Careful screening and scrutiny needed to select ambulatory surgery patients

The patient, an elderly woman, arrived at Red Rocks Surgery Center in Golden, Colorado, for an ophthalmology procedure. A paraplegic, she was using a scooter chair. Administrator Jane Klinglesmith, BS, RN, CNOR, watched her checking in at the admissions desk and noticed she was on dialysis. As she approached, Klinglesmith became aware that the patient was morbidly obese as well.

The patient was not happy to learn that she would have to have the procedure at a later date, in a hospital.

How could this happen?

Klinglesmith believes the referring physician may not have been aware of the patient’s weight because of her chair; her other conditions would not have automatically disqualified her for the procedure at the surgery center. As it happened, this particular patient had been added to the schedule late in the afternoon of the day before the procedure.

The incident illustrates how critical, yet difficult, it is to ensure that ambulatory surgery centers (ASCs) serve all eligible patients but none who are not eligible.

As a multispecialty ASC owned by Hospital Corporation of American (HCA), Red Rocks is bound by the hospital company’s policy “to create an overall culture that makes patient safety paramount,” and that includes following clinical and regulatory standards for patient selection.

The anesthesia factor

“Most ASC tragedies occur not from error, but from faulty patient selection,” according to anesthesiologist David Shapiro, MD, manager of the Ambulatory Surgery Company in Tallahassee, Florida. Good patient selection generally starts with the anesthesiologist, Dr Shapiro notes, because “in most surgery centers, almost anything you do includes anesthesia care.” He advises that when ASCs contract with anesthesiologists, as many do, they should be sure candidates are skilled in working with outpatients. “There’s a huge difference in what they do,” he says, “so don’t just hire them from hospitals. They need ASC-appropriate skills.”

The American Society of Anesthesiologists (ASA) has developed a 6-level scale to assess the physical status of a patient:

1. a normal, healthy patient
2. a patient with mild systemic disease
3. a patient with severe systemic disease
4. a patient with severe systemic disease that is a constant threat to life
5. a moribund patient who is not expected to survive without the operation
6. a declared brain-dead patient whose organs are being removed for donor purposes.

The list appears annually in the ASA Relative Value Guide but does not include specific criteria for each category. While it is a useful guideline, the ASA does not
consider the physical status classification to be a measure of an individual patient’s risk of undergoing a particular surgical procedure. There are no studies to show any correlation between ASA physical status and surgical risk.

**Consider the procedure**

The type of procedure is the second major criterion for proper patient selection; not all patients, regardless of ASA status, can safely undergo a given procedure. As technology advances, more complex procedures such as orthopedic implants are being approved for ASCs, but only for the most qualified patients. Such patients not only are in good general health but also have adequate care available at home after discharge.

Various agencies and professional organizations have issued guidelines for the assessment of risk factors for ambulatory surgery, and the Centers for Medicare and Medicaid Services (CMS) has published detailed rules for determining a patient’s status.

The Agency for Healthcare Research and Quality (AHRQ), part of the US Department of Health and Human Services, has issued patient selection guidelines for ambulatory surgery (visit www.ahrq.gov).

Before accepting a patient, the ASC staff or referring physician should obtain a medical history and conduct a physical examination that covers at least the following areas:

- ASA status
- body mass index
- respiratory status
- risk of thrombosis or embolism
- cardiovascular status via electrocardiogram, if clinically indicated
- complete blood count and blood chemistry, if clinically indicated.

The AHRQ recommendations state that patients with ASA status 1-3 may be considered for ambulatory surgery, depending on the type of procedure and type of anesthesia.

Age is another consideration. The AHRQ recommendations note that persons over age 60 are at increased risk of cardiovascular disease. Patients with a body mass index up to 34.9 kg/m² can be considered, but others generally should be treated in a hospital. Obese patients should be screened for obstructive sleep apnea. The more risk factors there are, the more likely it is that a particular patient should not have the procedure as an outpatient.

Section 416.52 of the CMS Conditions for Coverage, Standard: Admission and Pre-surgical Assessment, contains standards for preadmission procedures. First, the medical history and physical assessment (H&P) must be completed within 30 days of the scheduled procedure. The H&P may be completed the day of surgery but must be performed before the patient enters the OR because the information obtained (allergies, for example) could lead to modifying or even canceling the procedure. CMS specifically allows for a single H&P to cover more than 1 surgery as long as all are performed within the 30-day limit.

Regardless of the result of the H&P, Section 416.42(a)(1), Standard: Anesthetic Risk and Evaluation requires that a physician separately examine the patient immediately before surgery. “Patients may have had a change in health status after the H&P but may not recognize the significance for their planned surgery,” the CMS guidance explains.

The number and types of tests included in the physical assessment may vary by patient, ASC, and requirements of state regulators. At Red Rocks, an online ques-
Questionnaire allows patients to provide history and medication information at their convenience. They are asked to describe chronic conditions (comorbidities), allergies, medications they are currently taking, and past reactions to anesthetic drugs. Those without computer skills or access receive a phone call. “We do the best we can to get in touch with the patient ahead of the scheduled procedure,” Klingle-smith says.

**What tests, when?**

In the early days of outpatient surgery, many patients were admitted to the hospital the evening before the procedure so that clinicians could administer blood tests, a chest x-ray, an electrocardiogram (ECG), and a history and physical. They also would prepare the patients for anesthesia, instructing them about fluid and diet restrictions and medication changes as appropriate. A patient in good health might then be sent home and return the following day for the actual procedure.

“Now we have better technology,” Klingle-smith says, “and the referring physician can do some of those tests.” Other tests, such as ECGs, can be referred to clinical laboratories.

A federal law provides additional flexibility. The 1988 Clinical Laboratory Improvement Amendments (CLIA) established quality standards for laboratory testing that apply regardless of the type of facility where the tests are conducted. In 1992, the Food and Drug Administration published regulations under 42 CFR part 493 that permit waivers for facilities conducting tests that are easy to perform and without risk to patients. Many states have CLIA certification programs that allow Medicare-certified ASCs to provide onsite testing.

Such a policy keeps preadmission tests to a minimum but does not eliminate them completely. Among tests Red Rocks performs are those that could reveal very recent changes in a patient’s condition. For example, if a woman is of child-bearing age, she receives a pregnancy test. Diabetic patients are tested for blood glucose. Those receiving diuretic medications are tested for potassium levels.

Any adverse results could force cancellation at the last minute, Klingle-smith agrees, “but that is rare.”

In the final reckoning, no amount of testing or screening can outweigh the patient’s role in making ambulatory surgery successful. The very nature of outpatient surgery requires the patient’s understanding and cooperation. According to Klingle-smith, the most common reason for canceling a procedure is a patient’s lack of compliance with preparation instructions, such as failure to fast, take or halt medications, or arrange for an escort.

—Paula DeJohn

**References**
