Objective

Review specialty specific claims trends from a patient safety and malpractice perspective.
Areas of Liability Exposure

Risk Issues Identified With Anesthesia Closed Claims - 2008-2014 Hospital based only

- Documentation: 58%
- Communication: 31%
- Medications: 26%
- OR/Anesthesia Mishap: 10%
Effective Documentation

A quality medical record fosters:

- Effective communication among health care team
- Promotes effective management of patient care
- Serves as evidence of facts regarding diagnosis/treatment
- Helps defend allegations of negligence
- May help establish Standard of Care met
- Takes precedence over memory of past events
- Held to be more objective than verbal testimony
Documentation Issues

Breakdown of Documentation Issues 2008-2014 (Hospital-Based only)

- Inadequate documentation: 71%
- Illegible documentation: 12%
- Erroneous documentation: 7%
- Untimely documentation: 4%
- Apparent alterations: 4%
- EHR related: 2%

Total: 100%
Case: Inadequate Documentation

50 year old male underwent repair of umbilical hernia

LMA used and O2 saturations decreased

Unsuccessful intubation attempts and emergency tracheostomy

Patient suffered brain hypoxia – transferred to hospital

Remains in vegetative state

Lawsuit filed alleging improper management of patient’s airway
Case: Inadequate Documentation

The pre-anesthesia assessment lacked details:

- Classification of airway
- Neck extension
- History of prior intubation difficulty not noted
- Evaluation for presence of Obstructive Sleep Apnea
- Dentition
- Medical judgement regarding anesthesia plan questioned
Inadequate Documentation: Pre-Anesthesia Evaluation

Common Missing Factors:

- Pre-op test results: EKG’s, labs, etc.
- Significant co-morbidities that increase risk of difficult intubation or emergence
- Be aware of the ASA Difficult Airway Algorithm
- Airway evaluation / Mallampati score
- History of prior anesthesia difficulties
- Dental issues – loose teeth, caps
Inadequate Documentation – Anesthesia Record

What’s often missing:

◆ Details about emergency response / interventions
  – Notes regarding cardiac activity ceasing, major inconsistencies with the op note

◆ Maneuvers utilized for managing a difficult airway
  – Plaintiff’s alleged lack of attention to detail

◆ Anesthesiologist’s presence during induction/emergence
  – Led to allegations of improper CRNA oversight

◆ Positioning and padding / eye protection not noted

◆ Time out for blocks / invasive lines (Holding Room)
  – Verify patients identity; check consent for correct procedure / side / site / position
Inadequate Documentation: PACU

PACU – what’s often missing when evaluating claims:

- Patient status at handoff to PACU nurses
- Anesthesia Quality Institute:
  - ASA #6: Post-Anesthetic Transfer of Care: Use of Checklist or Protocol for Direct Transfer of Care from Procedure Room to ICU
  - ASA#9: Anesthesiology: Post-Anesthetic Transfer of Care Measure: Procedure room to a Post Anesthesia Care Unit
  - [Website](http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/MeasuresCodes.html)
Inadequate Documentation: PACU

PACU – What’s often missing when evaluating claims:

- Determination of patient status prior to PACU discharge
  - Assessment criteria approved by anesthesia department
  - Anesthesia to determine appropriate time for discharge
  - If patient refuses recommendations to stay: document instructions given to patient and risks discussed
## Additional Documentation Issues

<table>
<thead>
<tr>
<th>Untimely Notes</th>
<th>Erroneous Documentation</th>
<th>Alterations</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Memory can interfere with accuracy</td>
<td>• Anesthesia record and op note vary in terms of blood loss and fluids</td>
<td>• Physician integrity questioned</td>
</tr>
<tr>
<td>• Delayed documentation may appear self serving</td>
<td>• Documentation not updated after adverse event</td>
<td>• Consult a Claims Attorney before making a change to the record after receipt of notice of claim or lawsuit</td>
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</tbody>
</table>

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Additional Documentation Issues

**EHR Issues: Case Example**

- Two separate templates were opened for patient
- Both pre-populated with medications and doses
- One changed to reflect actual medications used and procedure events
- Patient suffered profound neurologic injury post-op
- Lawsuit alleged inappropriate anesthetic medications administered
- Both templates in chart led to confusion – plaintiff challenged the integrity of the overall documentation
Communication Issues

Breakdown of Communication Issues
2008-2014 (Hospital-Based only)

- Physician: Physician - 37%
- Physician: CRNA - 44%
- Inadequate Consent - 13%
- CRNA: Patient - 3%
- Physician: Staff - 3%
Communication Issues – Physician to Physician

Communication between the Anesthesiologist and the Surgeon:

