Office Based Anesthesia Safety and Accreditation

Fred E. Shapiro, DO
Recent Media Attention: High-Profile Events

Teen died of malignant hyperthermia during breast surgery; parents suing surgeon and anesthesiologist for not recognizing MH and having enough dantrolene stocked in outpatient surgery center.

Eight-year-old died after receiving three times the prescribed amount of sedation medication for a routine checkup and an emergency developed thereafter.

25-year-old died due to possible hypoxia and lack of monitoring after Propofol administration for wisdom tooth extraction.

Joan Rivers died of hypoxia and cardiac arrest after Propofol administration for endoscopic procedure for vocal changes and acid reflux.

Three-year-old died of possible apnea after general anesthesia for tooth extraction.
“Wild Wild West of Healthcare”

- Lack of uniform regulation of office based practice
- Increasing number and variety of cases
- Increasing complexity of cases and patients
- Sedation by anesthesia and non-anesthesia personnel
- Widely publicized fatalities and malpractice claims
Introduction to OBS

- 33 States legislation and growing
- ___states mandate accreditation
- Difficult to obtain outcome data
- Reporting of adverse events varies from state to state
# Office-Based Surgery & Anesthesia Requirements

<table>
<thead>
<tr>
<th>Requirement</th>
<th>AL</th>
<th>AZ</th>
<th>CA</th>
<th>CO</th>
<th>CT</th>
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<th>NJ</th>
<th>NV</th>
<th>NC</th>
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</thead>
<tbody>
<tr>
<td>Accreditation of Facility</td>
<td>X</td>
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<td>Physician Supervision of CRNAs</td>
<td>X</td>
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<tr>
<td>CME for Surgeons Supervising CRNAs</td>
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<td>Hospital Privileges to Perform Procedures</td>
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<tr>
<td>Reporting Requirements</td>
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<tr>
<td>Transfer Agreement</td>
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</table>
### Examples of Office-Based Surgery Outcomes Reporting Requirements by State

<table>
<thead>
<tr>
<th>State</th>
<th>Statutes, regulations, and policies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alabama</td>
<td>540-X-10-.11. Reporting Requirement. Reporting to the Alabama Board of Medical Examiners is required within 3 business days of the occurrence and will include all surgical-related deaths and all events related to a procedure(s) that resulted in an emergency transfer of the surgical patient to the hospital, anesthetic or surgical events cardiopulmonary resuscitation, unscheduled hospitalization related to the surgery, and surgical site deep wound infection.</td>
</tr>
<tr>
<td>Kansas</td>
<td>K.A.R. 100-25-3. Each physician who performs any office-based surgery or special procedure that results in any of the following quality indicators shall notify the board in writing within 15 calendar days following discovery of the event: 1. The death of a patient during any office-based surgery or special procedure, or within 72 hours thereafter 2. The transport of a patient to a hospital emergency department 3. The unscheduled admission of a patient to a hospital within 72 hours of discharge, if the admission is related to the office-based surgery or special procedure 4. The unplanned extension of the office-based surgery or special procedure &gt;4 hours beyond the planned duration of the surgery or procedure being performed 5. The discovery of a foreign object erroneously remaining in a patient from an office-based surgery or special procedure at that office 6. The performance of the wrong surgical procedure, surgery on the wrong site, or surgery on the wrong patient</td>
</tr>
<tr>
<td>Kentucky</td>
<td>Guidelines for Office-Based Surgery. Emergency Transfer and Reporting. In the event of anesthetic, medical, or surgical complication or emergency, all office personnel should be familiar with a documented plan for the timely and safe transfer of patients to a nearby hospital. This plan should include arrangements for emergency services and appropriate escort of the patient to the hospital. Anesthetic or surgical mishaps requiring resuscitation, emergency transfer, or death should be reported to the medical board within 3 business days using a specified form.</td>
</tr>
<tr>
<td>Louisiana</td>
<td>Chapter 73. Office-Based Surgery § 7313. Reports to the Board A. A physician performing office-based surgery shall notify the board in writing within 15 days of the occurrence or receipt of information that an office-based surgery resulted in the following: 1. An unanticipated and unplanned transport of the patient from the facility to a hospital emergency department 2. An unplanned readmission to the office-based surgery setting within 72 hours of discharge from the facility 3. An unscheduled hospital admission of the patient within 72 hours of discharge from the facility 4. The death of the patient within 30 days of surgery in an office-based facility</td>
</tr>
<tr>
<td>New Jersey</td>
<td>Subchapter 4A. Surgery, Special Procedures, and Anesthesia Services Performed in an Office Setting 3:35-4A.5 Duty to report incidents related to surgery, special procedures, or anesthesia in an office. Any incident related to surgery, special procedures, or the administration of anesthesia within the office which results in a patient death, transport of the patient to the hospital for observation or treatment for a period in excess of 24 hours, or a complication or untoward event as defined in N.J.A.C. 13:35-4A.3, shall be reported to the Executive Director of the Board within 7 days, in writing and on such forms as shall be required by the Board. Such reports shall be investigated by the Board and will be deemed confidential pursuant to N.J.S.A. 45:9-19.3</td>
</tr>
</tbody>
</table>
Proposed Legislation – FLORIDA

- **FL S 1486/FL H 1047**: Introduced in early 2018. These bills were introduced by Sen. Grimsley (R) and Rep. Gonzalez (R). The bills would define the term “adverse incident” and would **require a dentist practicing in the state to notify the board of any mortality or other adverse incident that occurs in the dentist’s outpatient facility**. “Adverse incident” would include incidents as a direct result of the use of **general anesthesia, deep sedation, and conscious sedation**, among others.
Proposed Legislation – NEW HAMPSHIRE

- **NH H 1577**: This bill was pre-filed on 11/13/2017 by Rep. Dean-Bailey (R). This bill provides for the regulation of the use of general anesthesia, deep sedation, or moderate sedation by dentists and the reporting of adverse events. Specifically, a licensed dentist, anesthesiologist or nurse anesthetist is required to be physically present while general anesthesia, deep sedation or moderate sedation is in effect. In addition, administration of general anesthesia or deep sedation to patients under 13 is subject to additional rules including, among other things, an informed consent statement that the procedure may be performed in a hospital setting with additional anesthesia personnel. And the addition of a requirement that a minimum of one staff member, in addition to the dentist, trained in the monitoring and resuscitation of pediatric patients shall be present when patients under 13 are undergoing dental treatment.
Proposed Legislation – UTAH

