



COMMONWEALTH
ANESTHESIA
ASSOCIATES

COMMONWEALTH ANESTHESIA ASSOCIATES

ANESTHESIOLOGY POLICIES AND PROCEDURES

APPROVED BY:

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ANESTHESIOLOGY POLICIES & PROCEDURES
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TITLE: MISSION STATEMENT	
EFFECTIVE DATE: JANUARY 2012	NUMBER: 1
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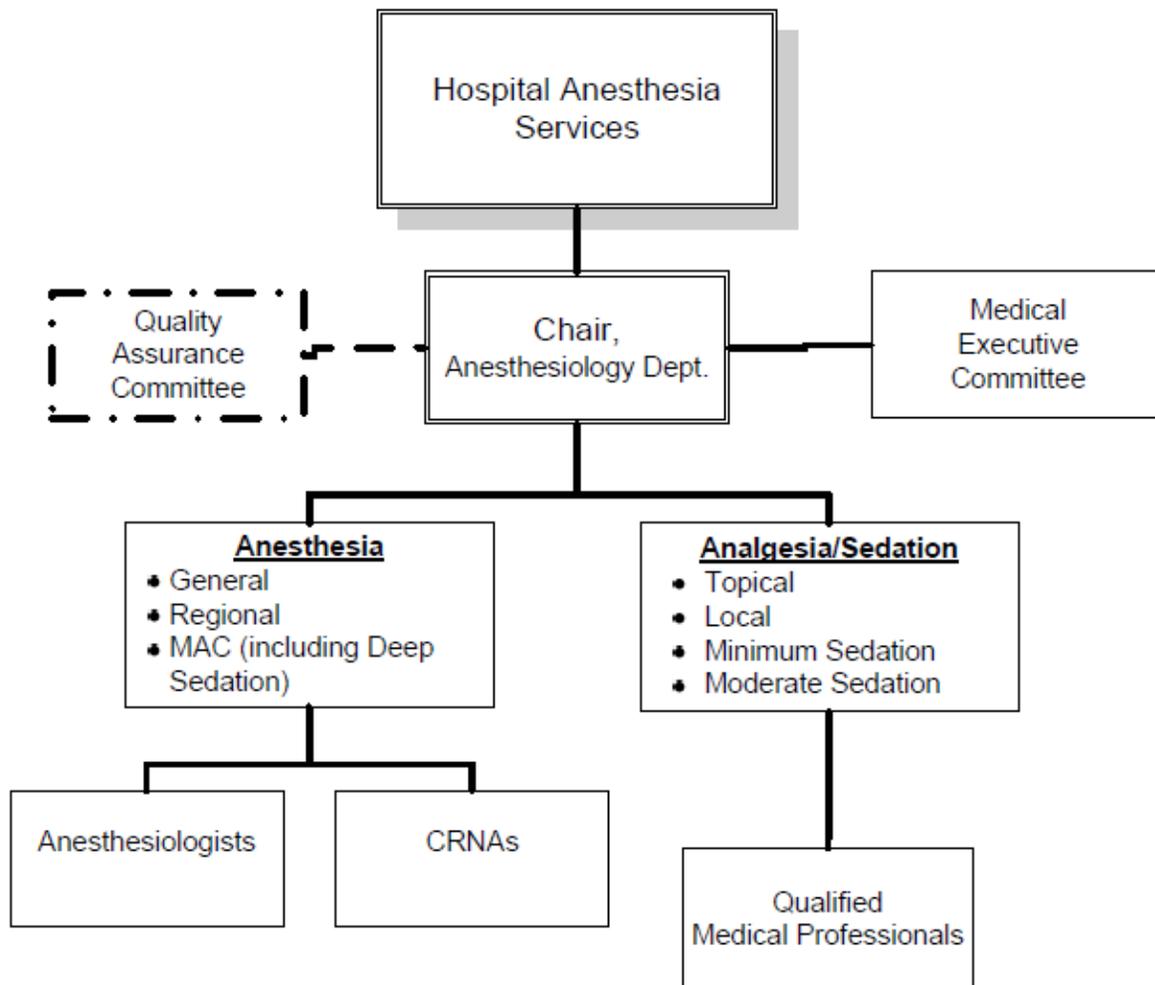
The mission of Commonwealth Anesthesia Associates is to provide safe, effective, and ethical care to our patients. To accomplish this mission, our group of board-certified anesthesiologists works in a care-team model with certified registered nurse anesthetists.

