

RULES AND REGULATIONS
DEPARTMENT OF ANESTHESIOLOGY
Revised March 2012

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SECTION I - ADMINISTRATION

I. Scope of Services

- A. Purpose.- The Department of Anesthesiology will provide medical care in the specialty of anesthesiology for all patients. Members of the Department of Anesthesiology will continually look for ways to improve the process and outcomes of anesthesia care. All patients, including pediatric patients will be served.
- B. Scope of Services: The Department of Anesthesiology provides complete anesthesia services, including consultation for patients and other physicians, general anesthesia, spinal and regional analgesia, sedation, management of obstetrical, and acute and chronic pain management. Service is available 24 hours a day, 7 days a week.
- C. Sites of Anesthesia Care:
 - 1. OR and obstetrical suite.
 - 2. Radiology
 - 3. PACU
 - 4. Other areas where operative or invasive procedures are performed. All general, regional and MAC anesthesia will only be performed by qualified Anesthesia personnel. IV conscious sedation will only be performed by qualified individuals in accordance with respective department's policies, and within the guidelines of and after having successfully completed an examination on the hospital's Procedural Sedation Policy.

II. Major Diseases/Conditions Managed

- A. Minor and major orthopedics, vascular, cardiothoracic, plastic, general surgery, gynecology, ENT, and ophthalmology.
- B. Code 99 airway management when applicable.
- C. Pain Management, providing diagnostic and therapeutic nerve blocks
- D. Patient controlled analgesia service and epidural pain service
- E. Management of Malignant Hyperthermia
- F. General Anesthesia/sedation-Provide anesthesia for scheduled and/or emergency operative, invasive or non-invasive procedures. Anesthesia includes general anesthesia, spinal anesthesia, regional anesthesia, and monitored anesthesia care
- G. Insertion of invasive lines including arterial lines, pulmonary artery catheters, central venous catheters and intravenous lines.
- H. Assist with problems as they arise in the CCU that relate to anesthesia care or airway management upon request.
- I. Supervision of Post Anesthesia Care Unit
- J. Obstetrical Anesthesia and Analgesia

III. Department Philosophy and Objectives

- A. Anesthesiology is a discipline within the practice of medicine specializing in:
 - 1. The medical management of patients who are undergoing surgery or other potentially painful or stressful medical procedures. This medical management includes the pre-procedure evaluation and treatment of patients, the prescription of anesthetic plans as necessary for the accomplishment of the procedure, the intraoperative monitoring of vital functions, and the post-operative care required to safely stabilize patients following their anesthetic care.
 - 2. Anesthetic care prescriptions may include elements of hypnosis, amnesia, pain reduction or elimination, muscular relaxation, reversal of anesthetic effects, and control of vital functions such as blood pressure, heart rate or rhythms, and physiologic or psychologic responses to surgical or procedural stresses.
 - 3. The management of acute pain following surgical procedures and chronic pain unrelated to medical procedures.
 - 4. The management of cardiopulmonary resuscitation.
- B. A competent anesthesiologist is a physician from whom one can expect the knowledge, skills, attitudes, and commitment to patients and to continuing education required for the practice of anesthesiology

1. Medical judgment - ready availability of mature medical judgment applicable to patients' care as this relates to the practice of the specialty;
2. Scholarship - the talent, training, and habits of study necessary for evaluating and appropriately applying knowledge.
3. Technical ability - facility in providing all technical services likely to be required in the practice of the specialty.

IV. Guidelines for the Ethical Practice of Anesthesiology

Anesthesiologists in the department should be familiar with and adhere to the ASA Guidelines for the Ethical Practice of Anesthesiology (Approved by House of Delegates on October 3, 1967 and last amended on October 17, 2001). In addition, anesthesiologists will be expected to comply with the accepted code of conduct contained in the bylaws of the Stamford Health System.

V. Organization of the Anesthesia Department

A. PHYSICIAN RESPONSIBILITIES FOR MEDICAL CARE

Anesthesiology is the practice of medicine. An anesthesiologist must be personally responsible to each patient for the provision of anesthesia care. An anesthesiologist exercises the same independent medical judgment on behalf of the patient as is exercised by other physicians. The anesthesiologist's responsibilities to the patient should include responsibility for preanesthetic evaluation and care, medical management of the anesthetic procedure and of the patient during surgery, post anesthetic evaluation and care, and medical direction of any nonphysician who assists in providing anesthesia care to the patient. The anesthesiologist should fulfill these responsibilities to the patient in accordance with the ASA Guidelines for the Ethical Practice of Anesthesiology and Guidelines for Patient Care in Anesthesiology. As a member of the hospital medical staff, an anesthesiologist is subject to and must observe, as well as be accorded the benefits of, the medical staff bylaws, rules and regulations generally applicable to all physicians granted privileges in the hospital. Additional rights and responsibilities may arise from rules and regulations specifically applicable to physicians in the department of anesthesia.

An anesthesiologist with full staff privileges must share on a fair and equitable basis in the responsibility for assuring 24-hour-a-day, 7-day-a-week availability of anesthesia care.

