Brain Injury: 13 Year Old Having Tonsillectomy

Pre Op Clearance

Lack of Transfer Protocol

Renal Patient: Death

Pre Op Clearance

Policy Regarding Chronic Kidney
Disease

Patient Not NPO: Arrest During Procedure

Credentialing; Podiatrist Assisting with Neck Surgery

Cardiac Clearance: Cardiologist Says No

Too Late

Communication Issues



Issues:

- **Preoperative Clearance/Communication**
- **Consent**
- **Vicarious Liability**
- **Credentialing**
- **Indemnity**



Anticipate The Unexpected !



Questions?

Disclaimer

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