- **R434-150** (UT 42334 2017): This proposed regulation implements **UT H 142** from this past legislative session and would **establish reporting requirements for anesthesia-related adverse events** that occur in outpatient settings. In addition to establishing reporting requirements, it would also define an adverse event, levels of sedation, and describe a level of harm scale. The comment deadline is 1/16/2018.
Pending Legislation – NEW YORK

- **NY A 1829/NY S 4422**: These companion bills were introduced in early 2017 and are pending carryover to the 2018 legislative session. They would provide for certification of nurse anesthetists, would define “office-based surgery” and would add the following language: Administration of anesthesia in office based surgery venues means the anesthesia component of the medical or dental procedure shall be supervised by an anesthesiologist, physician, dentist or podiatrist qualified to supervise the administration of anesthesia who is physically present and available to immediately diagnose and treat the patient for anesthesia complications or emergencies, and nurse anesthetists with the appropriate training and experience may be permitted to administer unconscious or deep sedation, and/or general anesthesia, regional anesthesia, and/or monitor the patient.
Recently Adopted Regulations – OREGON

- **Oregon Medical Board**: OAR 847-017-0003 (OR 39593 2017) was recently adopted and became effective 01/05/2018. This regulation relates to in office anesthesia administration and amends the rules to require an ASA physical status evaluation and documentation when performing a level II or III office-based procedure, and prohibits level II or III procedures from being performed on a patient with an ASA physical status of IV or above.
Recently Adopted Regulations – OREGON

- Oregon Board of Nursing - OAR 851-052-0060 (OR 39586 2017) was recently adopted and will become effective 01/01/2018. The adopted rule is attached to this email. Among other things, it prohibits CRNAs from providing moderate sedation, deep sedation or general anesthesia in an office setting for clients with an assigned ASA classification of 4 or above.
ISOBS 20 years:
Publications

**Manual of Office-Based Anesthesia Procedures**

Fred E. Shapiro

**Office-Based Anesthesia**

Considerations for Anesthesiologists in Setting Up and Maintaining a Safe Office Anesthesia Environment

2nd Edition - November 2008

- Members $10
- Non-Members $20

Purchase at: [www2.asahq.org/publications/](http://www2.asahq.org/publications/)

Authored in 2007


Overview of Safety Literature 2014-2018
The increasing volume of office-based medical and surgical procedures has fostered the emergence of office-based anesthesia (OBA), a subspecialty within ambulatory anesthesia. The growth of OBA has been facilitated by numerous trends, including innovations in medical and surgical procedures, the advent of ambulatory anesthesia facilities, and greater convenience. However, there is a lack of randomized controlled trials to determine how office-based procedures and anesthesia affect patient morbidity and mortality. As a result, studies on this topic are retrospective in nature. Some of the early literature broaches concerns about the safety of office-based procedures and anesthesia. However, more recent data have shown that care in ambulatory settings is comparable to hospitals and ambulatory surgery centers, especially when offices are accredited and their proceduralists are board-certified.

Enhance quality of care by engaging in proper procedure and patient selection, provider credentialing, facility accreditation, and incorporating patient safety checklists and professional society guidelines into practice.

strategies for minimizing patient complications and mortality in OBA, and future developments that could impact the field. (Anesth Analg 2014;119:276–85)
This study compares complication rates of cosmetic surgery performed at office-based surgical suites (OBSS) to ambulatory surgery centers (ASCs) and hospitals.

A prospective cohort of 129,007 patients undergoing cosmetic surgery between 2008 and 2013, grouped by type of accredited facility where the surgery was performed: OBSS, ASC, or hospital.

Complication rates: OBSS: 1.3%, ASCs: 1.9%, hospitals: 2.4%.

Multivariate analysis: lower risk of developing a complication in an OBSS compared to an ASC (RR 0.67, 95% CI 0.59-0.77, P < .01) or a hospital (RR 0.59, 95% CI 0.52-0.68, P < .01).

Accredited OBSS appear to be a safe alternative to ASCs and hospitals for cosmetic procedures. Plastic surgeons should continue to triage their patients carefully based on other significant comorbidities that were not measured in this present study.
- What we learned: Complication rates lower in OBSS accredited facilities

- Comparison to Previous Reports: Patient and procedure selection affect results. Most of bad outcomes in 2003 analyses were from unaccredited offices

- Safety: Standardizing the industry will improve safety
The Need for Accreditation of Office-Based Interventional Vascular Centers

Peter H. Lin,1,2 Fiona A. Chandra,3 Fred E. Shapiro,4 Brian M. Osman,5 Richard D. Urman,6 and Samuel S. Ahn,7 Houston and Dallas, Texas; Los Angeles, California; Cambridge and Boston, Massachusetts; and Miami, Florida

The rise in office-based interventional vascular laboratories in recent years was prompted in part by expedient ambulatory patient experience and favorable outpatient procedural reimbursement. While studies have shown that clinical safety and treatment efficacy can be achieved in office-based vascular facilities, critics have raised various concerns and suggested various strategies to ensure optimal care and reimbursement. In a study published in 2023, various strategies to improve patient care delivery in office-based laboratories including accreditations which serves as external validation of processes to ensure patient care and safety are also mentioned. Finally, the requirements to obtain accreditation in an office-based practice and the differences between these nationally recognized accrediting organizations are discussed herein.
This study analyzed treatment outcomes of procedures performed in our office-based endovascular suite.

Treatment outcomes of 5134 consecutive procedures performed in office-based endovascular suites from 2006 to 2013.

Procedures performed included diagnostic arteriogram, arterial interventions, venous interventions, dialysis access interventions, and venous catheter management.

Endovascular procedures can be performed safely in an office-based facility with excellent outcomes.
Ambulatory Surgical Risk

A Comparison between office and other ambulatory practices: Analysis from the National Anesthesia Clinical Outcomes Registry

By Samir R. Jani, MD, MPH, Fred E. Shapiro, DO, Rodney A. Gabriel, MD, Hubert Kordylewski, Richard P. Dutton, MD, MBA, and Richard D. Urman, MD, MBA

Ambulatory and office-based surgery is expanding rapidly. While growth continues, there are lingering patient safety concerns. To this end, the American Society of Anesthesiologists (ASA) created the Anesthesia Quality Institute (AQI), which collected patient and procedural characteristics on 23,341,130 anesthetics from all healthcare settings from 2010 to 2014. Of these, 179,618 office and 462,7379 ambulatory cases were isolated and compared. Our findings show that although both settings are often grouped together, there are statistically significant differences in patient demographics, procedure types, and reported adverse events. Among these reports, inadequate postoperative pain control and nausea/vomiting are the most common issue. More serious events such as death, cardiac arrest, and vision loss occurred but were rare.
The effect of outpatient facility type (ASC vs. office) and specific facility characteristics (e.g., facility accreditation, emergency response protocols, clinician qualifications, physical plant characteristics, other policies) on patient safety, patient experience and service availability in non-hospital-affiliated outpatient settings.

