Original Summary

Provision of Care Event (4) - 11-22-2024

Board of Registration in Medicine

File State: New

Owner: Erin Long - QPSD Quality Analyst

Entered Date: 11-22-2024

Fields labeled with an asterisk(*) are required.

Quality and Patient Safety Division

THE MASSACHUSETTS BOARD OF REGISTRATION IN MEDICINE (BORIM), THROUGH ITS PATIENT CARE ASSESSMENT (PCA) REGULATIONS, (243 CMR 3.00-3.14), IS RESPONSIBLE FOR ENSURING THAT ALL MASSACHUSETTS HOSPITALS AND AMBULATORY CLINICS, AS A CONDITION OF DEPARTMENT OF PUBLIC HEALTH (DPH) LICENSURE, HAVE QUALIFIED PCA PROGRAMS. THE REGULATIONS REQUIRE THAT HOSPITALS SUBMIT REPORTS OF QUALITY ASSURANCE ACTIVITIES (243 CMR 3.07) AND REPORTS OF UNEXPECTED PATIENT OUTCOMES KNOWN AS SAFETY AND QUALITY REVIEW (SQR) REPORTS (243 CMR 3.08). THROUGH THE SUBMISSION OF THESE REPORTS, HOSPITALS AND AMBULATORY CLINICS DEMONSTRATE TO THE BORIM THAT THEY HAVE ROBUST SYSTEMS AND PROCESSES IN PLACE TO IDENTIFY ADVERSE EVENTS, CONDUCT INTERNAL REVIEWS, AND IMPLEMENT CORRECTIVE MEASURES TO PREVENT A RECURRENCE AND TO IMPROVE PATIENT CARE.

Date and Facility Site

EVENT DATE AND HCF SITE

Date Event Occured	08-15-2022
File Owner	Erin Long - QPSD Quality Analyst
Site	[redacted]
Facility Type	Ambulatory Clinic
Cohort Teams	Ambulatory

Patient Involved in Event

PATIENT DETAILS

Date of Birth	01-01-1955
Age	67 years
Gender	Male
Race	White or Caucasian
Ethnicity	American
Admission Date	08-15-2022

Type of Patient Affected	Outpatient
Admitting Diagnosis	Right knee pain

Provision of Care

GENERAL INFORMATION ABOUT THE PROVISION OF CARE EVENT

Provision of Care Event Type	Unanticipated transfer to higher level of care

Safety and Quality Review

SAFETY AND QUALITY REVIEW FORM

Type of Report	Complete Report

A preliminary report should only be chosen if the investigation and/or report is NOT complete and additional information will be added in the future

Type of Event	Type 4

Type 1- Maternal Death related to delivery Type 2- Death in the course of, or resulting from, elective ambulatory procedure Type 3- An invasive diagnostic procedure or surgical intervention performed on the wrong organ, extremity, or body part Type 4- Death or major or permanent impairment of bodily function that was not ordinarily expected as a result of the patient's condition on presentation

Harm Level	Temporary harm
NQF Serious Reportable Event (SRE)?	No
Was this patient transferred to another facility	(●) Yes ( ) No ( ) Not applicable ( ) Unknown/Unsure
If the patient was transferred to another facility, was there difficulty in transferring the patient?	( ) Yes (●) No ( ) Not applicable ( ) Unknown/Unsure
Facility Staff Involved in Event	Credentialed Health Care Provider Involved • Orthopedic Surgeon Non-Credentialed Health Care Provider Involved • Registered Nurse (RN) • Other
Narrative of the Event	The patient is a 67-yo male presented to ABC Ambulatory Surgery Center for a right knee arthroscopy on 8/16/22. PMH: HTN, HLD, obesity, DM type 2, smoking, and a left knee replacement six months ago with no issues. Medications: Metformin, Lisinopril, Metoprolol ER, Simvastatin Preadmission Testing (PAT) had been completed the week prior to the scheduled procedure and instructions provided. On the day of the procedure, while in the waiting room, the patient endorsed increased anxiety and chest pain to the administrative assistant. The administrative assistant immediately notified the nurse. The patient was immediately moved to a pre-op room where the

Anesthesiologist arrived to assess the patient. VS: TA 98.4, HR 104, BP 188/98, RR 24, SPO2 92% on RA, the patient endorsed 7/10 midsternal chest pain.
The patient was alert and oriented x 3. The patient was provided oxygen at 2L N/C. Nitroglycerin was administered sublingually. EMS was called. The patient continued to endorse chest pain with difficulty of breathing. EMS arrived within 7 minutes of 9-1-1 call and transferred the patient to the hospital for further work-up. Follow-up with the patient post discharge revealed that he had a myocardial infarction.