We are committed to providing advocacy and education for our patients. We strive to create a fulfilling work environment for all CAA members by developing innovative care-plan strategies, providing ethical leadership for operating room and practice management and providing market responsive perioperative services.



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TITLE: ORGANIZATIONAL CHART	
EFFECTIVE DATE: JANUARY 2012	NUMBER: 2
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ANESTHESIOLOGY POLICIES AND PROCEDURES

TITLE: CHIEF OF ANESTHESIOLOGY'S RESPONSIBILITIES	
EFFECTIVE DATE: JANUARY 2012	NUMBER: 3
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The Chief of Anesthesiology is a board certified doctor of medicine or osteopathy whose responsibilities include, but are not limited to, the following:

1. Planning, directing and supervising all activities of the hospital's anesthesia services in all locations;
2. Recommending privileges for all individuals who have responsibility for providing anesthesia services. These privileges are processed through the Credentials Committee of the Medical Staff of the Hospital.
3. Assuring that the quality and appropriateness of the hospital's anesthesia services are monitored and evaluated; including the development of clinical criteria to be used for quality assurance purposes and that appropriate actions based on the findings are taken. The Department of Anesthesia services is integrated into the Hospital's overall QAPI program and anesthesia services to be monitored are provided by any anesthesia provider in any department or location in the Hospital, including the Operating Room Suites, Emergency Department, Radiology Department, Intensive Care, Obstetrical Suites, the Cardiac Catheterization Lab, etc.
4. Recommending to the Hospital's Administration and Medical Staff the type and amount of equipment required to provide the necessary scope of service.
5. Developing guidelines for anesthesia safety.
6. Reviewing, when appropriate, procedures performed by anesthesia providers, patient management issues, consultation issues, pain management issues, and quality assurance information to help ensure the best care for our patients.
7. Assigning or designating the assignment of room coverage and on-call responsibilities of anesthesia providers.



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TITLE: STAFFING FOR DELIVERY OF ANESTHESIA CARE	
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Anesthesia services will be available 24 hours a day, 365 days a year in all hospitals that CAA serves. Anesthesia services will be available in outpatient surgery services that CAA serves according to a schedule negotiated with that center.



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TITLE: ANESTHESIOLOGISTS' RESPONSIBILITIES	
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Anesthesiologists will be able to perform all of the independent services usually required in the practice of anesthesiology; including accepted procedures commonly used to make the patient insensitive to pain during the performance of surgical and pain-producing clinical maneuvers; to relieve pain-associated medical syndromes; to support life functions during the administration of anesthesia, to provide appropriate pre-anesthesia and post-anesthesia management of the patient; to provide consultation services related to other types of patient care, such as respiratory therapy, cardio-pulmonary resuscitation, and special problems in pain relief.

The anesthesiologist will be:

1. Educated at an accredited medical school;
2. Trained at an accredited anesthesiology residency program;
3. Licensed by the Commonwealth of Virginia;
4. Licensed by the United States Department of Justice Drug Enforcement Administration with a Controlled Substance Registration Certificate;
5. Board Certified and/or Board Eligible by either the American Board of Anesthesiologists or the American Osteopathic Board of Anesthesiologists;
 - a. This requirement may be waived in an individual circumstance if agreed to by Hospital Administration and CAA, as long as it is in compliance with existing by-laws;
6. Qualified for Medical Staff privileges at the Hospital;
7. Responsible for the personal provision of an anesthetic or medical direction or supervision of CRNAs.
8. Physically present at the facility, available by the anesthesia-specific communication device and immediately available if needed by the CRNA. Immediately available means the anesthesiologist is in or near the physical site where the CRNA is providing anesthetic care.