Review of 3049 abstracts and full-text articles against inclusion/exclusion criteria and assessed the quality of 22 identified articles.

Existing research appears to indicate no difference in patient safety for outpatient procedures performed in ASCs vs. physician offices. Research about specific facility characteristics is insufficient to draw conclusions.

More and higher quality research is needed to determine if there is a public health problem to be addressed through facility regulation and, if so, which facility characteristics may result in consistent improvements to patient safety while not adversely affecting patient experience or service availability.
Accreditation - Overview

- Regulation of facilities has evolved with rapid increase of Office-Based Surgery Centers
- Overview of Licensure – allows facilities to operate and provide services which is granted by states
- Certification – is granted by the Centers for Medicare and Medicaid Services (CMS)
- Accreditation – granted by various private organizations and indicates that a facility has met certain standards.
Accreditation of Ambulatory Facilities

Richard D. Urman, MD, MBA*, Beverly K. Philip, MD

http://dx.doi.org/10.1016/j.anclin.2014.02.016
1932-2275/14/$ – see front matter © 2014 Elsevier Inc. All rights reserved.

Important References:

# Provider Checklist

## Safety Checklist for Office-Based Surgery

from the Institute for Safety in Office-Based Surgery (ISOBS)

<table>
<thead>
<tr>
<th>Introduction</th>
<th>Setting</th>
<th>Operation</th>
<th>Before discharge</th>
<th>Satisfaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preoperative encounter; with practitioner and patient</td>
<td>Before patient in procedure room; with practitioner and personnel</td>
<td>Before sedation/analgesia; with practitioner and personnel*</td>
<td>On arrival to recovery area; with practitioner &amp; personnel</td>
<td>Completed post-procedure; with practitioner and patient</td>
</tr>
</tbody>
</table>

### Patient

- Patient medically optimized for the procedure? □ Yes □ No, and plan for optimization made.

- Does patient have DVT risk factors? □ Yes, and prophylaxis plans arranged. □ No

### Procedure

- Procedure complexity and sedation/analgesia reviewed? □ Yes

- NPO instructions given? □ Yes

- Escort and post-procedure plans reviewed? □ Yes

### Emergency equipment check complete (e.g. airway, AED, code cart, MH kit)? □ Yes

### EMS availability confirmed? □ Yes

### Oxygen source and suction checked? □ Yes

### Anticipated duration ≤ 6 hours? □ Yes □ No, but personnel, monitoring and equipment available

### Patient identity, procedure, and consent confirmed? □ Yes

### Is the site marked and side identified? □ Yes □ N/A

### DVT prophylaxis provided? □ Yes □ N/A

### Antibiotic prophylaxis administered within 60 minutes prior to procedure? □ Yes □ N/A

### Essential imaging displayed? □ Yes □ N/A

### Practitioner confirms verbally:

- Local anesthetic toxicity precautions
- Patient monitoring (per institutional protocol).
- Anticipated critical events addressed with team.

- Each member of the team has been addressed by name and is ready to proceed.

- Assessment for pain? □ Yes

- Assessment for nausea/vomiting? □ Yes

- Recovery personnel available? □ Yes

- Prior to discharge: (with personnel and patient)

- Discharge criteria achieved? □ Yes

- Patient education and instructions provided? □ Yes

- Plan for post-discharge follow-up? □ Yes

- Escort confirmed? □ Yes

- Unanticipated events documented? □ Yes

- Patient satisfaction assessed? □ Yes

- Provider satisfaction assessed? □ Yes

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This checklist is not intended to be comprehensive. Additions and modifications to fit local practice are encouraged. *Adapted from the WHO Surgical Safety Checklist. © 2010 Institute for Safety in Office-Based Surgery (ISOBS), Inc – All Rights Reserved – www.isobs.org

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Featured in 2016 in ASHRM resource manual for Office-Based Surgery

Published AORN J 2013
Effect of an Office-Based Surgical Safety System on Patient Outcomes

Noah M. Rosenberg, MD, a Richard D. Urman, MD, MBA, b Sean Gallagher, MD, c John Stenglein, MD, d Xiaoxia Liu, MS, b and Fred E. Shapiro, DO d

- 28-element perioperative ISOBS checklist
- Customized to an office-based plastic surgery
- 219 cases
- Baseline and post-op adverse outcomes
- post-checklist implementation chart review

Additional Goals:
- To decrease incidence of adverse outcomes in the perioperative period
- To educate the practitioner and support staff
Study Results

- Pre-checklist, 90% missing documentation of three or more elements.
- 15% of cases had adverse events of which pain (3.7%) and bleeding/bruising (3.2%) were most common.
- Post-checklist analysis: 90-100% increase in documentation of several key indicators and practices.
Study Results
pre → post checklist

- Site and side identification and marking
  
  **24.6% increase**
  
  \( p = 0.0258 \)

- Verbal confirmation of anticipated critical events

- Availability of case-specific equipment

- Confirmation of EMS policy

  **increased from 0% to 88-100%**

  \( p < 0.0001 \)
Study Results
pre → post checklist

- Total number of complications
  Pre-Checklist: 15.1 per 100 pts
  Decreased to 2.2 per 100 pts (p=0.0142)

Absolute Risk Reduction = 12.4
Checklists in the outpatient setting

- Patient satisfaction increased from 57.1% to 90.8%.
- Conclusion: with modifications to the WHO model, customized checklists can also be effective.
Avoidance of serious medical errors in refractive surgery using a custom preoperative checklist

Presented as a poster at the annual meeting of the American Academy of Ophthalmology, New Orleans, Louisiana, October 2013, the ASCRS Symposium on Cataract, IOL and Refractive Surgery, Boston, Massachusetts, April 2014, the annual meeting of the New England Ophthalmological Society, Boston, Massachusetts, May 2014, and the annual meeting of the International Society for Refractive Surgery, Chicago, Illinois, USA, October 2014.

