Emergencies in the ASC: Are You Prepared?

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The routine nature of the ophthalmic ASC operation may lull you into a false sense of complacency when it comes to emergency management. The elective, minimally invasive, short duration procedures we deliver are typically uneventful. And let's face it, we like it that way. Our predominantly senior patient population often awaits cataract surgery with minimal anxiety. They know what to expect, benefitting from shared experiences of friends and family, discussions with their surgeon and in some cases, their own previous surgical experience. Yet the need to be ready to effectively manage emergency situations in the ophthalmic ASC is imperative. It's a regulatory requirement, a risk management strategy and necessary prerequisite for patient safety.

Accrediting bodies and state licensing regulations address emergency management in the ASC. You should refer to your specific standards and regulations and familiarize yourself with the requirements of each to assure compliance. For the purposes of this article, we'll focus on national standards and regulations.

National Standards and Regulations

The CMS ASC Conditions for Coverage mandate specific requirements for emergency management.

416.44 (a) The ASC must have an effective procedure for the immediate transfer, to a hospital, of patients requiring emergency medical care beyond the capabilities of the ASC.

Governing Body approved policies and procedures should specify the circumstances under which an emergent transfer would occur, the decision-maker, the documentation standards and the procedure for executing the transfer safely and efficiently. Typically, these policies include code blue response, emergency transfer, crash cart, emergency supplies and equipment and incapacitated healthcare professional, at a minimum. Prior to July 2012, the Medicare Conditions for Coverage (CfC) specified required emergency equipment including a mechanical ventilator and tracheostomy set. Many ASCs felt this was overly burdensome given their limited scope of care. This has since been revised and the requirement now states: "ASCs, in conjunction with their governing body and the medical staff, develop policies and procedures which specify the types of emergency equipment that would be appropriate for the facility's patient population, and make the items immediately available at the ASC to handle intra- or postoperative emergencies. The emergency equipment identified by the ASC should meet the current acceptable standards of practice in the ASC industry."

Crash Cart Equipment

The crash cart must be fully equipped to handle an emergency anywhere in the facility. For example, a suction machine on the crash cart is necessary to respond to an emergency in the restroom or the waiting room, where wall suction isn't available. We recommend, at a minimum, the following crash cart equipment:

- An Automated External Defibrillator (AED) or Defibrillator
- Suction Machine, Yankauer, Suction Catheters
- Oxygen Tank
- CPR Back Board
- Sharps Container
- Emergency Medications for Adults and/or Pediatrics (refer to current Advanced Cardiac Life Support [ACLS] Algorithms)
- Airways, Intubation Equipment, Ambu Bag, Oxygen Masks, etc.
- IV Supplies, IV Fluids
- Stethoscope, Blood Pressure Cuff
- Protective Eye Wear/Goggles, Gowns, Gloves
- Stopwatch

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• ACLS Algorithms, Code Blue Record, Crash Cart Inventory

The anesthesia staff should be consulted to determine the drug inventory. The crash cart should be kept locked to preserve the integrity of its contents, unless it is use or open for inspection and inventory. The top of the cart is inspected daily for proper function of the AED or Defibrillator, suction machine and oxygen tank. Monthly, the lock is broken and the entire crash cart is inspected for inventory and outdated materials, equipment or medicine. These inspections, daily and monthly, are documented on the crash cart log and this inspection procedure is included in your crash cart policies and procedures.

Relationships and Responsibilities

The ASC must have a written transfer agreement with a "local" Medicare participating hospital or ensure that all physicians performing surgery in the ASC have admitting privileges at a "local" Medicare participating hospital. A "local" hospital means the ASC is to consider the most appropriate hospital facility to which the ASC will transport its patients in the event of an emergency. It is assumed to be the nearest hospital with appropriate capabilities.

If your facility's scope of care includes general anesthesia or if your formulary includes any malignant hyperthermia-triggering agents such as succinylcholine, you must be appropriately equipped to handle an malignant hyperthermia (MH) emergency. This includes 36 vials of Dantrolene. The Malignant Hyperthermia Association of the United States (MHAUS, at www.mhaus.org) is an excellent resource for information on the incidence of MH, screening measures, signs and symptoms and treatment protocols including recommended equipment and supplies, posters and training materials.

416.44(d) Personnel trained in the use of emergency equipment and in cardiopulmonary resuscitation must be available whenever there's a patient in the ASC.