Internal Review

INTERNAL REVIEW DETAILS

Event Reviewed by

Committees

- PCA Committee

Individual Reviewers

- Nurse Director
- Medical Director
- Office Administrator
- Other

If other, please list

Internal Review Findings

- Communication at Transfer of Care
- Equipment related
- Non-Credentialed provider skill/judgement

If other, please list

Description of Results of Internal Review

The internal review included the following:
1. Handoff/Communication:
There were communication issues surrounding the handoff between the nurse at the ABC Ambulatory Surgery Center and the academic medical center. The nurse had difficulty providing handoff to a clinical provider at the hospital in a timely manner, and therefore a hand off was not provided.
2. Communication and PAT instructions:
The investigation revealed the patient did not take his medications as instructed. The patient was advised to hold his metformin in the morning and to check his blood sugar before coming to the clinic. He was advised to take his blood pressure medications with a sip of water. The patient instead did not take any of his medications misunderstanding the instructions provided. It is uncertain if this may have contributed to the event, however an opportunity for improvement was identified.
3. Pre-operative Assessment:
The Center for Medicare and Medicaid Services (CMS) ASC Requirements for Comprehensive Medical History and Physical Assessment which in October 2019 removed the requirements at § 416.52(a) for a History and Physical within 30 days of the procedure and replaced them with requirements that defer to the ASC policy and operating physician’s clinical judgment to ensure that patients receive the appropriate pre-surgical assessments tailored to the patient and the type of surgery being performed.
The operating physician is required to document any pre-existing medical conditions and appropriate test results, in the medical record, before, during and after surgery and all pre-surgical assessments include documentation regarding any allergies to drugs, and that the

medical history and physical examination (H&P), if completed, be placed in the patient's medical record prior to the surgical procedure. Preadmission testing (PAT) and documentation was performed appropriately prior to the surgery according to policy, including the preoperative risk assessment. There may have been opportunities to involve the PCP prior to the procedure given the patient's medical history.
4. Equipment related:
Code Carts had not been maintained appropriately. The last Code Cart check was performed two months prior. It was discovered that several of the medications in the Code Cart were past the expiration date. In addition, the Code Cart lock was found to have been broken.

Quality Improvement Measures or Corrective Actions

Safety and Quality Improvement Measures

- Clinician related measure- Credentialed provider action
- Clinician related measure- Other
- Moderate action- Enhanced surveillance and auditing
- Weaker action- Education
- Weaker action- Policy/Protocol implementation, revision

If other, please list

Description of Quality Improvement Measures or Corrective Action

The following safety and quality improvement measures or corrective actions were taken because of this event:
The following safety and quality improvement measures or corrective actions were implemented:
• A new process for teach-back for patients (See attached PAT Teach-Back Form).
• A new policy for pre-op risk assessment. (Please see attached policy).
The following patients are excluded and are referred to an outside hospital for procedures:
o BMI greater than 45.
o Patients with AICDs (does not include cataract patients).
o Patient who are oxygen dependent.
o Patients with a history of difficult airway management.
o Patients with a known history of malignant hyperthermia or a family history of malignant hyperthermia.
The following patients require consultation with the PCP or specialty providers prior to booking:
o Patients on anticoagulation
o Patients with obstructive sleep apnea (OSA)
o Patient with MI or CVA within six months or a history of unstable angina
o Patients on dialysis
• Implemented new transfer agreement with the hospital. Through several meeting with leadership at both healthcare facilities, a formal transfer agreement was initiated. This agreement will allow for a streamlined process for patient transfers and updates.
• Creation of a Code Cart checklist. Daily Code Cart log to include a check of all medications, supplies, and cart lock. Will be assigned each day and verify completion during morning huddle.

Credentialed Health Care Provider(s) Data and Findings

WHEN APPLICABLE, PLEASE PROVIDE DE-IDENTIFIED PERFORMANCE DATA AND ANALYSIS FOR INVOLVED CREDENTIALED HEALTH CARE PROVIDERS.

Credentialed Health Care Provider Data and Findings

The anesthesiologist joined ABC Ambulatory Surgery Center in 2018 and also has privilidges at XYZ Hospital. The anesthesiologist meets or exceeds all of the requirements of Ongoing Professional Practice Evaluation (OPPE). The Medical Director has no concerns regarding this provider.

Attachments

ATTACHMENTS

FileName	Category	Description
Picture1.png		

Follow-Up on File

HEALTHCARE FACILITY- USE THIS SECTION TO ADD FOLLOW-UP ONLY AFTER A SUBMISSION HAS BEEN MADE. QPSD WILL ADD FOLLOW-UP TO A SUBMISSION ONCE THE REVIEW IS COMPLETE.

Follow-Up Actions
Not Specified

End of Form

Time Period	Indicator	Number of Events	Number of Events Involving This Provider	Number of ASC Admissions	Rate per 1000 ASC admissions	Benchmark* Per 1000 admissions
Q 1-3 CY 2022	All Cause Hospital Transfer/ Admission	7	2 including this event	1301	0.59	0.851
Q 1-3 CY 2022	All Cause Unplanned Hospital Admission within one day of discharge	2	1 including this event	1301	0.15	0.281
Q 1-3 CY 2022	Wrong Site Surgery	3	0	1301	0.23	0.026
Q 1-3 CY 2022	Normothermia	2	0	1301	99.8%	98.9%
Q 1-3 CY 2022	Surgical Site Infections	2	0	1301	0.15	n/a