Marie-Claude Robert MD, Catherine J. Choi MD, MS, Fred E. Shapiro DO, Richard D. Urman MD, MBA, Samir Melki MD, PhD ▪ ▪

- Study of 2951 consecutive patients who had primary or enhancement LVC between July 2009 and February 2014; of these, 1417 patients (2744 eyes) had LVC after the implementation of a presurgical safety checklist. The general checklist fashioned around the World Health Organization time-out procedure was used for 1534 patients (2969 eyes).

- Although there were 2 (0.07%) serious errors in the prechecklist cohort, none occurred following implementation of the safety checklist protocol (P = .23).

- Multiple potential sources of error exist in refractive surgery. The broad-scale implementation of a detailed presurgical safety checklist was helpful in minimizing and preventing serious errors (never-events) during LVC.
Patient Checklist

Published AORN J 2013

Harvard Pilgrim HealthCare

Featured in the HPHC newsletter summer 2016 (~400,000 subscribers)

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### Patient’s Checklist for Office-Based Procedures

*from the Institute for Safety in Office-Based Surgery (ISOBs)*

<table>
<thead>
<tr>
<th>Inquire</th>
<th>What are my doctor’s credentials?</th>
<th>Does the doctor have privileges to perform the same procedure at a hospital?</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Yes</td>
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<td></td>
<td>What is your doctor board-certified in?</td>
<td>Yes</td>
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<td>How many times recently has the doctor performed your type of procedure?</td>
<td>Yes</td>
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<td></td>
<td>What is your doctor’s reputation?</td>
<td>Yes</td>
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<tr>
<td></td>
<td>Who will be giving sedation/anesthesia, if needed, and who will be monitoring me while during sedation?</td>
<td>Yes</td>
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<tr>
<th>Stable</th>
<th>Are my medical conditions stable?</th>
<th>Are my medical conditions under control?</th>
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<td></td>
<td></td>
<td>Yes</td>
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</table>

<table>
<thead>
<tr>
<th>Office</th>
<th>Is the office accredited and licensed?</th>
<th>Is the office accredited and the sign posted on the wall?</th>
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<tr>
<td></td>
<td></td>
<td>Yes</td>
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<td></td>
<td>Who inspects and certifies the office for safety and infection control?</td>
<td>Yes</td>
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</table>

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<thead>
<tr>
<th>Best</th>
<th>Is this office the best place for my procedure?</th>
<th>Is the office the right setting for my procedure?</th>
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<td></td>
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<td>Yes</td>
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<tr>
<th>Suited</th>
<th>Can this office handle an emergency?</th>
<th>Is the office prepared for an unexpected emergency, such as drugs, equipment and training?</th>
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<tr>
<td></td>
<td></td>
<td>Yes</td>
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<tr>
<td></td>
<td>If I need additional medical care, where will I be transferred?</td>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Plan</th>
<th>What is the plan for my recovery after the procedure?</th>
<th>Who will monitor my recovery and who will supervise my discharge home?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Communication</th>
<th>How will I be able to communicate with the office?</th>
<th>Have you had a follow-up call or visit with your doctor or nurse?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Yes</td>
</tr>
</tbody>
</table>

|               | Have you communicated your questions and overall satisfaction to the office staff? | Yes | No |

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This checklist is not intended to be comprehensive. Additions and modifications to fit local practice are encouraged. *Adapted from the WHO Surgical Safety Checklist. © 2011 Institute for Safety in Office-Based Surgery (ISOBs), Inc – All Rights Reserved – www.isobs.org*
Survey the usefulness of an ambulatory surgical checklist for patients through a survey including both patients (n=35) and providers (n=52). Overall, 94% of patients and 83% of providers thought the checklist would be beneficial for patients. In addition, 37% of providers indicated potential barriers to checklist implementation, including fear of confusing the patient, making patients doubt the care they were receiving, taking too much time, and lack of resources.

Based on survey responses, the study suggests that the ambulatory surgical checklist can potentially facilitate patient education, enable more active patient participation, increase patient satisfaction, and decrease patient anxiety.
A template for designing a patient checklist was developed incorporating methods from previous literature and resources regarding checklists. This template includes a development, drafting, and validation phase. Sample content for inclusion in potential checklists for patients with diabetes and patients undergoing anesthesia was devised.

Further development of checklists will need to be guided by specific medical conditions and acceptance by patients and providers.

Providers can use these checklists as a method to gauge a patient’s understanding of an intervention, solidify the patient-doctor relationship, and improve patient safety.
Office-Based Anesthesia: How to Start an Office-Based Practice

Matt M. Kurrek, MD, FRCP(C)\textsuperscript{a}, Rebecca S. Twersky, MD, MPH\textsuperscript{b,*}

doi:10.1016/j.anclin.2010.02.006
1932-2275/10/$ – see front matter © 2010 Elsevier Inc. All rights reserved.

<table>
<thead>
<tr>
<th>Table 1</th>
<th>Key differences between the 3 accrediting organizations in the United States</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>TJC</td>
</tr>
<tr>
<td>Number of offices accredited</td>
<td>453</td>
</tr>
<tr>
<td>Fee in US $ per 3 year cycle (± Medicare certification fee)</td>
<td>$6950</td>
</tr>
<tr>
<td>Surgeon qualification</td>
<td>–</td>
</tr>
<tr>
<td>Anesthesia qualifications</td>
<td>LIP</td>
</tr>
<tr>
<td>Perioperative anesthesia care</td>
<td>+</td>
</tr>
<tr>
<td>Operating room personnel</td>
<td>–</td>
</tr>
<tr>
<td>Overnight stays</td>
<td>–</td>
</tr>
<tr>
<td>Patient discharge</td>
<td>–</td>
</tr>
<tr>
<td>Patient transfer</td>
<td>–</td>
</tr>
<tr>
<td>Peer review</td>
<td>+</td>
</tr>
<tr>
<td>Adverse event reporting</td>
<td>–</td>
</tr>
</tbody>
</table>

Abbreviations: AAAASF, American Association for Accreditation of Ambulatory Surgical Facilities; AAAAHC, Accreditation Association for Ambulatory Health Care; LIP, licensed independent practitioner; TJC, The Joint Commission; +, addressed in standards; −, not addressed in standards; ±, not clearly addressed in standards.
Box 1
Common elements of a checklist during an inspection prior to provision of anesthesia services

