



Healthcare

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Ambulatory Surgery Centers: Enhancing Continuity of Care

Consider the following scenario:

A generally healthy 32-year-old presented to a five suite mixed specialty ambulatory surgery center (ASC) for a diagnostic right-shoulder arthroscopy. The ASC was at full capacity on the morning of the procedure, and the surgeon of record was delayed in arriving at the operating suite due to an inpatient emergency. In an effort to keep the procedure on schedule, the nurse in the pre-operative holding area was instructed to mark the surgical site and transfer the patient to the operating suite. The nurse marked the left shoulder with the word "yes," but failed to verify the correct site with the patient or confirm it against the pre-operative record.

Once in the operating suite, the circulating nurse noted the marking on the left shoulder and proceeded to prep the patient, but did not request site verification from the anesthesiologist or surgical technician. The surgeon arrived moments before induction, and the procedure began immediately, without a time-out verification by the surgical team. The problem went undetected until mid-procedure, when the surgeon questioned the relative lack of disease upon exploration. The pre-operative MRI was consulted at this point, and the error was detected.

The patient subsequently filed a professional liability lawsuit, naming as defendants the attending surgeon, the ASC, and the pre-operative and circulating nurses. Pre-trial discovery revealed that the recently hired pre-operative nurse had received no training in wrong site-wrong surgery protocols, and had not been told who was authorized to mark a surgical site. In addition, the circulating nurse testified that she believed the site had been marked by the

surgical technician just before her arrival at the operating suite. The ASC lacked a written protocol for patient handoff communication between pre-operative and surgical staff, as well as a comprehensive policy regarding procedure verification, surgical site marking and mandatory time-out checks. In light of these considerable deficiencies in care and operations, the ASC could present no defense and settled for a six-figure sum.

ASCs were created to maximize efficiency and patient convenience while maintaining a high level of quality. Advances in surgical and anesthesia care over the last few decades have made it possible for ASCs to offer an ever-widening range of patient services, including complex, sophisticated surgical and radiological procedures. However, as the case history illustrates, ambulatory care presents significant risks. As surgeons juggle office practices, hospital schedules and outpatient procedures, the fast pace and competing demands of their work can potentially compromise continuity of care, resulting in serious or even fatal errors.

A sound handoff process is vital to protecting patients and reducing liability exposure. The checklist on pages 3-7 is designed to help ASCs achieve safe, seamless transitions in care by focusing on such key areas as staffing, training and communication.

Federal report highlights ASC safety- and health-related challenges

The Centers for Medicare & Medicaid Services (CMS) State survey and certification process is the primary oversight tool for ensuring the health and safety of Medicare and Medicaid patients treated at ambulatory surgery centers (ASCs). Approximately 3,700 ASCs (or two-thirds of the nation's total) are certified by their state health agency on behalf of CMS – known as “nondeemed” ASCs. The remaining facilities earn accreditation (which serves as their CMS certification) through a Medicare-approved agency, such as The Joint Commission. The latter are referred to as “deemed” ASCs.

In September 2019, the U.S. Department of Health & Human Services, Office of Inspector General released [Medicare's Oversight of Ambulatory Surgery Centers: A Data Brief](#). The brief identifies trends in survey deficiencies among non-deemed ASCs, as well as consumer complaints registered against both nondeemed and deemed facilities. The data, compiled from fiscal years 2013 to 2017, underscore the continued challenges that ASCs encounter in meeting health and safety requirements. The following are key findings of the report:

- **Slightly more than three-fourths of surveyed facilities were cited for at least one deficiency** and 25 percent had serious deficiencies, defined as pervasive noncompliance that poses a serious threat to patient health and safety.
- **Infection control was the most commonly cited deficiency** among both nondeemed and deemed ASCs, comprising between 19 and 22 percent of all deficiencies cited for each year. With respect to nondeemed ASCs, more than half were deficient in infection control procedures, such as making sure surgical equipment is properly sanitized.
- **Nearly one-third of the surveyed ASCs were deficient in pharmaceutical requirements, environmental controls or patient rights mandates**, and some failed to meet all three of these conditions for Medicare coverage.
- **Of 732 complaints registered against ASCs, nearly half were substantiated** by findings that staff had failed to properly assess patients pre-operatively, lacked medical records for some patients and did not adhere to adopted procedures.