B. MEDICO-ADMINISTRATIVE ORGANIZATION AND RESPONSIBILITIES

The department of anesthesia has the responsibility to promote and ensure patient access to quality care in anesthesia and the optimal utilization of hospital facilities. To fulfill this responsibility, it is necessary to grant staff privileges to a sufficient number of qualified physicians to assure the existence of patient access to quality anesthesia care and optimal utilization of facilities. Additionally, the anesthesia department must develop a practicable system that will assure the constant personal availability of a member of the department. The department must also monitor and enforce adherence to standards of care, the medical staff bylaws and the rules and regulations particularly applicable to the anesthesia staff. The discharge of these administrative responsibilities should be guided by the following principles: The assumption and performance of medico-administrative responsibilities, though for the ultimate benefit of patients, are undertaken on behalf of, and as the agent for, the hospital. The fact that a physician has medico-administrative responsibilities should not affect that physician's, or any other physician's, individual responsibilities to patients or the physician's rights under the medical staff bylaws. All members of the staff should share in the discharge of medico-administrative responsibilities to the extent necessary or appropriate.

Administration of the anesthesia department should be directed by a qualified anesthesiologist member of the medical staff. The director should be elected or appointed in the same manner as the directors of the other clinical departments in the hospital.

The director of the anesthesia department should be responsible for medico-administrative functions in a manner similar to directors of other clinical departments and should be a permanent member of the Medical Executive Committee with shared voting responsibilities with the Radiology, Pathology, and and Emergency Departments on a rotating basis.

A description of the details of the operation of the anesthesia department, including all policies and procedures applicable to personnel in the department follows and is based on the hospital procedure and policy manual. Such policies and procedures are consistent with the medical staff bylaws, the hospital charter and administrative regulations and local law, and are also based upon the ASA Manual for Anesthesia Department Organization and Management and other ASA guidelines and suggestions, adapted to suit local conditions. The department of anesthesia must not be operated in a manner which restricts the patient's access to quality care or inhibits the development of the specialty of anesthesiology .

C. RESPONSIBILITIES of DEPARTMENT CHAIR, ANESTHESIOLOGISTS, and CERTIFIED REGISTERED NURSE ANESTHETISTS

1. DEPARTMENT CHAIR

The Chair of the Department of Anesthesiology will be selected and appointed by the Board of Directors in accordance with the Bylaws of the Medical Staff. The Chair shall be responsible for assuring that the following functions are performed, either by him/herself or by specific delegation to a qualified member of the department:

- i. Integration of the Department into the primary function of the hospital.
- ii. Recommending privileges for all individuals with primary anesthesia responsibility which shall be processed through established medical staff channels.
- iii. Recommending the availability of a sufficient number of qualified and competent personnel to provide the services needed for the daily surgical schedule and 24-hour, 7-day-a-week availability of anesthesia care.
- iv. Recommending the amount of space and other resources needed by the department.
- v. Continuing surveillance of the professional performance of all individuals who have delineated clinical privileges in the department.
- vi. Recommending to the administration and medical staff the type and amount of equipment necessary for administering anesthesia and for related resuscitative efforts, ensuring through at least annual review that such equipment is available.
- vii. Development of regulations concerning anesthetic safety.
- viii. Ensuring evaluation of the quality of anesthesia care rendered throughout the facility .
- ix. Ensuring that important internal processes and activities (those that affect patient outcomes most significantly) throughout the organization are continuously and systematically assessed and improved.
- x. The establishment of a program of continuing education for all individuals having anesthesia privileges, which includes in-service training and is based in part on the results of the evaluation of anesthesia care. The extent of the program shall be related to the scope and complexity of the anesthesia services provided.
- xi. Participation in the development of policies relating to the functioning of anesthesiologists and administration of anesthesia in various departments or services of the hospital. When requested, the Chair or Chair's designee should provide consultation in the management of problems of acute and chronic respiratory insufficiency as well as a variety of other diagnostic and therapeutic measures related to hospital patient

care.

xii. Reporting as required to the Credentials Committee, Quality Improvement Committee, Safety Committee, Infection Control Committee, Operating Room Committee, and other such committees as appropriate.

xiii. Specific duties as provided in appropriate sections of the Hospital Bylaws.

2. ANESTHESIOLOGISTS

a. Primary Function

i. Perform accepted procedures commonly used to render patient insensible to pain during the performance of surgical, obstetrical, and other pain-producing clinical maneuvers, and to relieve pain-associated medical syndromes.

ii. Support life functions during the period in which anesthesia is administered.

iii. Provide consultation relating to various other forms of patient care, such as problems in pain relief.

b. Specific Duties

i. Preoperative evaluation and reasonable explanation to the patient of the proposed anesthetic procedure, and obtaining informed consent.

ii. Pre-medication of the patient if needed.

iii. Administration of anesthesia to the patient on the basis of the ASA standards and guidelines; i.e., the anesthesiologist will be personally responsible for the conduct of the selected anesthetic and will be immediately available at all times to fulfill this responsibility.

iv. Will make a documented postoperative visit or visits as indicated.