Administration:
- Qualification (credentialing and licensing of personnel, including cardiopulmonary resuscitation [CPR], advanced cardiac life support [ACLS], and pediatric advanced life support [PALS])
- Accreditation status
- Malpractice coverage
- Anesthesia record, consent, discharge instructions
- Quality improvement, adverse event reporting and peer review
- Patient follow-up
- Policy and procedure manual
- Emergency planning and drills (power outage, fire, evacuation, ACLS, and other disasters)
- Equipment disinfection and handling of biohazardous waste and sharps
- Storage and ordering of controlled and anesthesia drugs
- Hospital transfer agreement

Facility Engineering:
- Patient flow
- Compressed gases and scavenging
- Fire safety (stretcher stair evacuation, sprinkler system?, fire extinguishers)
- Evacuation
- Equipment: inspection, maintenance, testing, and backup
- Help
- Essential electrical systems (backup power and light)
- Telephone for assistance

Equipment Check:
- Suction (and backup) with suction catheters
- Oxygen (and backup)
- Positive pressure ventilating device capable of delivering O₂ (including reliable O₂ source)
- Appropriately sized airways, laryngoscope blades, masks, and laryngeal mask airways (LMAs)
- Standard ASA monitors (blood pressure, electrocardiograph, stethoscope, pulse oximetry, capnograph, temperature)
- Anesthesia machine with scavenging system
- Functioning resuscitation equipment and defibrillator
- Emergency airway equipment
- Medication cart (including routine, ACLS, and other emergency drugs)
- Malignant hyperthermia (MH) supplies (availability of dantrolene as well as other medications and supplies to treat MH when triggering agents are used)
ASA Manual: Considerations for Setting up and maintaining a safe office-based anesthesia environment 2009

Administration and Facility
- Facility Classification
- Provider Credentialing
- Records and Documentation
- Quality Improvement
- Facility and Safety
- Controlled Medications
- Practice Management

Clinical Care
- Procedure Selection
- Patient Selection
- Perioperative Care
- Monitoring and Equipment
- Pediatric Patients
- Dental Anesthesia
- Emergencies
- Transfer of Care

Resource Materials
- References
- ASA Standards Guidelines and Statements
- Federal Rules and Regulations
- State Regulations
- Organizations

Appendices
- ASA OBA Guidelines
- ASA Statement on Qualifications of Anesthesia Providers in Office-Based Setting
- Algorithms for Emergency Situations

Office-Based Anesthesia
Considerations for Anesthesiologists in Setting Up and Maintaining a Safe Office Anesthesia Environment
2nd Edition - November 2008
Members $10
Non-Members $20
Purchase at www.ase.org/publications/
Oral and maxillofacial surgeons have had considerable autonomy in operating their offices. Oral and maxillofacial surgeons have had a singular history of safety, training, and success in outpatient anesthesia in their offices.

Preventable patient morbidity and mortality in private office-based surgical facilities of a variety of professions have brought increased scrutiny to the office environment.

The present report describes the experiences of 3 oral and maxillofacial surgeons with 3 accrediting agencies in obtaining office accreditation and offers recommendations to be considered for the future of our specialty in terms of private office certification.
Joint Commission Accreditation

- Management of human resources
- Improving practice performance
- Management of information
- Management of medication
- Provision of care, treatment, and services
- Patient ethics, rights, and responsibilities
- Surveillance, prevention, and control of infection
- Environment of care
- Leadership
The organization or practice has a license or registration to conduct its scope of service.

The test, treatments, or interventions provided at the organization are prescribed or ordered by a licensed independent practitioner in accordance with state and federal requirements.

The organization or practice must be surgeon-owned or surgeon-operated.

The organization or practice provides invasive procedures to patients. Local anesthesia, minimal sedation, moderate sedation or general anesthesia are administered. (Includes laser eye surgery using topical anesthesia)

Revised Survey Eligibility Criteria for Office-Based Surgery

The Joint Commission’s Accreditation Committee recently approved revised eligibility criteria for organizations surveyed under the Office-Based Surgery program. These revisions are the result of a comprehensive review of the survey eligibility criteria to ensure that they are current and relevant for organizations seeking accreditation or reaccreditation. For organizations first seeking accreditation*, several questions have been added to the electronic application for accreditation (E-App) that require applicants to make certain attestations regarding their backgrounds.

Any office-based surgery organization may apply for Joint Commission accreditation if all the following eligibility requirements are met:

- The organization is in the United States or its territories or, if outside the United States, is operated by the U.S. government or under a charter of the U.S. Congress.
- If required by law, the organization has a license or registration to conduct its scope of services. The organization can demonstrate that it continually assesses and improves the quality of its care, treatment, and/or services. This process includes a review by clinicians, including those knowledgeable in the type of care, treatment, and/or services provided at the organization.
- The organization identifies the services it provides, indicating which care, treatment, and/or services it provides directly, under contract, or through some other arrangement.
- The organization provides services that can be evaluated by The Joint Commission’s standards.
- The tests, treatments, or interventions provided at the organization are prescribed or ordered by a licensed independent practitioner\(^1\) in accordance with state and federal requirements.
- The organization meets parameters for the minimum number of patients/volume of services required for organizations seeking Joint Commission initial or reaccreditation; that is, three patients served, with at least one patient having a procedure at the time of survey.
- The organization is limited to business occupancy, which is defined as an occupancy that can only have three or fewer individuals at the same time, who are either rendered incapable of self-preservation in an emergency or are undergoing general anesthesia.
- The organization must be surgeon-owned or surgeon-operated (for example, a professional services corporation, private physician office, or small group practice).
- The organization provides invasive procedures to patients. Local anesthesia, minimal sedation, conscious sedation, or general anesthesia are administered. (Excluded are practices that limit procedures to excisions of skin lesions, moles, and warts and abscess drainage limited to the skin and subcutaneous tissue.)

Questions may be directed to your account executive (630-792-3007) for current customers or to Business Development for applicants (630-792-5259).

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* Organizations that are new to The Joint Commission include those that have never been surveyed by The Joint Commission or have not been accredited for at least four months.

