A review of SVMIC hospital-based anesthesiology claims from 2008 – 2015, where a loss was paid on behalf of an insured, reveals three basic areas (excluding errors in medical judgment) that contributed to the determined indefensibility of such claims. These reasons are illustrated in the graph at the right.

**Documentation Issues**

Maintaining a well-documented medical record, from both a patient care and a risk management standpoint, is crucial. As the graph above illustrates, documentation issues were a factor in 59% of claims paid in Anesthesiology. Of those, 71% were found to have inadequate documentation which can negatively impact the ability to defend the care provided to a patient.

**Pre-Anesthesia Evaluation:** In one case, a 350 pound, 50-year-old male, with a known history of difficult intubation underwent an outpatient umbilical hernia repair. A laryngeal mask airway was used. Shortly after the procedure began, the patient’s oxygen saturation decreased. Intubation was unsuccessful and an emergency tracheostomy was performed. The patient became hypoxic and remains in a vegetative state. A lawsuit was filed alleging improper management of the patient’s airway during the procedure. A review of the medical record revealed several critical omissions in the pre-anesthesia documentation. These omissions included: airway assessment; evaluation of neck extension; inquiry into the history of prior difficult intubation; evaluation for the presence or absence of obstructive sleep apnea and evidence of dental assessment. The failure to document a thorough pre-op anesthesia evaluation allowed the plaintiff to successfully argue that the anesthesia team lacked vital information about their patient, causing them to be ill prepared for the possibility of airway difficulties and that using an LMA and performing the procedure in the ambulatory setting was a departure from the standard of care.

**Anesthesia Record:** In addition to documentation issues with the pre-anesthesia record, our claims review revealed a number of inadequate documentation issues within the anesthesia record. Examples of information that was missing include:

- Details about emergency response/interventions: The lack of documentation that cardiac activity ceased during a crisis, as well as major inconsistencies with the operative record, allowed the plaintiff to allege careless and improper emergency response.
- Maneuvers utilized for managing a difficult airway: The failure to document the events that unfolded in these cases, or the maneuvers utilized, paved the road for the plaintiff to allege negligent treatment and lack of attention to detail.
- Anesthesiologist’s presence during induction/emergence: The failure to document such led to allegations of improper CRNA oversight in a number of claims.
- Positioning and padding: In cases where the patient suffered nerve damage leading to permanent disabilities following a procedure, insufficient notes hampered the defense.
PACU Documentation:
Documentation of patient status when handing off to PACU nurses was lacking in several cases where the patient suffered a complication post-procedure. This made it easy for the plaintiffs to argue that there was negligent post-anesthetic transfer of care. Also lacking in the cases reviewed was documentation reflecting proper assessment of the patient status prior to PACU discharge, which, in turn, led to allegations of discharging the patient too early and without anesthesiologist oversight.

Informed Consent: In the majority of the cases reviewed, lack of informed consent was asserted by the plaintiff. Most often, the only documentation associated with the consent process was a boiler plate hospital surgical consent form which did not reflect the details of the discussion during which the anesthesia providers outlined the anesthesia risks. That made it difficult for the defense to argue that the particular anesthesia complication had been explained to, and was understood by, the patient prior to the procedure.

Communication Issues
Effective communication is essential in establishing trust and building good patient rapport, which in turn plays a role in a patient’s perception of the quality of care received and helps ensure compliance. Anesthesiologists have very little time for personal patient engagement, so it’s important to take advantage of every opportunity. In 32% of the claims reviewed, communication breakdowns were noted. Case examples include:

Physician-to-physician breakdowns: Hand-off issues between anesthesia providers was a common theme in this category of cases. A tragic example involved a 50-year-old who underwent a Nissen fundoplication. An epidural was placed for post-op pain management. The anesthesiologist who placed the epidural left on vacation without advising his partner of such placement. Without this information, or the benefit of a note in the chart reflecting the epidural placement, the covering anesthesiologist did not include a neurological evaluation during any of the post-op visits. On the third post-op day the patient complained of leg numbness and developed cauda equina syndrome.