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3. CERTIFIED REGISTERED NURSE ANESTHETISTS

a. Delegation of functions to nonphysician personnel should be based on specific criteria.

b. All personnel must satisfy the requirements of Core Privileges and Credentialing Procedures at the Stamford Hospital.

c. The individual's education, training, and demonstrated skills shall be approved by the medical staff on the recommendation of the physician responsible for anesthesia care. Such criteria should include competence to follow the anesthesia plan prescribed by the anesthesiologist and the technical ability to:

i. Induce anesthesia under the direction of an anesthesiologist.

ii. Maintain anesthesia at prescribed levels.

iii. Monitor and support life functions during the perioperative period.

iv. Recognize and report to the anesthesiologist any abnormal patient responses during anesthesia.

v. Adhere to the Anesthesia Care Team Principles (Approved by ASA House of Delegates on October 26, 1982 and last amended on October 17, 2001)

Anesthesiology is a recognized specialty of medicine. Anesthesia care personally performed or medically directed by an

anesthesiologist, a physician who has successfully completed a training program in anesthesiology, accredited by ACGME or equivalent organizations or the American Osteopathic Association, constitutes the practice of medicine. Certain aspects of anesthesia care may be delegated to other properly trained and credentialed professionals. These professionals, medically directed by the anesthesiologist, comprise the Anesthesia Care Team. Such delegation and direction should be specifically defined by the anesthesiologist director of the Anesthesia Care Team and approved by the hospital medical staff. Although selected functions of overall anesthesia care may be delegated to appropriate members of the Anesthesia Care Team, responsibility and direction of the Anesthesia Care Team rest with the anesthesiologist. Members of the medically directed Anesthesia Care Team may include physicians and nonphysician personnel.

In order to apply the Anesthesia Care Team concept in a manner consistent with the highest standards of patient care, the following essentials should be observed:

1. Medical Direction: Anesthesia direction, management or instruction provided by an anesthesiologist whose responsibilities include:
 - a. Preanesthetic evaluation of the patient.
 - b. Prescription of the anesthesia plan.
 - c. Personal participation in the most demanding procedures in this plan, especially those of induction and emergence, if applicable.
 - d. Following the course of anesthesia administration at frequent intervals.
 - e. Remaining physically available for the immediate diagnosis and treatment of emergencies.
 - f. Providing indicated postanesthesia care.

2. An anesthesiologist engaged in medical direction should use sound judgment in initiating other concurrent anesthetic and emergency procedures in accordance with Connecticut Statute section 20-87a. A crna who is prescribing and administering medical therapeutics during surgery may only do so if the physician who is medically directing the prescriptive activity is physically present in the institution, clinic or other setting where the surgery is being performed.

VI. Delineation of Clinical Privileges

The granting, reappraisal and revision of clinical privileges shall be in accordance with medical staff bylaws and rules and regulations.

The granting of privileges to prescribe and personally administer or medically direct or supervise provision of anesthesia care shall be based upon verified information using, but not limited to, the following criteria:

A. ANESTHESIOLOGIST

1. All members of the department shall satisfy board certification requirements as outlined in the stamford hospital bylaws.
2. Must have completed residency program of anesthesiology that is approved by the Accreditation Council of Graduate Medical Education (ACGME) and the American Board of Anesthesiology
3. Current medical licensure and registration to practice
4. Federal and state narcotics registration
5. Relevant training and clinical experience
6. Demonstrated current competence and ability to recognize and manage anesthetic-related complications
7. Health status (mental and physical)
8. References and recommendations from credible sources
9. Maintain required number of medical education hours of credit as set forth in the medical staff bylaws of the Stamford Health System.

B. CERTIFIED REGISTERED NURSE ANESTHETIST

1. Must have graduated from an accredited school of nursing and an accredited school of nurse anesthesia.
2. Must maintain certification according to American Association of Nurse Anesthetists guidelines.
3. Must fulfill all credentialing requirements of the Stamford Hospital.
4. Must have a current Connecticut State RN license.
5. Must meet the American Association of Nurse Anesthetists (AANA) requirements of 40 hours over two years in CME for re-licensure and recertification.
6. The CRNA scope of practice will be limited based upon the Delineation of Privileges for the CRNA as adopted by the Medical Board of The Stamford Hospital. This includes the following:
 - a. The CRNA will only perform anesthetic functions within the hospital when an anesthesiologist is physically present within the hospital.
 - b. The CRNA will not perform regional blocks or have direct patient responsibilities in the Obstetrical Suite.

C. CLASSES OF CLINICAL PRIVILEGES

1. LIMITED PRIVILEGES IN ANESTHESIOLOGY

This class of privileges is assigned to those physicians who are qualified to perform specific anesthetic procedures under specific conditions, and/or to use parenteral sedation to a level at which the patient's reflexes may be obtunded. Physicians with these privileges must meet the same standards as an anesthesiologist would for the same privileges.

2. CORE PRIVILEGES IN ANESTHESIOLOGY

Privileges granted to those physicians are competent by virtue of training and experience in the following:

- a. The medical management of patients who are rendered unconscious and/or insensible to pain and emotional stress during surgical, obstetrical and certain other medical procedures using general anesthesia, regional anesthesia and/or parenteral sedation to a level at which a patient's protective reflexes may be obtunded. The performance of preanesthetic, intra-anesthetic and postanesthetic evaluation and management, and appropriate measures to protect life functions and vital organs, is required.
- b. The protection of life functions and vital organs (e.g., brain, heart, lungs, kidneys, liver) under stress of anesthetic, surgical and other medical procedures
- c. The management of problems in pain relief;
- d. The management of cardiopulmonary resuscitation;
- e. The management of pulmonary care where applicable.