1. A licensed independent practitioner is an individual permitted by law and by the organization to provide care, treatment, or services without direction or supervision. A licensed independent practitioner operates within the scope of his or her license, consistent with individually granted clinical privileges. When standards reference the term licensed independent practitioner, this language is not to be construed to limit the authority of a licensed independent practitioner to delegate tasks to other qualified health care personnel (for example, physician assistants and advanced practice registered nurses) to the extent authorized by state law, a state’s regulatory mechanism, or federal guidelines, and by organizational policy.
### TJC 2016 OBS Compliance Data

#### Top Standards Compliance Data for 2016

**Office-Based Surgery Practices**

<table>
<thead>
<tr>
<th>%</th>
<th>Standard Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>60%</td>
<td>HR.02.01.03</td>
<td>The practice grants initial, renewed, or revised clinical privileges to individuals who are permitted by law and the organization to practice independently.</td>
</tr>
<tr>
<td>57%</td>
<td>IC.02.02.01</td>
<td>The practice reduces the risk of infections associated with medical equipment, devices, and supplies.</td>
</tr>
<tr>
<td>41%</td>
<td>EC.02.04.03</td>
<td>The practice inspects, tests, and maintains medical equipment.</td>
</tr>
<tr>
<td>24%</td>
<td>IC.01.03.01</td>
<td>The practice identifies risks for acquiring and transmitting infections.</td>
</tr>
<tr>
<td>24%</td>
<td>NPSG.07.01.01</td>
<td>Comply with either the current Centers for Disease Control and Prevention (CDC) hand hygiene guidelines or the current World Health Organization (WHO) hand hygiene guidelines.</td>
</tr>
<tr>
<td>23%</td>
<td>IC.01.05.01</td>
<td>The practice plans for preventing and controlling infections.</td>
</tr>
<tr>
<td>22%</td>
<td>IC.02.04.01</td>
<td>The practice offers vaccination against influenza to licensed independent practitioners and staff.</td>
</tr>
<tr>
<td>22%</td>
<td>MM.03.01.01</td>
<td>The practice safely stores medications.</td>
</tr>
<tr>
<td>22%</td>
<td>MM.01.01.03</td>
<td>The practice safely manages high-alert and hazardous medications.</td>
</tr>
<tr>
<td>20%</td>
<td>WT.03.01.01</td>
<td>Staff and licensed independent practitioners performing waived tests are competent.</td>
</tr>
</tbody>
</table>

**Note:** The data determined for the office-based surgery practices program were derived from an average of 88 applicable surveys.
AAAHC Accreditation
Association for the Accreditation of Ambulatory Health Care (AAAHC)

- Chapter 1—Rights of patients
- Chapter 2—Governance
- Chapter 3—Administration
- Chapter 4—Quality of care provided
- Chapter 5—Quality management and improvement
- Chapter 6—Clinical records and health information
- Chapter 7—Infection and Safety
- Chapter 8—Facilities and environment
- Chapter 9—Anesthesia services
- Chapter 10—Surgical and related services eg laser
- Chapter 15—Pharmaceutical services
- Adjunct chapters
- Chapter 12—Dental services
- Chapter 16—Pathology and medical laboratory services
- Chapter 17—Diagnostic and other imaging services
- Chapter 24—Health education and health promotion
AAAHC Quality Roadmap 2017

Office-Based Surgery

The findings here are similar to those previously identified in other settings with additional difficulties with:

- benchmarking
- a formal, documented infection prevention and control program
- cleaning, disinfection, and sterilization of medical equipment per manufacturers’ instructions
- monitoring/disposal of expired products (medications, reagents, solutions, and supplies) that have a manufacturer’s printed expiration date in compliance with facility policy and manufacturers’ guidelines
- completing a written evaluation of emergency drills

AAAHC Quality Roadmap 2017

PERCENT DEFICIENCY (>10) FOR OBS

- 2.II.D
- 4.E.4
- 5.I.B.4
- 5.I.C
- 5.I.D
- 6.F
- 7.I.B.4
- 7.I.D.2
- 7.I.F.2
- 7.II.Q
- 8.E
- 11.I

- Credentialing & Privileging
- Documentation
- Quality Improvement/Benchmarking
- Patient Safety/Infection Control and Prevention

AAAHC: Common OBS Deficiencies

- benchmarking
- a formal, documented infection prevention and control program
- cleaning, disinfection, and sterilization of medical equipment per manufacturers’ instructions
- monitoring/disposal of expired products (medications, reagents, solutions, and supplies) that have a manufacturer’s printed expiration date in compliance with facility policy and manufacturers’ guidelines
- completing a written evaluation of emergency drills

AAAASF Accreditation

AMERICAN ASSOCIATION FOR THE ACCREDITATION OF AMBULATORY SURGICAL FACILITIES (AAAASF)

- General environment
- Procedure room environment, policy, and procedures
- Postanesthetic procedure recovery area environment, policies, and procedures
- General safety in facility
- Intravenous fluids and medications
- Medical records
- Quality assessment/quality improvement
- Personnel
- Anesthesia
- Inspection and self-evaluation
AAAASF Top 10 Deficiencies

1. Life Safety Code, section 9999.5.90, of the Medicare survey
2. Universal Precautions, ASC standard 800.42.12
3. Infection Control Techniques, section 200.55.11
4. Surgical Logs, sections 600.040.001 to 600.040.009
5. Advanced Directives
6. Emergency Preparedness
7. Administration of Drugs
8. Preparedness if surgeon or anesthesia provider becomes incapacitated
9. Operating Room Equipment, specifically AED Biomedical Technician inspection
10. Biomedical Technician Inspection
Accreditation 2018 Updates

- Revised Survey Eligibility Criteria for Office-Based Surgery
Goal 1: Improve the accuracy of patient identification.
- Use at least two patient identifiers when providing care, treatment, or services.
- Eliminate transfusion errors related to patient misidentification.

Goal 3: Improve the safety of using medications.
- Label all medications, medication containers, and other solutions on and off the sterile field in perioperative and other procedural settings.
- Maintain and communicate accurate patient medication information.

Goal 7: Reduce the risk of health care–associated infections.
- Comply with either the current Centers for Disease Control and Prevention (CDC) hand hygiene guidelines or the current World Health Organization (WHO) hand hygiene guidelines.
- Implement evidence-based practices for preventing surgical site infections.

Universal Protocol for Preventing Wrong Site, Wrong Procedure, and Wrong Person Surgery
- Conduct a preprocedure verification process.
- Mark the procedure site.
- A time-out is performed before the procedure.
Effective January 31, 2018, In order to maintain accreditation, office-based surgery practices will be required by Accrediting Organizations to provide continual monitoring of end tidal CO2 using capnography for moderate sedation, deep sedation and general anesthesia in the New York State office-based setting.

