



ANESTHESIOLOGY - RISK REDUCTION STRATEGIES

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The majority of physicians overall who are involved in a claim tend to be between the ages of 35 and 55 with most falling into the upper range of that age span when the claim occurs. Interestingly, according to data submitted to The Physician Insurers Association of America (PIAA), Anesthesiologists tend to be in the 35-45 year age group when a claim occurs. Among the claims data submitted to the PIAA data sharing project, encompassing 28 different specialties, anesthesiology ranks 7th in the number of claims closed with an average indemnity payment of \$226,044.

API has been submitting information to the data sharing project since 2003 for claims closed with an indemnity payout greater than or equal to \$100,000. Anesthesiology as a specialty within this group ranks fourth; following behind obstetrics and gynecology, orthopedic surgery, and general surgery. Of the claims* reported since API began contributing to the data sharing project, general anesthesia is the 5th most prevalent procedure involved; and the 4th most expensive with an average indemnity payment of \$301, 989. The total indemnity for claims paid over \$100,000 for general anesthesia is over \$6 million for the reporting timeframe June 2003- June 2009. Epidural/Caudal anesthesia ranks 37th out of the top 40 most prevalent procedures with an average indemnity of \$216, 125.

The 5 most frequent misadventures for API anesthesiology claims* are:

1. Improper performance (most related to operative procedures on the spine/spinal canal)
2. Lack or improper performance of preoperative evaluation (most related to orthopedic, gynecologic and abdominal procedures)
3. Problems with patient monitoring in surgery (most related to general anesthesia with varied conditions)
4. Errors in agent use or selection (varied conditions and procedures)
5. Intubation problems (most related to general anesthesia with varied conditions)

The 5 most expensive misadventures for API anesthesiology claims* are:

1. Problems with administration of blood or fluids
2. Problems with patient monitoring in surgery
3. Errors in agent use or selection
4. Improper performance
5. Lack or improper performance of preoperative evaluation

Not surprisingly, the operating room is ranked first for location of loss, but is followed in frequency by labor and delivery, the patient's room, not in an inpatient facility and the emergency department.

API recognizes that individual facilities have their own forms for anesthesia related documentation. However, it is important to realize that there is often information which needs to be documented that has not been allowed for on the hospital form. Therefore, it is critical for the anesthesiologist to document proactively and thoroughly regardless of the fields specified by the

* Based upon API claims paid \geq \$100,000.

hospital. For example, the hospital form may not have a space for documentation of the machine number used, but the number should still be documented.

The goal of the API Risk Management Department is to provide physicians with tools and information to implement risk management and mitigation techniques within their practice. The following are risk reduction strategies:

- Document a thorough preanesthetic review of the patient's medical history, anesthesia history, medication history, and objective diagnostic data. This includes a review of the readily accessible patient medical records.
- Perform and document a preanesthesia evaluation to include an appropriate physical exam with assignment of the ASA status and a mallampati score. At a minimum, the physical examination should include assessment of the airway, lungs, and heart.
- Document the machine number.
- ET tube placement confirmation by breath sounds and description of placement.
- Legible, complete, and accurate documentation of drugs and agents used.
- Legible, complete, and accurate documentation of IV fluids used including blood and blood products.
- Documentation of any unusual events and resolution; pre, peri and postanesthesia.
- Documentation of status of patient at conclusion of anesthesia and documentation of vital signs including O₂ sat and PACU score at transfer from OR to PACU.

The presence or supervision of a CRNA brings additional risks. Documentation of the presence of the anesthesiologist during induction of anesthesia and emergence from anesthesia is recommended. For long procedures, breaks should be planned for and not arranged at the last minute if at all possible. Induction, transfers in supervision or monitoring, and emergence from anesthesia can be times when risk increases as seen from review of API anesthesia related claims.

References:

Physician Insurers Association of America, *Risk Management Review, 2009 Edition, Anesthesiology*. American Society of Anesthesiology, *Practice Advisory for Preanesthesia Evaluation*, update October 15, 2003.

American Patient Safety Foundation Resource Center, www.apsf.org, February 2010.

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* Based upon API claims paid \geq \$100,000.