Due consideration should be given to individual physician capabilities and the resources of the health care facility. The specifics of each individual's privileges will be included in his/her credentials folder. Education, certification, quality improvement activities, health status, and continuing medical education activities are criteria, which are evaluated at the time of initial appointment and reappointment to all classes of anesthesiology medical staff privileges.

SECTION II - PERFORMANCE IMPROVEMENT

I. PURPOSE

The purpose of this plan is to define the format within which the Anesthesia Department carries out its Quality Improvement Program.

II. SCOPE AND RESPONSIBILITY

A. To assure that the care provided is in accordance with recognized standards of practice, the Anesthesia Department has developed an ongoing Performance Improvement Program which incorporates concurrent surveillance, objective peer review, and meaningful continuing education. The program attempts to identify and measure the process and activities that are high-volume and high-risk in order to identify opportunities to improve care. All care provided by the Department is concurrently monitored. Input into the system may be received from any source, including, but not limited to, members of the medical staff, nursing staff, administrative staff, risk management, medical records, and quality improvement and utilization review. This includes the preoperative, intraoperative, and postoperative phases and applies to both in-patients and out-patients on the obstetrical and surgical services.

B. The Director of Anesthesia is responsible for reporting, monitoring and evaluating the outcomes and processes of the Performance Improvement Program.

C. The Performance Improvement Program will consider the following dimensions of performance:

- Efficacy
- Appropriateness
- Availability
- Timeliness
- Effectiveness
- Continuity
- Safety
- Efficiency
- Respect and Caring

D. The Anesthesia Performance Improvement uses the following flags for performance improvement activities and benchmarking:

- 24 HR CONSULT / REQUEST DELAY
- ACUTE MI WITHIN 72 HRS OF ANESTH
- ARRHYTHMIA INTRA-OP OR POST-OP
- ASPIRATION PNEUMONIA < 2 D POST OP
- CARDIAC ARREST < 24 HRS POST OP
- COMPLICATION
- DEATH WITHIN 48 HRS OF ANESTH
- DENTAL INJURY DURING ANESTHESIA
- EQUIP MALFN/FAILURE/DISCON - PAT INJURY (OR POTEN)

EXTENSION OF SPINAL OR EPIDURAL
FAIL TO REGAIN CONSCIOUSNESS, APHASIA, PARALYSIS WITHIN 24 HRS OF OPERATION
NEW NEURO DEFICIT AT DC
NEW ORGAN FAILURE POSTOP
REINTUBATION IN RECOVERY ROOM
RESP ARRST < = 24 HRS FOLL ADMINI OF ANESTH
OTHER

III. REVIEW METHODOLOGY

- A. An Occurrence Record with a list of Anesthesia-Related Perioperative Indicators will be completed describing perioperative occurrence of items on the list. The form will include date, type of operation, surgeon, anesthesiologist, and other relevant clinical information.
- B. The completed occurrence records are collected and reviewed periodically by the Anesthesia Department Performance Improvement Committee. The first review determines if, in fact, the event was anesthesia related. No further action is necessary on those events deemed not to be anesthesia related, except possible referral to another service if appropriate.
- C. Anesthesia related occurrence data will be organized and maintained in an ongoing manner with regard to frequency of each occurrence.
- D. Those occurrences found to be anesthesia-related undergo in-depth review by the committee, including contacting the attending Anesthesiologist to request his/her input, and are presented on a regular basis at the full departmental meeting where they are discussed and final decisions rendered.
- E. An evaluation of the standard of care is made and coded as follows:
 - 1 – Questioned finding is expected and acceptable. No clinical management issues.
 - 2 – Questioned finding is not necessarily routine, but not totally unexpected. No clinical management issues.
 - 3 – Questioned finding is unexpected. No clinical management issues.
 - 4 – Questioned finding is unexpected. Clinical management issues present.
 - 5 – Questioned finding is very unexpected. Substantive clinical management issues present.
 - 7 – Questioned finding represents a technical problem or complication, which is unpreventable.
 - 8 - Questioned finding represents a technical problem or complication, which is preventable.
 - 9. – Questioned finding represents a documentation issue.
- F. In addition to the above, other potential material for quality review / improvement, which may be identified by other sources, will be acted upon by the Anesthesia Performance Improvement Committee as deemed appropriate.

IV. REPORTING AND REAPPRAISAL

The Department of Anesthesia's Performance Improvement Program will be assessed annually by the Chair of the

Anesthesiology Department for its effectiveness and consistency within the organizational performance improvement framework. The findings, conclusions, recommendations and actions taken will be communicated to the following:

1. Leadership Management Team
2. Hospital Performance Improvement Committee
3. Medical Executive Committee

V. RELATIONSHIPS WITH HOSPITAL-WIDE PROGRAMS

In addition to the comprehensive program described above, the Anesthesia Department also participates in those other medical staff functions that are carried out on a hospital-wide basis. Pertinent information relative to the Anesthesia staff is communicated from these committees to the Chief of Service for information and any follow-up deemed necessary.

VI. CORRECTIVE ACTION

When indicated, a plan of correction will be formulated and implemented. All correction plans will be evaluated for effectiveness.