Quick Links

- Agency for Healthcare Research and Quality (AHRQ). [Improving Patient Safety in Ambulatory Surgery Centers: A Resource List for Users of the AHRQ Ambulatory Surgery Center Survey on Patient Safety Culture](#). March 2016.
- AHRQ's pocket guide, titled [“TeamSTEPPS: Team Strategies & Tools to Enhance Performance and Patient Safety,”](#) January 2014.
- Ambulatory Surgery Center Association, [“Staffing of the PACU/Patient Acuity Tool,”](#) posted 2012.
- American Board of Perianesthesia Nursing Certification, Inc. [Certification requirements and related information](#).
- American Society of PeriAnesthesia Nurses, [2019-2020 PeriAnesthesia Nursing Standards, Practice Recommendations and Interpretive Statements](#).
- Association of periOperative Registered Nurses (AORN), [“Patient Hand Off Toolkit.”](#) Available to members for download. Also see AORN's position statement, [“Perioperative Registered Nurse Circulator Dedicated to Every Patient Undergoing an Operative or Other Invasive Procedure,”](#) revised March 2019.

Slightly **more than three-fourths** of surveyed **facilities** were cited for **at least one deficiency** and 25 percent had serious deficiencies, defined as pervasive noncompliance that **poses a serious threat to patient health and safety**.

Ambulatory Surgery Center Safety Checklist

Risk Control Elements	Yes/No	Comments
Staffing		
Patient selection criteria reflect available nursing skills , as well as the risks posed by anesthesia and surgery in relation to such factors as the patient's physical status, potential complications and comorbidity indices. (See the American Society of Anesthesiologists® Physical Status Classification System .)		
Nurses and other licensed providers are assessed upon hire for competency levels , and findings and deficiencies are documented.		
Annual continuing education (CE) requirements are established for all licensed practitioners , and CE attendance is documented in personnel files.		
Written policy defines actions to take when patient care requirements exceed internal capabilities , establishing criteria for transfer or referral to an acute care setting.		
Staffing ratios are established for all areas of surgical care based upon applicable state regulations and professional association/ accreditation guidelines (e.g., 1:1 for operating rooms, 1:2 for post-anesthesia care units).		
Staffing levels factor in key variables , including:		
• Patient population (e.g., adult/pediatric ratio).		
• Acuity and complexity of case mix.		
• Number of reserved procedure and/or operating rooms.		
• Average length of patient stay.		
• Physical layout of care unit.		
• Sophistication of technology used.		
• Training and experience of nurses.		
• Overall staff skills and competencies.		
• Availability of ancillary staff support.		
Staffing ratios are established for specific procedures , and remain consistent over time.		
Staffing models emphasize flexible shifts of between eight and 12 hours , depending upon the ASC's level of resources. If staggered shifts are utilized (e.g., pre-operative staff arrive at 5 a.m., operating room [OR] staff arrive at 6 a.m., post-operative staff arrive at 7 a.m.), scrupulous attention must be paid to patient handoffs and staff transitions.		
Written policy authorizes management to call in additional staff in response to actual or anticipated shortages.		
Nursing staff members are cross-trained in at least two phases of operative care (e.g., pre- and post-operative).		

