During a preoperative screening, a nurse learns that a patient scheduled for a hernia operation in your ambulatory surgery center (ASC) has several comorbidities, including cardiac disease and chronic obstructive pulmonary disease. The history and physical are sketchy.

In another case, a patient seems confused about the procedure she is having even though she has signed the surgical consent.

If these scenarios sound familiar, it’s not surprising. They represent some of ASCs’ top liability risks. Here is a look at 3 of the top risk management issues for ASCs:

- patient selection
- management of complications and emergencies
- informed consent.

Another top issue, patient discharge, will be discussed in the March OR Manager.

Patient selection

Without question, patient selection is “the number one risk management issue for ASCs,” says Michael Midgley, RN, MPH, CPHRM, a risk management consultant for AIG Consultants, Inc, Health Care Management Division, New York City, who spoke at the 2006 FASA annual conference.

It’s essential for facilities to have specific, written criteria to guide patient selection.

“ASCs must have written criteria for surgical procedures they can accommodate,” he says. These need to be formally approved by the medical director and credentialing/privileging committee.

“If you don’t define the approved cases, there’s a danger physicians may try to go beyond what is appropriate for an ASC,” he says.

The criteria need to be available to the scheduler and nurse manager to consult when procedures are scheduled. Midgley recommends having a list of procedures considered appropriate for your ASC, “the more specific the better.” For example, if your center performs cholecystectomies, are both laparoscopic and open procedures acceptable?

Ultimately, the medical director is responsible for the criteria and for seeing that they are followed, he adds.

Medical oversight

Though surgeons and anesthesiologists are typically independent contractors, the ASC has an obligation to provide oversight for their activities.

“If there is a surgical complication that results in a negligence claim, the ASC will be better able to defend itself if there is documentation that can demonstrate that it exercises oversight,” he says.

ASCs grant credentials and privileges to the medical staff, a process that needs to be repeated every 2 years. Any physician concerns should be considered in recredentialing. Concerns may be identified through the performance improvement program, patient safety initiatives, patient complaints, complication rates, and so forth. This should be clearly outlined in the medical staff bylaws.

Patients also need to be informed about the relationship between ASCs and their
providers, Midgley encourages ASCs to post a sign at the reception desk stating that the surgeons and anesthesia providers are independent contractors. Some ASCs also ask patients to sign a document stating that they have been informed of this fact.

By informing patients of this nonemployer relationship, the ASC reduces the potential for liability claims, he notes.

Managing complications and emergencies

ASCs need well-planned policies and procedures for managing emergencies, such as an adverse reaction to anesthesia or unexpected blood loss.

“Many negligence claims involve a cascade of bad decisions and delayed reactions,” Midgley says.

He emphasizes the need for education and drills to sharpen clinicians’ responses. A good time for drills is on a light surgery day. Managers could set up a mock emergency and allow clinicians to practice.

Be sure to document drills that are held.

“It’s one thing to have a policy saying you do drills, but you need to demonstrate that you actually perform them,” he says. Document attendance as well as the drill’s scenario and debriefing that took place afterward.

When complications arise, a timely recognition and response are critical.

“In many emergencies, it’s the failure to identify a change in the patient’s condition that leads to disaster. A subtle change in vital signs can be the first clue. This needs to be emphasized with the nursing team—it comes down to good communication with the medical staff and alerting the surgeon of subtle changes. Don’t wait to see if the patient’s condition will improve in 15 minutes—it may be too late,” he says.

Other points to consider:

• ASCs need a transfer agreement with a local hospital to accept patients in emergencies. The agreement should be specific. For example, in case of a cardiac emergency, does the hospital have a cardiac interventionalist available during the hours the ASC is open?

• Postop phone calls to patients need to be documented. If patients don’t answer the first time, several attempts should be made and documented.

• There needs to be a procedure for routinely collecting data from surgeons and nurses about postoperative infections. This data should be included in the ASC’s performance improvement plan.

Informed consent

The purpose of informed consent is to make sure the patient is fully informed about all of the risks and benefits of the procedure and related care so the patient can make an informed decision about whether to have the treatment.

Informed consent also is a regulatory requirement. Medicare’s guidelines for surveyors on the conditions of participation for ASCs state that patients’ medical records must include, among other things, “documentation of properly executed informed patient consent.” Accrediting bodies, including the Accreditation Association for Ambulatory Health Care and the Joint Commission also have informed consent requirements.

The informed consent for surgery is, of course, the surgeon’s responsibility. The patient also needs to be informed about anesthesia and other care provided in the facility.

Though it is not a requirement, Midgley recommends 3 separate informed consent documents—to cover the surgeon, anesthesia services, and the surgery center itself.

“Typically, there are 3 separate entities involved, and this needs to be reflected in the informed consent process. This may seem a little labor intensive, but it’s to protect all of the parties involved,” he says.

Ideally, the surgical consent is documented on the surgeon’s own letterhead. The anesthesia consent is also best documented on the anesthesia group’s letterhead.

The ASC’s consent form should meet legal and regulatory requirements and is best drafted by the facility’s legal counsel.
Consent documents are kept in the patient’s record, which is retained for the period specified by law.

**Patients warranting a careful look**

These situations require special attention in patient selection.

**ASA 3 and above**

Typically, ASCs specify that any procedure for a patient above ASA Class 3 requires the approval of the medical director. (ASA refers to the American Society of Anesthesiologists patient status classification.)

**Morbid obesity**

Consider whether patients over 300 pounds are appropriate candidates for the ASC. They are more likely than other patients to have comorbidities like diabetes and difficult airways. Also consider whether the facility has the equipment, such as beds, assistive devices, and imaging equipment to care for these patients appropriately and safely.

**Children**

“Most experts are not recommending outpatient surgery for infants under 9 months of age,” Midgley says.

**Patients having lengthy surgery**

Procedures over 3 hours typically need to be performed in the inpatient setting, advises Midgley. The same is true for patients needing an extended recovery stay.

**Certain procedures with higher complication rates**

For example, open gastrointestinal procedures have an increased rate of infection. Some procedures require a patient to be in one position for an extended period, with the potential for nerve injuries.

**Hard-to-control pain**

Patients whose postoperative pain will be difficult to control may not be good candidates for an ASC. An example is those who require a patient-controlled analgesia pump.

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**Who owns ambulatory surgery centers?**

The lion’s share—88% of surgery centers—have some element of physician ownership. About half are owned 100% by physicians. Hospitals have an ownership in 32% of ASCs, a 3% increase over 2 years ago. The ownership survey, conducted by the American Association of Ambulatory Surgery Centers (AAASC), was sent to about 500 ASCs with an 18% response.

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