VII. AUTHORITY

The Chair of the Department of Anesthesiology (or designees) will have the authority to implement this program of quality improvement and enforce the necessary corrective actions.

SECTION III - DEPARTMENT RESPONSIBILITIES

I. Anesthesia Coverage/Availability -The Department of Anesthesiology provides complete anesthesia services, including general, spinal, regional, conscious sedation, and pain management. Service is available 24 hours a day, 7 days a week.

II. ASA Physical Status Definition -To avoid confusion as to the basis upon which the Department of Anesthesiology classifies physical status in operative patients, the following represents the official American Society of Anesthesiologists classification. The anesthesiologist is responsible for determining the ASA classification of all patients receiving anesthesia and documenting this information in the preanesthesia assessment and anesthesia plan of care.

CLASSIFICATION OF PHYSICAL STATUS

P-1 - A normal healthy patient.

P-2 - A patient with mild systemic disease.

P-3 - A patient with severe systemic disease.

P-4 - A patient with severe systemic disease that is a constant threat to life.

P-5 - A moribund patient who is not expected to survive without the operation.

P-6 - A declared brain-dead patient whose organs are being removed for donor. purposes.

E - Patient requires emergency procedure.

III. Emergency Service Coverage

Adequate and timely availability of anesthesia services when emergent or urgent need for operating room services must be provided.

Availability of anesthesiologists is documented on a monthly call schedule which is posted and available on a daily basis.

All on-call anesthesiologists are to be available for anesthetic requirements within thirty (30) minutes of notification, in conjunction with the Anesthesia Call Policy as currently adopted and updated from time to time and approved by the Medical Executive Committee.

SECTION IV - INFECTION CONTROL GUIDELINES

I. PERSONNEL and EQUIPMENT

- A. Equipment that has become "soiled" or potentially contaminated during the procedure (e.g. intubation and suction equipment) should be kept separate from the clean working area of the anesthesia cart or machine.
- B. It is routine practice that the parts of the anesthesia circuit, which come into direct contact with the patient, will be disposable and used only for a single patient.
- C. Soiled blood pressure cuffs and head straps should be washed in a detergent and dried. Forceps and laryngoscope blades should be rinsed to remove debris, washed and scrubbed with a brush and a germicide detergent, or in accordance with accepted hospital policy.
- D. Anesthesia machines, equipment carts and monitors need to be surface cleaned each day by a cloth soaked in a germicide according to infection control guidelines. The horizontal surfaces of the machine and cart should be cleaned between cases.
- E. For patients who present known infectious hazards, the specific Operating Room Policies and Procedures will apply.
- F. Hand washing and/or decontamination with suitable materials, by anesthesia personnel, should be done before and after each patient exposure.

II. RESOURCES AND REFERENCES

The most recent publication of the *ASA's Recommendations for Infection Control for the Practice of Anesthesiology* should be utilized as a resource, as well as OSHA guidelines referenced in the Federal Register, "Occupational Exposure to Blood Borne Pathogens," 29 CFR; Part 1910.1030; Vol. 56:235; Dec 1991; p64175-82.

SECTION V - SAFETY GUIDELINES

- I. Anesthetic apparatus must be inspected and tested by the anesthetist before use. If a leak or other defect is observed, the equipment must not be used until the fault is repaired.
- II. Only non-flammable agents shall be used for the preoperative preparation of the surgical field, when electrical equipment employing an open spark is to be used during an operation, for example, cautery or coagulation equipment.
- III. Non-flammable anesthetic agents will be used in all anesthetizing locations.
- IV. The condition of all operating room electrical equipment shall be inspected quarterly by Biomedical Engineering and a written report of the results and any required corrective action shall be maintained.
- V. The results of any required annual conductivity testing shall be made known to personnel who work primarily in these areas.
- VI. Anesthesia personnel shall familiarize themselves with the rate, volume, and mechanism of air exchange within the surgical and obstetrical suites, as well as with humidity control.
- VII. All anesthesiologists shall be familiar with the applicable sections of the most recently published NFPA Bulletin No. 99.
- VIII. All waste gas from the anesthesia machine is disposed by connection to the vacuum system in each operating room.
- IX. Laser Surgery
 - All personnel must wear protective goggles.
 - All patients will wear protective eye coverings.
 - Laser-safe endotracheal tubes will be used when performing head and neck laser procedures for patients receiving a general anesthetic.
- X. There shall be readily available to each anesthetizing location, an emergency cart with a defibrillator, emergency drugs and other resuscitation equipment equivalent to that used in the operating room.
- XI. An anesthesia safety checklist shall be completed at the beginning of the day for each day on which an anesthesia machine is to be used., and a record of the checklist completion shall be maintained affixed to each anesthesia machine.

SECTION VI - EDUCATION

The Department of Anesthesia will participate in continuing education programs.

Each anesthesiologist is responsible for participating in a program of continuing medical education consistent with the ASA "Guidelines for a Minimally Acceptable Program of Any Continuing Education Requirement".

Each anesthesiologist is responsible for submitting documentation of fulfillment of CME requirements to the Anesthesia Department Office and or the Hospital Medical Staff Office as applicable. The minimum number of continuing medical education credits will be maintained as set forth in the medical staff bylaws of the Stamford Health System.

