Being prepared for emergency transfers

Patient transfer 1: During colonoscopy, the colon was perforated. Patient was given Cipro IV and became hypotensive. Anesthesiologist accompanied patient in ambulance and then to the OR.

Patient transfer 2: Postprocedure patient received in PACU in respiratory distress, pulse ox 85%-90% on room air. O₂ supplemented with nonrebreather mask. Anesthesia and surgeon agreed to ACLS transfer via local medic unit.

Patient transfer 3: Following removal of hardware, bleeding continued. Dorsalis pedis artery was lacerated. Vascular surgeon called. Artery repaired. Patient transferred to hospital.

These are excerpts of reports submitted to the Pennsylvania Patient Safety Reporting System of patients transferred unexpectedly from ambulatory surgery centers (ASCs) to hospitals in Pennsylvania. Spotting a trend in unanticipated emergency care at ASCs, a state agency looked into the issue.

The agency, the Pennsylvania Patient Safety Authority (PSA), routinely collects reports of adverse events and near misses in the state’s health care facilities. Of 1,960 reports by ambulatory surgery facilities from June 2004 to July 2005, 35% required unanticipated patient care or patient transfer to another provider.

The PSA reviewed a random sample of 100 ASC adverse event reports. The results: 35 cases involved unanticipated care. Of these:

• 19 (54%) were postoperative transfers that required immediate surgery, follow-up care, or observation.
• 11 (31%) involved preoperative procedure cancellations, nearly all because of cardiac-related symptoms. In each case, the patient was transferred or referred to another facility for follow-up care and usually was taken by ambulance to a hospital emergency department.
• 5 (14%) were categorized as intraoperative changes in the patient’s condition that necessitated aborting the procedure. Perforations were the most frequently reported cause for urgent transfer to the hospital, followed by uncontrolled bleeding.

Expecting the unexpected

The substantial increase in procedures at ambulatory surgical facilities means it is critical for clinical staff to anticipate and prepare for emergency care and transfers, notes the article, “Expecting the unexpected: Ambulatory surgical facilities and unanticipated care” (Pennsylvania Patient Safety Reporting System. Patient Safety Advisory. 2005; 2:6-8.)

“Our goal is to review events and share lessons learned so we can prevent future adverse events,” says Alan B.K. Rabinowitz, administrator of the PSA, a nonregulatory agency.

Transfer risk predictors

A literature review by the PSA showed these conditions most often lead to hospital admission or procedure cancellation for ambulatory surgery patients:

• hospitalization within the previous 6 months, with a 2-fold increased risk associated with multiple prior inpatient hospital admissions
• age of 85 years and older, with a 2-fold increased risk in the 65- to 69-year-old cohort
• peripheral vascular disease
• operating room time greater than 1 hour
• malignancy
• positive HIV status
• heart disease
• requirement for general anesthesia.

For patients with these risk factors, it may be best to reschedule the procedure at a hospital, the PSA suggests.

“Examining the patient’s history of recent hospitalization and reviewing identified risk factors may provide insight into the potential for transfer or admission post-procedure as well as the likelihood of case cancellation,” the report notes. “Though everyone wants to avoid a cancellation, it is frequently better to interrupt the surgical schedule and inconvenience the patient than to risk an emergent situation.”

Preventive steps
To reduce emergency transfers and adverse events, the PSA also recommends that ASCs examine these areas for risk analysis and quality improvement:

• **Patient selection.** During preoperative assessments, ASCs should evaluate preoperative medical needs, the expected postoperative care, and the level of home support to determine the most appropriate procedure location.

• **Emergency preparedness.** Regulatory and accrediting bodies address the issue of ASC preparedness for emergencies. The Pennsylvania PSA recommends that emergency preparedness procedures include:
  —designating which practitioner from the ASC escorts the patient during transfer
  —determining when to activate the 911 system
  —deciding where the patient will go
  —ensuring that staff prepared in advanced cardiac life support (ACLS) and/or pediatric advanced life support (PALS), depending on patient age, is available at all times
  —ongoing staff education about how and when to activate the emergency plan, including conducting routine drills.

• **Transfer readiness.** ASCs should review their state health department requirements for patient transfer readiness. Rabinowitz says Pennsylvania requires an ASC to have:
  —a written transfer agreement with a hospital that has emergency and surgical services and/or where the ASC's surgeons have admitting privileges
  —a written agreement with an ambulance service staffed by certified emergency medical technicians for the safe transfer of patients to the hospital.

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Resources on patient emergency transfer

American College of Surgeons
www.facs.org

Association of periOperative Registered Nurses
www.aorn.org

Pennsylvania Patient Safety Authority
www.psa.state.pa.us/psa