- Obese patient undergoing hernia repair
- No discussion of plan of care / emergency airway needs
- Not prepared when patient experienced respiratory difficulty during procedure
- Negligent airway management alleged
Communication Issues: Physician to Physician

Communication between the Anesthesiologist and the Covering Physician:

- 50 year old having Nissen Fundoplasty
- Epidural placed for post-op pain
- Patient transferred to PACU and then to the medical surgical floor with epidural
- Procedural Anesthesiologist went on vacation
- Patient developed cauda equina syndrome
- Covering physician not aware of epidural
Communication Issues: Physician to Physician

Communication Between Anesthesiologist and Covering Physician

Recommendations:

- Provide information about patients with anticipated problems to covering physician
- Ensure proper orders for care are in place upon transfer
- Protocol for removal of indwelling catheters
- Document post-op assessments
Communication Issues: Physician to Provider

Communication between the Anesthesiologist and the CRNA – Case Example

Anesthesiologist has oversight liability for CRNA:

- Anesthesiologist administered Morphine bolus via epidural to 11 month old
- Called out of room – CRNA to oversee infusion
- Morphine inadvertently infused in 20 minutes due to an inaccurate setting on the timing mechanism of the pump
- CRNA unaware of Anesthesiologist’s plan of much slower initial infusion
- Baby suffered devastating neurologic injury
Communication Issues

Communication Between Anesthesiologist and CRNA – Tips:

- Review the pre-anesthesia evaluation
- Anesthesiologist presence during induction and emergence
- CRNA to communicate all unusual events
- Be approachable
- Written protocols outlining CRNA duties
- Crisis Checklist
- Emergency response drills
Communication – Informed Consent

Legal and Ethical Obligation

Effective tool to help establish rapport and compliance

Separate anesthesia consent form
Communication – Informed Consent

Discussion should include:

- Anesthesia plan
- Associated risks and benefits specific to plan
- Alternatives (and associated risks)
- Potential modification of the plan
- In terms understandable to a lay person
- Educate and get consent forms signed prior to any sedation
- Patient needs time to ask questions of the anesthesiologist
Medication Issues – Examples

- **Adverse Reaction**: anaphylaxis after cephalosporin given to patient with known PCN reaction – slow to realize and treat anaphylaxis, patient died

- **Contraindicated medication**: gave Toradol for perioperative pain relief in patient with known renal disease in PACU – patient required hemodialysis thereafter

- **Wrong Dose**: Improper dilution of Neo-Synephrine - used wrong syringe size - patient (an infant) received 10 times intended dose

- **Wrong Med Given**: paralytic given instead of the intended lidocaine

- **Administration Issues**: air emboli introduced into lines through med. administration – devastating stroke

http://www.apsf.org/resources/med-safety/
Medication Issues: IV Infusion Lines

Prevention of IV infusion lines confusion:
- Trace all lines back to the origin
- Recheck upon the patient’s arrival in a new setting
- Position different lines on different sides
- Label each infusion line
- Do not force connections
OR / Anesthesia Mishaps

Breakdown of OR/Anesthesia Mishap 2008-2014 (Hospital-Based only)

- Intraoperative Burn: 40%
- Inappropriate response to emergency: 40%
- Intraoperative Positioning: 20%
OR / Anesthesia Mishaps

Intra Operative Burns – Case Example:

- 45 year old – lesion removal using MAC
- Oxygen flared leading to 2\textsuperscript{nd} degree burns
- Head in unstable position
- Tented drapes
- Entire team should have been alerted to patients high risk status
Intraoperative Burns

Fire Prevention Guidelines:
- Attention to use of heat and ignition sources
- Manage fuels
- Minimize oxygen concentrations
- Prevent tenting of surgical drapes
- Emergency drills

http://www.apsf.org/resources/fire-safety
OR / Anesthesia Mishaps

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OR / Anesthesia Mishaps

Intraoperative Positioning:
- Brachial Plexus injury as a result of padding during surgery
- Skin sloughing off after failure to monitor weight bearing portions of the face
- Compartment syndrome in arms as a result of improper positioning

Inappropriate Response to Emergencies:
- Failure to do anesthesia equipment checks
- A dim bulb in the fiberoptic scope caused delay in intubating and possibly contributed to hypoxic encephalopathy
- Uncharged cardioversion paddles delayed resuscitation attempts
Physician – Patient Relationship

Your biggest and best defense is maintaining a good doctor / patient relationship:

◆ Maintain eye contact
◆ Show genuine expressions of interest
◆ Provide contact information
Physician – Patient Relationship

Disappointing Outcome + Lost Benefit of Doubt = LAWSUIT

Good Listening Skills + Clarity of Message = BENEFIT OF THE DOUBT
Questions – Contact Risk Evaluation Services
1-800-342-2239