Since each member of the Department of Anesthesiology must hold a valid license to practice, he/she must also be in compliance with the State Board of Medical Quality Assurance requirements for continuing medical education.

SECTION VII - CARE OF PATIENTS

I. INFORMED CONSENT

It is the policy of The Stamford Hospital that the patient must be given the opportunity to give an "informed consent" prior to the administration of anesthesia by an anesthesiologist. Written verification of the informed consent must be on the patient's chart prior to the initiation of anesthesia.

II. DO NOT RESUSCITATE ORDERS

- A. The administration of anesthesia necessarily involves some practices and procedures that might be viewed as "resuscitation" in other settings. Prior to procedures requiring anesthetic care, any existing directives to limit the use of resuscitation procedures (that is, do-not-resuscitate orders and/or advance directives) should, when possible, be reviewed with the patient or designated surrogate to determine if modification of these directives is desirable. Possible modifications may include:
1. Full Attempt at Resuscitation
 2. Limited Attempt at Resuscitation with refusal of certain specific procedures such as intubation, cardiac compressions, defibrillation.
 3. Limited Attempt at Resuscitation determined by the anesthesiologist and surgical team based upon the patient's wishes and the clinical situation.
- B. Any modifications made to the patient's directive should be documented in the medical record, and should include if or when the original directives will be re-instated after the patient recovers from anesthesia and / or leaves the post-anesthesia care unit.
- C. When an anesthesiologist finds the limitations of intervention decisions to be irreconcilable with one's own moral views, then the anesthesiologist should withdraw in a nonjudgmental fashion, providing an alternative for care in a timely fashion.
- D. The Department of Anesthesiology will follow the current guidelines stated in the Do Not Resuscitate Policy of The Stamford Hospital.

III. STANDARDS FOR PATIENT CARE

These standards apply to all patients who receive anesthesia or monitored anesthesia care. Under unusual circumstances these standards may be modified. When this is the case, the circumstances shall be documented in the patient's record.

A. PRE-OPERATIVE TESTS

Preanesthetic laboratory and diagnostic testing is often essential; however, no routine laboratory or diagnostic screening test is necessary for the preanesthetic evaluation of patients. Appropriate indications for ordering tests may include the identification of specific clinical indicators or risk factors (e.g. age, pre-existing disease, and magnitude of the surgical procedure). Anesthesiologists should order test(s) when, in their judgment, the results may influence decisions regarding risks and management of the anesthesia and surgery. Relevant abnormalities should be noted and action taken, if appropriate. Pre-Operative testing data shall be available through the hospital's computerized systems where applicable; each anesthesiologist shall be familiar with the mechanisms necessary to obtain such data.

B. BASIC STANDARDS FOR PRE ANESTHESIA CARE

Standard I

An anesthesiologist shall be responsible for determining the medical status of the patient, developing a plan of anesthesia care, and acquainting the patient or the responsible adult with the proposed plan. The development of an appropriate plan of anesthesia care is based upon:

- a. Reviewing the medical record.
- b. Interviewing and examining the patient to:
 - i. Discuss the medical history, previous anesthetic experience and drug therapy.
 - ii. Assess those aspects of the physical condition and concurrent health problems that might affect decision regarding perioperative risk and management.
- c. Obtaining and/or reviewing tests and consultations necessary to the conduct of anesthesia.
- d. Determining the appropriate prescription of preoperative medications as necessary to the conduct of anesthesia.

The responsible anesthesiologist shall verify that the above has been properly performed and documented in the patient's record.

C. STANDARDS FOR BASIC ANESTHETIC MONITORING

These standards apply to all anesthesia care although, in emergency circumstances, appropriate life support measures take precedence. These standards may be exceeded at any time based on the judgment of the responsible anesthesiologist. They are intended to encourage quality patient care, but observing them cannot guarantee any specific patient outcome. They are subject to revision from time to time, as warranted by the evolution of technology and practice. They apply to all general anesthetics, regional anesthetics and monitored anesthesia care. This set of standards addresses only the issue of basic anesthesia monitoring, which is one component of anesthesia care. In certain rare or unusual circumstances, 1) some of these methods of monitoring may be clinically impractical, and 2) appropriate use of the described monitoring methods may fail to detect untoward clinical developments. Brief interruptions of continual monitoring may be unavoidable. Under extenuating circumstances, the responsible anesthesiologist may waive the requirements marked with an asterisk (*); it is recommended that when this is done, it should be so stated (including the reasons) in a note in the patient's medical record. These standards are not intended for application to the care of the object or co-patient in labor or in the conduct of pain management.

Note that "continual" is defined as "repeated regularly and frequently in steady rapid succession" whereas "continuous" means "prolonged without any interruption at any time."

Standard I

Qualified anesthesia personnel shall be present in the room throughout the conduct of all general anesthetics, regional anesthetics, and monitored anesthesia care.

Objective: Because of the rapid changes in patient status during anesthesia, qualified anesthesia personnel shall be continuously present to monitor the patient and provide anesthesia care. In the event there is a direct known hazard, e.g., radiation, to the anesthesia personnel which might require intermittent remote observation of the patient, some provision for monitoring the patient must be made. In the event that an emergency requires the temporary absence of the person primarily responsible for the anesthetic, the best judgment of the anesthesiologist will be exercised in comparing the emergency with the anesthetized patient's condition and in the selection of the person responsible for the anesthetic during the temporary absence.