Standards: When capnography is utilized:

- **Continual monitoring occurs.**
- The end tidal CO2 alarm is audible to the clinical staff responsible for monitoring the patient.
- Capnography will be documented at frequent intervals in the physiologic monitoring record.
Changes to NY Office-based Surgery Law Effective April 13, 2016

Department of Health

You are here: Home Page > Health Care Professionals & Patient Safety > Office-Based Surgery

Office-Based Surgery

Alert

Changes to Office-based Surgery Law Effective April 13, 2016

Effective April 13, 2016, the deadline for submission of OBS AE reports has been extended from 24 hours to 72 hours.

Also effective April 13, 2016, office-based surgery (OBS) practitioners must report two additional types of adverse events (AE). These include:

1. Unplanned emergency department visits within seventy-two hours of office-based surgery; and,
2. Unscheduled assignment to observation services within a hospital within seventy-two hours of the office-based surgery.

These new types of OBS adverse events are in addition to the following previously mandated types of AE:

1. Unplanned transfer to a hospital or emergency department from an OBS practice;
2. Unscheduled admission to the hospital for longer than 24 hours within seventy-two hours of office-based surgery;
3. Patient death within thirty days;
4. Suspected transmission of blood-borne pathogens from staff to patients or between patients; and;
5. Any other serious or life-threatening event.

The Department of Health has adopted the National Quality Forum’s Serious Reportable events as our definition of “other serious or life-threatening events” involving OBS patients, found in Frequently Asked Questions of Practitioners Number 23. Frequently Asked Questions for Practitioners (Revised September 2013)

*DOH is in the process of building an electronic AE reporting system; please continue to complete the paper AE reporting form until the electronic form is available. When reporting one or more of the new AE types:

- In Question 1, select “any other serious...event” and;
- In Question 6, write in the date and type of event being reported (ED visit, observation stay, etc.) in the blank space available.

The AE form can be found here: Office-Based Surgery - Adverse Event Report.

Electronic Office-based Surgery Adverse Event Reporting is Coming

Office-based Surgery adverse event reporting is being transitioned to an electronic system in 2018. Training will be provided prior to implementation.

In the meantime, continue to send adverse event reports to the address below or submit via the secure file transfer application on the DOH Health Commerce System website. Contact the Office of Quality and Patient Safety to learn more about this method of submission.

Office of Quality and Patient Safety (OQPS) Contact information:

- Mail: Office-Based Surgery
  Office of Quality and Patient Safety
  New York State Department of Health
  Coming Tower, Room 1938
  Albany, NY 12237

- Phone: (518) 408-1219

- Email: obs@health.ny.gov


Announcements

Annual Practice Report Information

- Office Based Surgery Practice Report Letter (PDF)
- Office Based Surgery Alert (PDF)
- Office Based Surgery Practice Report Frequently Asked Questions (PDF)
- HCO HERDS Procedure (PDF)
- HESDRS Quick Reference (PDF)

Newsletter

- Office Based Surgery Update (PDF)

Health Commerce System (HCS)

- New Users - HCS Account Password Change Process (PDF)
- Directions to Upload a file for Secure File Transfer on HCS (PDF)
- Secure File Transfer Quick Reference Guide (PDF)

Cannography

- Statement on Use of Cannography in Office-Based Surgery effective January 31, 2016 (PDF)

https://www.health.ny.gov/professionals/office-based_surgery/
Changes to NY Office-based Surgery Law Effective April 13, 2016

- Adverse events required to be reported within 72 hours of occurrence (extended from 24 hrs)
- Must report two additional types of adverse events (AE).
  - Unplanned emergency department visits within seventy-two hours of office-based surgery; and,
  - Unscheduled assignment to observation services within a hospital within seventy-two hours of the office-based surgery. *
NY previously mandated types of AE:

- Unplanned transfer to a hospital or emergency department from an OBS practice;
- Unscheduled admission to the hospital for longer than 24 hours within seventy-two hours of office-based surgery;
- Patient death within thirty days;
- Suspected transmission of blood-borne pathogens from staff to patients or between patients, and;
- Any other serious or life-threatening event.

*The DOH has adopted the National Quality Forum's Serious Reportable Events as our definition of "other serious or life-threatening events" involving OBS patients.
Office Based Surgery Alert:

Annual Practice Report

What? Public Health Law § 230-d(4)(b) provides the New York State Department of Health (NYSDOH) with the authority to require Office Based Surgery (OBS) practices to report procedural information and other data as needed for the interpretation of adverse events. The NYSDOH intends to propose a regulation that would require reporting of such additional information.

In the interest of patient safety, and to ensure compliance readiness with respect to the upcoming regulations, the NYSDOH strongly encourages all OBS practices to report this additional information for calendar year 2017. The OBS program has developed an online annual reporting tool so that OBS practices may submit this data. The reporting tool’s twelve questions include requests for practice descriptors, such as National Provider Identifier, and counts of the volume and types of procedures performed in the practice during a calendar year.

When? The initial reporting period will be from March 31, 2018 through June 30, 2018. OBS practices should report their 2017 data during this period using the reporting tool. Subsequent annual reporting periods will be announced by the NYSDOH by December 31st of each year.

Why? This information is necessary to assist the NYSDOH Office of Quality & Patient Safety (OQPS) in evaluating adverse events reported by OBS practices across the state. The NYSDOH will also make de-identified, aggregated data available to OBS practices and stakeholders, to increase awareness about adverse events and to facilitate OBS quality improvement.

Emergency manual

- AAAASF Emergency Preparedness in Becker’s Review
- Cardiac arrest, MH, fire drills, and disasters – these are the drills that accreditation agencies mandate once yearly
- We prepared a principal manual to respond to OBA crisis, customized

Link to Manual:
https://www.emergencymanuals.org/tools-resources/free-tools/
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<td>Allergies</td>
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<td>Cardiac arrest- PEA/asystole</td>
<td>Anaphylaxis (adult + ped dosing)</td>
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<tr>
<td>Bradycardia- unstable</td>
<td>Difficult airway</td>
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<tr>
<td>Tachycardia- unstable</td>
<td>Hemorrhage</td>
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</table>

<table>
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<td>Hypercarbia</td>
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<td>Hypotension (adult + ped dosing)</td>
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<tr>
<td>Bradycardia- unstable</td>
<td>Hypoxia</td>
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<tr>
<td>Tachycardia- unstable</td>
<td>LAST (adult + ped dosing)</td>
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<td>Emergency</td>
<td>Loss of access</td>
</tr>
<tr>
<td>Fire- airway or surroundings</td>
<td>Mental status change</td>
</tr>
<tr>
<td>Evacuation and preparedness</td>
<td>MH (adult + ped dosing)</td>
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<tr>
<th>Spinal Anesthesia: General Complications</th>
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<th>Loss of Oxygen</th>
<th>Administrative</th>
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<tr>
<td>Loss of Power</td>
<td>Transfer of care MH patient</td>
</tr>
<tr>
<td></td>
<td>Transfer of care non-MH patient</td>
</tr>
</tbody>
</table>
Customizing an Emergency Manual

Steven Young, M.D.
Fred E. Shapiro, D.O., FASA
Committee on Ambulatory Surgical Care

Richard D. Urman, M.D., M.B.A., CPE, FASA
Committee on Ambulatory Surgical Care

Alexander A. Hannenberg, M.D.