Physician-to-CRNA breakdowns: Another frequent communication breakdown observed in the case analysis was between the anesthesiologist and CRNA. In one case an anesthesiologist prepared a morphine bolus to be given to an 11-month-old patient by epidural catheter for post-op pain control. The anesthesiologist was then called out of the room leaving the CRNA to oversee the infusion without specifically discussing the infusion plan. When he returned to the room, he discovered that the timing on the pump had been set inaccurately resulting in the patient receiving an excessive volume of morphine which caused lower extremity paralysis.

Physician-to-patient: As stated earlier, in a majority of cases reviewed, lack of informed consent was alleged by the plaintiffs. Certainly there is a legal obligation on the part of the anesthesiology provider to provide patients sufficient information about the proposed anesthesia plan with which they may make an informed health care decision. But what is often overlooked is the opportunity this discussion affords for the anesthesiologist to establish a rapport with patients, which makes it a valuable risk management tool.

Medication Issues
Medication errors were present in 26% of the reviewed cases. The types of errors that occurred follow:

Adverse Reaction: Patient with a prior penicillin reaction experienced an anaphylactic reaction after cephalosporin was administered. A delay in diagnosis and treatment interventions contributed to the patient’s death.

Contraindicated medication: CRNA failed to review the patient’s history which reflected known renal disease before ordering Toradol for perioperative pain relief. It was alleged that such medication caused the patient’s progressive renal failure and eventual hemodialysis.

Wrong dose: Patient received 10 times the intended dose of Neo-Synephrine due to improper dilution and usage of the wrong syringe size.

Wrong Medication: A paralytic was inadvertently administered by anesthesiologist who intended to give lidocaine. Patient became apneic and required resuscitation.
LESSONS LEARNED

- Clearly and completely document the pre-operative anesthesia evaluation, including classification of airway, evaluation of neck extension, prior anesthesia difficulty, inquiry into the presence or absence of obstructive sleep apnea as well as dental assessment. Additionally, there should be detailed documentation reflecting the intra-operative anesthesia management and patient monitoring including emergency response and interventions; maneuvers utilized for managing a difficult airway; position and padding; time outs; and the presence of an anesthesiologist during key portions of the procedure. Lastly, include detailed documentation of the patient’s status when transferring to the PACU, to include times and oxygenation status.

- Conduct all important patient communication before pre-operative medications are administered.

- Clearly and timely communicate/document information about patients with anticipated problems to covering anesthesiologists.

- Insist on seeing complicated patients before the day of surgery.

- Engage in a full and clear discussion with patients about the anesthesia plan and the associated risks, benefits, alternatives, and expected outcomes. Be sure these discussions are documented in a separate Anesthesia Consent Form rather than relying on a generic hospital surgical consent form which typically does not include the information specific to anesthesia management.

- To ensure good communication between the anesthesiologist and the CRNA: communicate clearly regarding the anesthesia plan; ensure that the anesthesiologist is present in the OR upon induction, during key portions of the procedure, as well as emergencies and be sure this is documented; and insist that CRNAs communicate with the anesthesiologist regarding all unusual events and readings. The anesthesiologist needs to be approachable; have written protocols delineating the responsibilities and duties of the CRNA; consider having an emergency manual or “crisis checklist” available at each OR anesthesia station; and practice emergency response with mock crisis situations.

- To help prevent medication errors: review patient history before ordering or administering medication; use standardized concentrations, prepared by the pharmacy when possible, in ready-to-use syringes with standardized labels; identify medications before drawing up and/or administering them and verify with a second source (second person or barcode reader linked to medical records); keep medication drawers and workspace organized (i.e. separate look-alike/sound-alike drugs; standard positioning of syringes and ampules). For a comprehensive listing of medication safety recommendations, please refer to http://apsf.org/newsletters/pdf/spring_2010.pdf and https://www.ismp.org/newsletters/acutecare/showarticle.aspx?id=123.

- For additional information about ways to improve patient safety and reduce your liability exposure, we encourage you to visit SVMIC.com and complete the self-study “Liability Exposure in Anesthesiology”.

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