ANESTHESIOLOGY POLICIES AND PROCEDURES

TITLE: CERTIFIED REGISTERED NURSE ANESTHETISTS (CRNA) – DUTIES AND RESPONSIBILITIES	
EFFECTIVE DATE: JANUARY 2012	NUMBER: 6
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1. The CRNA will be:
 - a. Licensed as a Registered Nurse in the Commonwealth of Virginia;
 - b. Certified by the American Association of Nurse Anesthetists.
2. The CRNA will provide anesthesia services under the medical direction or supervision of an Anesthesiologist on the staff of the Hospital. A CRNA may not provide anesthesia services without the medical direction or supervision of a staff Anesthesiologist.
3. The CRNA is responsible to the Anesthesiologist in all things pertinent to the anesthetic.
4. The CRNA may provide post-anesthetic patient care in the PACU or hospital as necessary, document the problems and treatment initiated, but will inform the supervising or directing Anesthesiologist as early and appropriate as determined by the clinical condition of the patient.
5. The CRNA may establish airways in emergency situations anywhere in the hospital.
6. The CRNA is responsible for preparing anesthesia related medication and for verifying functioning of all equipment that would ordinarily be used in a proposed anesthetic.
7. Evaluations and care delivered by the CRNA will be documented in the patient's record.



ANESTHESIOLOGY POLICIES AND PROCEDURES

TITLE: PRE-ANESTHESIA EVALUATION - DELINEATION OF ANESTHESIA CARE	
EFFECTIVE DATE: JANUARY 2012	NUMBER: 8
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1. A pre-anesthesia evaluation will be performed by an anesthesia provider on every inpatient or outpatient receiving anesthesia services, and will be documented in the patient's medical record. This evaluation, for elective surgery patients, will take place within 48 hours prior to pre-operative medication being administered, unless the circumstances of the particular situation would dictate otherwise. If the pre-anesthesia evaluation is performed by a CRNA, it must be reviewed and confirmed by the Anesthesiologist on duty.
2. Pre-Anesthesia Care Standards
 - a. Determine medical, anesthetic, drug, and allergy history.
 - b. Perform any examinations that would provide information that might assist in the decision regarding anesthetic risks and management. Indicate physical status (ASA definition).
 - c. Order or review pertinent diagnostic tests.
 - d. Identify potential anesthesia problems (e.g., difficult airway, ongoing infection, limited vascular access).
 - e. Obtain consultation as necessary.
 - f. Formulate an anesthetic plan and discuss risk/benefits of the plan with the patient or the patient's legal representative.
3. The pre-anesthesia medical record entry will ordinarily indicate the planned technique of anesthesia (i.e., general, spinal, or other regional). Exceptions to this can be made whenever the precise technique of anesthesia might be more appropriately determined in the operating suite where the precise immediate pre-operative status of the patient can be re-evaluated.



ANESTHESIOLOGY POLICIES AND PROCEDURES

TITLE: ASA CLASSIFICATION SYSTEM	
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The ASA classifications are as follows:

- **ASA I** No organic, physiologic, biochemical or psychiatric disturbance. Normal healthy patient.
- **ASA II** Mild-moderate systemic disturbance; may or may not be related to reason for surgery (i.e., hypertension, diabetes mellitus)
- **ASA III** Severe systemic disturbance (i.e., heart disease, poorly controlled hypertension)
- **ASA IV** Life threatening systemic disturbance (i.e., congestive heart failure, persistent angina pectoris)
- **ASA V** Moribund patient, little chance for survival, surgery is last resort (i.e., uncontrolled bleeding, ruptured abdominal aortic aneurysm)
- **ASA VI** Declared brain dead patient whose organs are being removed for donor purposes.
- **E** Patient requires emergency procedure (i.e., appendectomy, D&C for uncontrolled bleeding)



ANESTHESIOLOGY POLICIES AND PROCEDURES

TITLE: INTRAOPERATIVE ANESTHESIA MONITORING AND DOCUMENTATION	
EFFECTIVE DATE: JANUARY 2012	NUMBER: 10
REVISION DATES: JULY 2011	PAGE 1 OF 1

1. A careful and thorough check of all anesthesia equipment and supplies will be done by the anesthesia provider prior to use on each case.
2. All reusable anesthesia equipment in direct contact with patient will be checked for cleanliness prior to use.
3. Each patient's vital signs will be evaluated and documented immediately prior to the induction of anesthesia.
4. Intraoperative monitoring will be consistent with "Standards for Basic Monitoring" published and affirmed by the American Society of Anesthesiologists (see attached).
5. An operative anesthesia record will be kept and will include documentation indicating:
 - a. Name and hospital identification number of the patient;
 - b. Name(s) of practitioner who administered anesthesia, and as applicable, the name and profession of the supervising anesthesiologist or operating practitioner;
 - c. Name, dosage, route and time of administration of drugs and anesthesia agents;
 - d. Technique(s) used and patient position(s), including the insertion/use of any intravascular or airway devices;
 - e. Name and amounts of intravenous fluids, including blood or blood products if applicable;
 - f. Time-based documentation of vital signs as well as oxygenation and ventilation parameters;
 - g. Any complications, adverse reactions, or problems occurring during anesthesia, including time and description of symptoms, vital signs, treatments rendered, and patient's response to treatment.