Standard II

During all anesthetics, the patient's oxygenation, ventilation, circulation and temperature shall be continually evaluated.

a. OXYGENATION

Objective: To ensure adequate oxygen concentration in the inspired gas and the blood during all anesthetics.

Methods:

- i. Inspired gas: During every administration of general anesthesia using an anesthesia machine, the concentration of oxygen in the patient breathing system shall be measured by an oxygen analyzer with a low oxygen concentration limit alarm in use.

- ii. Blood oxygenation: During all anesthetics a quantitative method of assessing oxygenation such as pulse oximetry shall be employed. Adequate illumination and exposure of the patient is necessary to assess color. In patients undergoing MRI procedures where physical separation from the patient may preclude direct observation, pulse oximetry alone will suffice for assessing oxygenation.

b. VENTILATION

Objective: To ensure adequate ventilation of the patient during all anesthetics.

Methods:

- i. Every patient receiving general anesthesia shall have the adequacy of ventilation continually evaluated. While qualitative clinical signs such as chest excursion, observation of the reservoir breathing bag and auscultation of breath sounds may be useful, quantitative monitoring of the carbon dioxide content and/or volume of expired gas is strongly encouraged.
- ii. When an endotracheal tube or laryngeal mask is inserted, its correct positioning must be verified by clinical assessment and by identification of carbon dioxide in the expired gas. Continual end-tidal carbon dioxide analysis, in use from the time of endotracheal tube/laryngeal mask placement, until extubation/removal or initiating transfer to a postoperative care location, shall be performed using a quantitative method such as capnography, capnometry or mass spectroscopy.
- iii. When ventilation is controlled by a mechanical ventilator, there shall be a continuous use of a device that is capable of detecting disconnection of components of the breathing system. The device must give an audible signal when its alarm threshold is exceeded.
- iv. During regional anesthesia and monitored anesthesia care, the adequacy of ventilation shall be evaluated, at least, by continual observation of qualitative clinical signs.

c. CIRCULATION

Objective: To ensure the adequacy of the patient's circulatory function during all anesthetics.

Methods:

- i. Every patient receiving anesthesia shall have the electrocardiogram continuously displayed from the beginning of anesthesia until preparing to leave the anesthetizing location.
- ii. Every patient receiving anesthesia shall have arterial blood pressure and heart rate determined and evaluated at least every five minutes.
- iii. Every patient receiving general anesthesia shall have, in addition to the above, circulatory function continually evaluated by at least one of the following: palpation of the pulse, auscultation of heart sounds, monitoring of tracing of intra-arterial pressure, ultrasound peripheral pulse monitoring, or pulse plethysmography or oximetry.

d. BODY TEMPERATURE

Objective: To aid in the maintenance of appropriate body temperature during all anesthetics.

Method: There shall be readily available a means to continuously measure the patient's temperature.

D. STANDARDS FOR POSTANESTHESIA CARE

(These standards apply to postanesthesia care in all locations.)

Standard I

All patients who received general anesthesia, regional anesthesia, or monitored anesthesia care shall receive appropriate postanesthesia management.

- a. A Postanesthesia Care Unit (PACU) or an area which provides equivalent post-anesthesia care shall be available to receive patients after surgery and anesthesia. All patients who receive anesthesia shall be admitted to the PACU except by specific order of the anesthesiologist responsible for the patient's care. Based on the judgment of the responsible anesthesiologist, in the case of ambulatory surgery, a patient may bypass the phase I PACU and be directly admitted to phase II PACU; in the case of a CCU patient, a patient may be directly admitted to the CCU for continuous monitoring and management.
- b. The medical aspects of care in the PACU shall be governed by policies and procedures, which have been reviewed and approved by the Department of Anesthesiology.
- c. The design, equipment and staffing of the PACU shall meet requirements of the facility's accrediting and licensing bodies.
- d. The nursing standards of practice shall be consistent with those most recently approved by the American Society of Post Anesthesia Nurses (ASPAN).

Standard II

A patient transported to the PACU shall be accompanied by a member of the Anesthesia Care team who is knowledgeable about the patient's condition. The patient shall be continually evaluated and treated during transport with monitoring and support appropriate to the patient's condition.

Standard III

Upon arrival in the PACU, the patient shall be re-evaluated and a verbal report provided to the responsible PACU nurse by the member of the anesthesia care team who accompanied the patient.

- a. The patient's status on arrival in the PACU shall be documented.
- b. Information concerning the preoperative condition and the surgical/anesthetic course shall be transmitted to the PACU nurse.
- c. The member of the Anesthesia Care Team shall remain in the PACU until the PACU nurse accepts responsibility for the nursing care of the patient.

