Rx: Loss Control—Loss Control Defined and A Look at Pre-anesthetic Evaluation

This is the first of a series of columns on loss control, that is, based on studies of malpractice insurance claims as relates to anesthesia, how to minimize potential risks to the patient.

If this were a perfect world, there would be no need for a column about loss control. In this hypothetical perfect world, there would be no adverse reaction to anesthesia, no broken teeth, no equipment or human failures. Yet, each of us knows that despite all efforts to make the delivery of anesthesia as safe as possible, to practice the highest level of care, the delivery of anesthesia does involve risk to the patient. This potential for injury, for loss, is ever present; the purpose, then, of loss control is to minimize this potential.

Loss control defined

“Loss control” is a system to reduce the frequency (number of incidents or claims) and severity (cost), or where possible, to prevent loss through a process of measurement, evaluation, education, monitoring and control. Loss control activities are basically twofold—predictive or anticipatory and reactive or retrospective. Predictive activities identify potential problem areas where, unless controls are initiated and followed, eventually a loss will occur. Actions initiated to prevent recurrence of an event which produced a loss are reactive. Both activities are important and are used in the development of loss control efforts.

The word “loss” has been used repeatedly in the preceding paragraphs, and it will be helpful to elaborate on its meaning within this context. Loss can mean many things. It is not only an injury suffered by a patient and his family, but is also the loss of time, reputation and money involved in investigation and defense of allegations, as well as the monetary cost of the settlement of a claim. Loss control efforts encompass all aspects of “loss” and are accomplished through: (1) emphasis on “quality care”—practice that is consistent with professional standards, and (2) the mechanism to prove that “quality care” was provided—accurate and complete documentation.

While few would argue about the need for loss control efforts in general, implementation of specific control mechanisms may meet with resistance. This resistance is commonly expressed as one or more of the following arguments:

1. The “we’ve never had a loss” argument. This says that since no previous loss has occurred, what has been
done and is being done must be sufficient, so loss control is unnecessary.

2. The “there’s no chance it will happen” argument. This uses the logic that since the statistical probability of the loss is remote, there is no need to spend time and money to prevent it.

3. The “it can’t happen to me” argument. This states that while others make mistakes, I know I’m careful, so loss control doesn’t apply to me.

Loss control as relates to anesthesia

That loss control is indicated in the delivery of anesthesia is based upon statistical studies of malpractice claims by several organizations (the U.S. Department of Health, Education and Welfare Secretary’s Commission on Medical Malpractice; the National Association of Insurance Commissioners; and the Insurance Company of North America) which analyzed claims by frequency and severity. Historically, injuries and claims identified in the area of anesthesia are characterized by low frequency and high severity when contrasted with other malpractice loss areas. The most common loss areas, patient falls and medication errors, are very frequent in their occurrence, but not usually severe in outcome.

While reported claims do not occur often in anesthesia, when they do occur, the consequences are generally serious and costly. This is supported by a review of statistics of participants in the American Association of Nurse Anesthetists insurance program over the past several years, 1968-74. This study showed that two areas—cardiac arrest and bodily injury (including brain, lung, nerve and eye damage)—accounted for about 50% of the claims and 94% of the cost. Detailed information was available for 58% (348) of total claims reported (600) and showed that a total of $2,161,155 was paid in claim settlements, an average of $6,210 per claim. When only claims involving cardiac arrest and bodily injury are considered, the average jumps to $12,876 per claim.

It should be noted that malpractice settlement costs have been on the rise since 1974, the last year of the study. It should also be noted that this study was not exhaustive of all claims involving a CRNA, including only those participating in the insurance program. Therefore, total frequency and cost was much higher. The risk of serious patient injury and a large loss have been shown not to be a remote possibility, but a real one. Consequently, the need for loss control is clearly demonstrated.

The use of malpractice claim studies, such as the one just described, is an example of a retrospective activity. Major problem areas, such as cardiac arrest and bodily injury, are identified and can then be further analyzed to identify more specifically why these types of injury occurred and what action should be taken to help prevent future incidents. One way this can be accomplished is through a thorough review of particular claims. By the fact of a claim, one knows an incident has occurred, but that only identifies the result. What must be sought is the cause, the failure in the system, whether human or mechanical. Only when that is known can appropriate corrective action be taken.

Although claim review is described as being a reactive process, that is not altogether correct. Review of malpractice claims is indeed a retrospective process, reacting to what has already occurred. However, these claims are reviewed in the aggregate, composed of claims which occurred throughout the country. Application of loss control suggestions, based on retrospective analysis by CRNAs in other areas, may be viewed as anticipatory or preventative on an individual basis. Other anticipatory activities will be discussed more fully in future columns.

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1Study conducted by Timothy Gibson, former Director, Health Care Loss Control. INA Loss Control Services, Inc.

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Based upon the just mentioned studies, general categories of system failures were identified. One of these areas is in “Failure From Pre-Anesthesia Evaluation,” which will be this month’s topic. Other problem areas will be the subject of future AANA Journal articles.

Failure from pre-anesthesia evaluation

A failure from pre-anesthesia evaluation may be a result of the following:

1. Absence of, or inadequate, pre-anesthesia evaluation of the patient.
2. Failure to identify potential causes of a misadventure, such as, drug usage (prescription and/or illicit, previous anesthesia history, allergies, problems common to specific locale (such as high chemical residues or exposures).
3. Inadequate communication between person making the pre-anesthesia evaluation and the person actually administering the anesthesia.
4. Inadequate communication between the attending physician and/or surgeon resulting in incomplete physical examination data.

There is a very definite purpose to pre-anesthesia evaluation. It is a critical part of total anesthesia care as it identifies existing and potential patient problems, both physiological and psychological, which may affect the plan and course of anesthetic management. It is anticipatory in that potential problems are identified before anesthesia is given so that appropriate action can be taken to prevent untoward reactions and injury where possible.

It may be necessary, and in some cases advisable, to utilize medical consultation from the surgeon, anesthesiologist or other medical specialist. An adequate evaluation is essential to determine existing or potential problems; otherwise, the welfare of the patient may be jeopardized and the CRNA open to allegations of malpractice. Communication between the CRNA and others providing care is an essential component of quality care. It goes without saying, that all activities must be thoroughly and properly documented. “Quality care”, properly documented, will not only reduce the likelihood of a claim being alleged, but will facilitate proving that “quality care” was delivered.

A comprehensive pre-anesthesia evaluation will not prevent all untoward patient reactions during anesthesia. Although it cannot eliminate all risk, it remains an effective tool of control. The following list of items should be evaluated during the pre-anesthesia visit and properly documented. (This list is not all-inclusive and other items may be added as indicated by patient needs.)

1. Patient is interviewed (prior to transfer to operating room): (a) to determine anesthetic and drug history, and (b) review results of necessary laboratory tests and examinations (CBC, SMA-12, urinalysis, chest X-ray, EKG, electrolytes, etc.)
2. ASA classification is established.
3. The patient is informed as to the type of anesthesia—spinal, regional, general—to be used.
4. The patient or his next of kin is made aware that anesthesia will be administered by a nurse anesthetist where applicable.
5. Pre-anesthesia medications are identified, and ordered, with time and dosage noted.
6. Necessary tests and medications are ordered.
7. Consultation is obtained as indicated.

Future articles

The preceding is an example of what will be offered in future columns. It is not the intent of these articles to make each CRNA a loss control professional, but rather, to provide you with some tools which may help assure that you remain loss free.
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