Risk Control Elements	Yes/No	Comments
Staffing (continued)		
Staffing levels are analyzed monthly and correlated with adverse event/near miss data and the following nursing-sensitive patient outcomes:		
• Shock		
• Hemorrhage		
• Reintubations		
• Bloodstream infections		
• Pneumonia		
• Failure-to-rescue occurrences		
• Malignant hyperthermia		
• Transfers to an acute care setting		
• Thirty-day mortality rates		
Job descriptions for all levels of nursing and clinical ancillary staff are reviewed and updated as necessary to maintain and enhance continuity of care.		
Staff are promptly informed of any changes in supplies and equipment, and are oriented and retrained when necessary.		
Perioperative Registered Nurse (RN) Circulators		
The role of the perioperative RN circulator is expanded to include coordination of the nursing care of all surgical patients during the pre-operative, intra-operative and post-operative phases.		
RN circulators delegate, monitor and evaluate the activities of the surgical team, and also execute directives and interventions in urgent and emergency situations.		
Written policy designates circumstances when more than one RN circulator is required per procedure, such as high patient acuity level, extensive monitoring requirements or complex surgical technology.		
RN circulators are provided with clear indicators for medical staff interventions or consultations, such as emergency airway obstruction, sudden drop in hemostasis, unexpected bleeding, hypo/hyperthermia, reactions to medications or blood transfusions.		
RN circulators are authorized and empowered to initiate a pause in surgical procedures and transfers until all members of the surgical team arrive at a mutually acceptable resolution to actual or potential problems.		
RN circulators keep OR supervisors/management apprised of patient status, as well as the need for assistance in the event of complications or emergencies.		
RN circulators interpret facility policy for OR personnel in the event of a question or conflict.		
RN circulators are required to reassess patients and review documentation prior to transfer to post-operative care or discharge.		

Risk Control Elements	Yes/No	Comments
Post-operative Nursing		
Required skills of post-operative nursing personnel are formally defined and regularly reviewed.		
Nursing staff undergo specialized training in post-operative care, with emphasis on assessing and managing the following:		
• Airway patency		
• Level of consciousness		
• Pain		
• Nausea/vomiting		
• Body temperature		
• Surgical site intactness		
• Patency of drainage tubes		
• Patency/rate of intravenous infusions		
• Circulation/sensation in extremities		
• Level of sensation after regional anesthesia		
• Emergency situations		
RNs are given the opportunity to be certified in post-anesthesia care – i.e., to become a certified post anesthesia nurse (CPAN).		
All ASC clinical personnel are trained in rapid response techniques to manage acute post-operative events, including airway obstruction, hemorrhage and unstable hemodynamics.		
A written discharge criteria protocol is adopted, and a scoring system is used to identify when the anesthesia provider must manage the discharge.		
Written discharge protocols are reviewed on an annual basis.		

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Risk Control Elements	Yes/No	Comments
Patient Handoffs		
<p>A written policy is established and implemented governing patient handoff practices, emphasizing the need to confirm staff responsibility for patient care, provide critical change updates, enhance continuity of care, and communicate across disciplines and professional boundaries.</p>		
<p>A standard reporting format supports the handoff process, such as the <u>"SBAR" technique</u> (i.e., Situation, Background information, Assessment findings, Recommendations) or <u>"MAPS"</u> (i.e., Medications, Allergies, Procedure/pertinent information, Special needs).</p>		
<p>The selected handoff reporting format is utilized by staff to convey and recall instructions, record information and plan patient care at the following critical moments:</p>		
<ul style="list-style-type: none"> • Temporary relief or coverage breaks. 		
<ul style="list-style-type: none"> • Transfer of care from one physician to another. 		
<ul style="list-style-type: none"> • Initiation or cessation of respiratory support. 		
<ul style="list-style-type: none"> • Transfer from pre-operative area to OR. 		
<ul style="list-style-type: none"> • Transfer from surgical areas to the post-anesthesia unit or recovery unit. 		
<ul style="list-style-type: none"> • Discharge home. 		
<ul style="list-style-type: none"> • Transfer to an acute care facility. 		
<p>Staff routinely repeat information as they receive it, in order to foster interactive, face-to-face dialogue at transitional points.</p>		
<p>Staff members adhere to approved language and terms when conducting handoffs, and refrain from vague, uninformative and potentially confusing phrases, such as "The patient is okay" or "She is stable."</p>		
<p>Discussion "triggers" are utilized during patient handoffs, such as:</p> <ul style="list-style-type: none"> • "I am concerned about ..." • "I am uncomfortable with ..." • "I think we have a safety issue." 		
<p>Policy requires a "read-back" between at least two caregivers upon receipt of critical information (such as STAT test results) and before any invasive intervention, in order to verify correct patient, site and procedure.</p>		
<p>Staff members are trained in effective communication techniques, including listening actively and requesting an interpreter when necessary.</p>		
<p>Family members are included in handoff discussions at the time of discharge, with the patient's permission.</p>		
<p>Discharge instructions are reviewed with the patient, taking into consideration his or her fluency in English and level of health literacy.</p>		
<p>Patients are contacted regarding their physical status for a minimum of one week following discharge.</p>		