American Society of Anesthesiologists

www.asamonitor.org

Customizing an Emergency Manual

Over the past 20 years, office-based surgery has shown an exponential increase in both the number and complexity of patients and types of procedures. Fortunately, serious CSS crises are rare in the office-based surgical (OBSS) setting, but when they do occur, both anesthesia and non-anesthesia providers must be well equipped to provide the best possible care for the patient. Given these patient safety concerns, the Centers for Medicare & Medicaid Services recently added the use of a World Health Organization (WHO) type safe surgery checklist for minor procedures, and used below a procedure starts, as a measure of quality for ambulatory surgery centers. Another type of checklist includes emergency checklists, with treatment algorithms, like the advanced cardiac life support (ACLS) algorithm, which are often encountered in the O.R. and hospital wards.

However, checklists need not only be used in O.R. settings. Checklists can be modified and carried out successfully in the office-based setting. For example, Kraft et al. published the first pilot study evaluating the feasibility of educating office practitioners and patients on crisis management. They adapted a 20-item postoperative checklist based on the WHO Surgical Safety Checklist in an office-based plastic surgery practice and determined, via a prospective post-checklist implementation chart review, a reduction in surgical complications. From pre- to post-implementation, they saw 15.1 complications per 100 patients to 2.72 complications per 100 patients, a 12.4 percent absolute risk reduction of total number of complications.

The design of our OBSS setting emergency manual (EM) was loosely based upon concepts from Dr. Atul Gawande’s “Checklist for Checklists” and the current American College of Surgeons’ O.R. Crisis Checklists. In designing the EM, typographic of the checklist became important as it affects the reader’s ability to read quickly and grasp the significant points during times of crisis. To ensure good flow and readability, we chose to use sans serif font, used larger font letters for important words, avoided long strings of text in italics and used black on one white background. We ensured that each chapter fits on one page by minimizing the required content necessary to guide provider responses from start to finish. The use of checklists that can deliver patient care without having the page during a crisis. In consultation with Dr. Alex Hannenberg, we included the Atrauma manual into a template for our office-based EM.

Building items in the EM must be to signify the importance or importance factor of that item. In a clinical setting, this means reminding the provider of the critical nature of the item and the potential risk to the patient if it is forgotten. On the other hand, non-selective items form the other “normal” aspects of the response. It is tempting to hold every step, however, this can detract from the efficiency and effectiveness of the checklist. Numbering of items to do was unusual...
Principles of responding to OBA crises

ISOBS

- **IMMEDIATE** call for help
- **SECURE** a plan for crisis
- **OBTAIN** transfer of care plan/agreements
- **BEST: PRACTICE** = Best practice
- **SAFETY** = Timely transfer

What's the plan?
Objectives: In-situ simulation to highlight safety issues, regulatory requirements, and perceptions of safety processes by the plastic surgery office staff.

Methods: High-fidelity human patient simulator brought to an office-based plastic surgery setting to enact a half-day full-scale, multidisciplinary medical emergency.

Facilitated group debriefings conducted after each scenario - team training, communication, crisis management, and adherence to evidence-based protocols and regulatory standards.

AHRQ Medical Office Safety Culture Survey completed by participants before and after session.
Scheduled Drug Disposition for the mobile anesthesiologist in the office

- Whose DEA?
- The practice or the practitioner?
ASA Considerations: Office-Based Manual 2008

- 222 – prescription form
- 223 – Certificate of registration; DEA form for the practitioner
- 224 – for the office, principal place of business or practice
- Secured with double lock system
- Fill form of theft or have pharm periodically review every quarter to look for expired meds
Glossary:

**Administer**: To directly cause a medication to be applied externally or internally to a patient.

**Controlled drugs or medications**: Clinical drugs that are under the jurisdiction of the Controlled Substances Act. These are stratified into Schedule II, III, IV and V based on presumed abuse potential.

**DEA Form 222**: Schedule I & II Drug Order Form. Each triplicate form comes in packs of seven from the DEA, has a unique serial number and is preprinted from DEA with physician’s or office’s name.

**DEA Form 223**: The DEA Controlled Substances Certificate of Registration issued to the practitioner or entity.

**DEA Form 224**: Application for Registration. Renewed every three years on form 224a. The address on the form is important. DEA registrations are issued for principal place of business or professional practice where controlled substances are distributed or dispensed. To have controlled drugs shipped to your “office,” the office address must be the same as the shipping address. A home address or P.O. box number is not acceptable.

**DEA Form 106**: Report of Theft or Loss of Controlled Substances Form.

**DEA Form 41**: Request to Dispose of Stocked Controlled Substances Form.

**Dispenser**: An individual medical provider (such as a pharmacist or physician) or a medical business (such as a pharmacy or hospital) that provides a supply of medication.
Sux, MH, and Dantrolene

If the office does NOT use Succinylcholine or inhalation agents?

Do I need to stock Ryanodex/Dantrolene?
CONCLUSIONS:

- Results provide no insight into the triggering mechanism for MH (i.e., succinylcholine could in isolation have an extremely low incidence of inducing MH, yet markedly increase the risk when administered in combination with volatile anesthetics).

- Until more epidemiologic data are collected and analyzed, having dantrolene available, where succinylcholine may be used, is reasonable, and this practice should be maintained.
Procedures in class B ambulatory facilities are performed exclusively with oral or IV sedative-hypnotics and/or analgesics. These facilities typically do not stock dantrolene because no known triggers of malignant hyperthermia (ie, inhaled anesthetics and succinylcholine) are available.

This article argues that, in the absence of succinylcholine, the morbidity and mortality from laryngospasm can be significant, indeed, higher than the unlikely scenario of succinylcholine-triggered malignant hyperthermia.
References