Standard IV

The patient's condition shall be evaluated continually in the PACU

- a. The patient shall be observed and monitored by methods appropriate to the patient's medical condition. Particular attention should be given to monitoring oxygenation, ventilation, circulation and temperature. During recovery from all anesthetics, a quantitative method of assessing oxygenation such as pulse oximetry shall be employed in the initial phase of recovery. This is not intended for application during the recovery of the obstetrical patient in whom regional anesthesia was used for labor and vaginal delivery.
- b. An accurate written report of the PACU period shall be maintained. Use of an appropriate PACU scoring system is encouraged for each patient on admission, at appropriate intervals prior to discharge, and at the time of discharge.
- c. General medical supervision and coordination of patient care in the PACU should be the responsibility of an anesthesiologist.
- d. There shall be a policy to assure the availability in the facility of a physician capable of managing complications and providing cardio-pulmonary resuscitation for patients in the PACU.

Standard V

A physician is responsible for the discharge of the patient from the postanesthesia care unit

- a. When discharge criteria are used they must be approved by the Department of Anesthesiology and the medical staff. They may vary depending upon whether the patient is discharged to a hospital room, to the ICU, or home.
- b. In the absence of a physician responsible for the discharge, the PACU nurse shall determine that the patient meets the discharge criteria. The name of the physician accepting responsibility for discharge shall be noted on the record.
- c. The discharge criteria for the Ambulatory Surgery Unit and the Stamford Surgical Center shall be established and maintained in accordance with respective and pertinent bylaws of the respective institutions.

E. DOCUMENTATION OF ANESTHESIA CARE

While anesthesia care is a continuum, it is usually viewed as consisting of preanesthesia, peri-anesthesia and postanesthesia components. Anesthesia care should be documented to reflect these components and to facilitate review. The record should include documentation of the following:

- I. Preanesthesia Evaluation
 - A. Patient interview to review:
 - Medical history
 - Anesthesia history
 - Medication history
 - B. Appropriate physical examination.
 - C. Review of objective diagnostic data (e.g., laboratory, ECG, X-ray).
 - D. Assignment of ASA physical status.
 - E. Formulation and discussion of an anesthesia plan with the patient and/or responsible adult.
- II. Perianesthesia (time-based record of events)
 - A. Immediate review prior to initiation of anesthetic procedures:
 - Patient reevaluation
 - Check of equipment, drugs and gas supply
 - B. Monitoring of the patient (e.g., recording of vital signs).
 - C. Amounts of all drugs and agents used, and times given.
 - D. The type and amounts of all intravenous fluids used, including blood and blood products, and times given.
 - E. The technique(s) used.
 - F. Unusual events during the anesthesia period.
 - G. The status of the patient at the conclusion of anesthesia.
- III. Postanesthesia
 - A. Patient evaluation on admission and discharge from the postanesthesia care unit.
 - B. A time-based record of vital signs and level of consciousness.
 - C. All drugs administered and their dosages.
 - D. Type and amounts of intravenous fluids administered, including blood and blood products.
 - E. Any unusual events including postanesthesia or postprocedural complications.
 - F. Postanesthesia visits.

SECTION VIII - POST ANESTHESIA CARE UNIT

I. PURPOSE - The function of the Postanesthesia Care Unit (PACU) is to provide the concentrated and comprehensive

care necessary in the immediate postanesthetic period for patients who have had surgical, obstetric, diagnostic or therapeutic procedures.

II. ORGANIZATION - In general, physicians shall be responsible for the patients' medical care and the Nursing Service shall be responsible for the patients' nursing care. Policies and procedures should be formulated, published and reviewed periodically through a combined effort of the two groups.

A. Medical Supervision

1. The Chair of the Department of Anesthesia, shall assume overall medical responsibility .
2. Individual postanesthetic patient care shall be the responsibility of the anesthesiologist and the physician performing the procedure.

B. Nursing Supervision-The PACU Supervisor or head nurse should be administratively responsible to a designee of the nursing service but medically responsible to the Chair of the Department of Anesthesia.

III. ADMISSION CRITERIA

The anesthesiologist or physician in charge of the PACU shall determine which patients shall be admitted to the PACU. This may include patients who have had general, regional, or local anesthesia..

IV. DISCHARGE CRITERIA

Patients may be discharged only after vital signs are stable. All PACU patients will have recorded (at regular intervals) a postanesthesia recovery score (PARS). Patients may be discharged from the care of the anesthesiologist only after an evaluation of the patient's condition by the anesthesiologist. When the responsible anesthesiologist (or designee) is not personally present to make the decision to discharge and or cannot sign the discharge order, patients may be discharged from the care of the anesthesiologist in the PACU on attaining a PARS of 8 to 10. In such instances, the name of the anesthesiologist responsible for the discharge is recorded in the patient's medical record.

V. POSTANESTHESIA RECOVERY SCORE

1. Activity

- a. able to move 4 extremities voluntarily or on command = 2
- b. able to move 2 extremities voluntarily or on command = 1
- c. able to move 0 extremities voluntarily or on command = 0

2. Respiration

- a. able to deep breathe and cough freely = 2
- b. dyspnea or limited breathing = 1
- c. apneic = 0

3. Circulation

- a. blood pressure varies 20% of preanesthetic level = 2
- b. blood pressure varies 20% to 50% of preanesthetic level = 1
- c. blood pressure varies 50% of preanesthetic level = 0

4. Consciousness

- a. fully awake = 2
- b. arousable on calling = 1
- c. not responding = 0

5. Color

- a. pink = 2

b. pale, dusky, blotchy, jaundiced, other = 1
c. cyanosis = 0