Risk Control Elements	Yes/No	Comments
Policy Implementation/Error Analysis		
<p>Protocols addressing intake and admission, pre-operative preparation, intra-operative monitoring, post-procedure recovery and discharge are documented and followed.</p>		
<p>Integrated care pathways and clinical guidelines are utilized for common surgical procedures and interventions, covering critical processes such as standing physician orders, pre- and post-operative monitoring, pharmaceutical management and discharge preparation.</p>		
<p>A system wide infection control program is documented, implemented and reviewed annually, in order to reinforce the importance of the following universal biosafety practices:</p>		
<ul style="list-style-type: none"> • Hand hygiene and use of personal protective equipment. 		
<ul style="list-style-type: none"> • Injection safety and safe medication handling. 		
<ul style="list-style-type: none"> • Equipment reprocessing (e.g., sterilization and high-level disinfection). 		
<ul style="list-style-type: none"> • Environmental hygiene. 		
<ul style="list-style-type: none"> • Safe handling of bodily fluids and bio-hazardous substances. 		
<p>Pharmaceutical services include the following components, among others:</p>		
<ul style="list-style-type: none"> • Oversight by licensed pharmacist(s) or a satellite pharmacy for medication preparation and dispensing. 		
<ul style="list-style-type: none"> • Safeguards against drug interactions and drug allergies. 		
<ul style="list-style-type: none"> • Documented guidelines for I.V. admixture preparation. 		
<ul style="list-style-type: none"> • Pain management guidelines and documentation requirements for dispensing of controlled drugs. 		
<ul style="list-style-type: none"> • Patient access to medication counseling services. 		
<p>Life safety functions undergo a documented schedule of testing and maintenance to ensure a safe, functional and supportive environment of care, including items such as fire alarms and sprinkler systems, fire extinguishers, fire dampers, fire doors, emergency egress lights and exit signs, as well as backup generators and medical gas supply.</p>		
<p>Integrated protocols are designed and implemented to guide the dissemination of information to patients, including patient rights, disclosure of physician financial interest or ownership in the facility, and access to grievance procedures.</p>		
<p>Root-cause analyses are conducted following deviations from documented policy in order to assess the procedural, system and human breakdowns that led to the deviations.</p>		
<p>Opportunities for performance improvements are identified in such areas as staff training, communication skills, documentation procedures, response to diagnostic findings and medication errors.</p>		

This tool serves as a reference for organizations seeking to evaluate risk exposures associated with continuity of care in ambulatory surgery settings. The content is not intended to represent a comprehensive listing of all actions needed to address the subject matter, but rather is a means of initiating internal discussion and self-examination. Your clinical procedures and risks may be different from those addressed herein, and you may wish to modify the tool to suit your individual practice and patient needs. The information contained herein is not intended to establish any standard of care, serve as professional advice or address the circumstances of any specific entity. These statements do not constitute a risk management directive from CNA. No organization or individual should act upon this information without appropriate professional advice, including advice of legal counsel, given after a thorough examination of the individual situation, encompassing a review of relevant facts, laws and regulations. CNA assumes no responsibility for the consequences of the use or nonuse of this information.

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