All ASC clinical staff must have current Basic Life Support (BLS) certification. Although only one ACLS-certified RN must be present when a patient is in the facility, it's considered a best practice to require all RNs working in the facility to be ACLS-certified to provide the highest standard of care and maximize your staffing flexibility. At least one pediatric advanced life support (PALS) certified RN is required whenever a pediatric patient is present. If you routinely care for pediatric patients, the best practice would be to require PALS certification for all RNs.

CMS requires a registered nurse to be available for emergency treatment whenever there's a patient in the ASC. Per CMS, "available" means on the premises and sufficiently free from other duties that the nurse is able to respond rapidly to emergency situations. The RN(s) designated to provide emergency treatment must be able to use any of the required equipment, so long as such use falls within an RN's scope of practice. Therefore, if you have one RN handling patient care preop/PACU and one RN circulating in the OR, you need at least one additional RN in your staffing plan to meet this requirement. Remember,

LPNs and technicians are not interchangeable with RNs.

Regular drills or mock codes — at minimum annually — are critical to ensure your facility staff is sufficiently familiar with your emergency policies and procedures, supplies and equipment and prepared for the unexpected. If your facility is equipped for an MH emergency, an MH drill should be held annually as well. (Be sure to save outdated Dantrolene sodium to use in your MH drill.) Your anesthesia staff is a great resource for this training and should be involved in the planning, execution and evaluation of your mock codes. During the mock code, staff roles should be clarified and discussed. For instance, during a code blue situation, an RN must respond with the crash cart. A code blue outside the OR will be initiated by an ACLS-certified RN until a physician is available to direct the code. One RN must be responsible for documentation on the Code Blue Record while another RN should be establishing the IV and administering medications at the direction of the physician. Clarification of roles and responsibilities during mock codes will eliminate confusion during an actual emergency.

Treating Seniors

The ophthalmic ASC patient population is predominantly seniors, most of whom have underlying systemic disease. Appropriate preoperative screening is essential to ensure patients are directed to the most suitable care environment. Medicare requires a comprehensive history and physical (H&P) completed within 30 days prior to surgery. Prior to admission, an ASC RN reviews the H&P and the patient health history questionnaire. This process, when approached diligently, may uncover a "red flag" or cause for concern that should be discussed with the surgeon and/or anesthesia staff prior to admission. In addition, the surgeon reviews the H&P and performs a pre-surgical assessment (CfC 416.52a) and the anesthesia provider will perform a pre-anesthesia evaluation (CfC 416.42a).

In our combined 35 years in ophthalmic ambulatory surgery, we've seen acute myocardial infarcts, third-degree heart blocks, acute congestive heart failure, seizures and even sudden death. It's important to remember that our patient population is often healthy only by the degree to which they're controlled on medication. Thus, compliance with medication regimens can be a major issue. Additionally, many seniors are reluctant to complain about their problems, not wanting to burden others. Still others are unable to accurately articulate their medical history. Emergencies DO OCCUR in ophthalmic ASCs.

In our experience, the two components of the ASC operation that are most critical to effective emergency management are 1) clinical competence and 2) staff training and education. The value of strong clinical assessment skills in your nursing staff can not be understated. We're proponents of hiring RNs with experience in critical care areas such as ICU, L&D and ER for preop and PACU. We've seen RNs identify an emerging crisis before it becomes a full-blown crisis on more than one occasion. Additionally, critical care experience usually means they can handle emergencies with calm and competence, which is essential for effective emergency management, particularly in an ASC, where no one expects emergencies.

Appropriate investment in staff training and education is a must. This is challenging for ASCs where the standard staffing model includes many part-time and per diem staff members. We recommend one mandatory annual education day to review disaster preparedness, emergency management, OSHA, and other mandated training, as well as targeted training on clinical topics, customer service, quality assessment and performance improvement (QAPI) or other areas of focus in the organization. This investment of time and talent has reaped great dividends in our organizations as it ensures a consistent standard of knowledge and competency across the entire staff.

While we're grateful that emergencies in the ophthalmic ASC are the exception rather than the rule, it's advisable to avoid a false sense of security. If your ASC handles enough cases, you'll eventually face a serious emergency. Take the time and make the investment to get prepared now to be sure your emergency patient is afforded the best possible care. ◇

Resources

American Heart Association www.heart.org and MHAUS www.mhaus.org.

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