STANDARDS FOR BASIC ANESTHETIC MONITORING

Committee of Origin: Standards and Practice Parameters

**(Approved by the ASA House of Delegates on October 21, 1986, and last amended on
October 20, 2010 with an effective date of July 1, 2011)**

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 anesthetic 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. These standards are not intended for application to the care of the obstetrical patient in labor or in the conduct of pain management.

1. STANDARD I

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

1.1 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 left responsible for the anesthetic during the temporary absence.

2. STANDARD II

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

2.1 Oxygenation –

2.1.1 Objective –

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

STANDARDS FOR BASIC ANESTHETIC MONITORING

2.2 Methods –

- 2.2.1 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.*
- 2.2.2 Blood oxygenation: During all anesthetics, a quantitative method of assessing oxygenation such as pulse oximetry shall be employed.* When the pulse oximeter is utilized, the variable pitch pulse tone and the low threshold alarm shall be audible to the anesthesiologist or the anesthesia care team personnel.* Adequate illumination and exposure of the patient are necessary to assess color.*

3. VENTILATION

3.1 Objective –

To ensure adequate ventilation of the patient during all anesthetics.

3.2 Methods –

- 3.2.1 Every patient receiving general anesthesia shall have the adequacy of ventilation continually evaluated. Qualitative clinical signs such as chest excursion, observation of the reservoir breathing bag and auscultation of breath sounds are useful. Continual monitoring for the presence of expired carbon dioxide shall be performed unless invalidated by the nature of the patient, procedure or equipment. Quantitative monitoring of the volume of expired gas is strongly encouraged.*
- 3.2.2 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.* When capnography or capnometry is utilized, the end tidal CO₂ alarm shall be audible to the anesthesiologist or the anesthesia care team personnel.*
- 3.2.3 When ventilation is controlled by a mechanical ventilator, there shall be in continuous use 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.
- 3.2.4 During regional anesthesia (with no sedation) or local anesthesia (with no sedation), the adequacy of ventilation shall be evaluated by continual observation of qualitative clinical signs. During moderate or deep sedation the adequacy of ventilation shall be evaluated by continual observation of qualitative clinical signs and monitoring for the presence of exhaled carbon dioxide unless precluded or invalidated by the nature of the patient, procedure, or equipment.

STANDARDS FOR BASIC ANESTHETIC MONITORING

4. CIRCULATION

4.1 Objective –

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

4.2 Methods –

- 4.2.1 Every patient receiving anesthesia shall have the electrocardiogram continuously displayed from the beginning of anesthesia until preparing to leave the anesthetizing location.*
- 4.2.2 Every patient receiving anesthesia shall have arterial blood pressure and heart rate determined and evaluated at least every five minutes.*
- 4.2.3 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 a pulse, auscultation of heart sounds, monitoring of a tracing of intra-arterial pressure, ultrasound peripheral pulse monitoring, or pulse plethysmography or oximetry.

5. BODY TEMPERATURE

5.1 Objective –

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

5.2 Methods –

Every patient receiving anesthesia shall have temperature monitored when clinically significant changes in body temperature are intended, anticipated or suspected.

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

* 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.



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TITLE: POST ANESTHESIA CARE	
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1. Patients having general anesthesia or central neuraxial anesthesia (epidural/spinal) will go to the Post Anesthesia Recovery Unit (PACU) or to a Special Care Unit for their initial recovery. The attending Anesthesiologist may transfer a patient directly to Phase II Recovery if discharge criteria are documented prior to the patient leaving the Operating Suite.
2. Patients undergoing other anesthetic techniques may go to the Post Anesthesia Recovery Unit (PACU), or may be transferred directly to Phase Two Recovery in Outpatient Surgery or to a Special Care Unit. Variations in this routine will be determined by a member of the Anesthesia Care Team (ACT – Anesthesiologist or CRNA) along with the surgeon based on the specifics of the case.
3. When discharge criteria have been met, a patient may be released from the Post Anesthesia Care Unit (PACU) by an Anesthesiologist's written or verbal order.
4. Obstetrical patients requiring anesthesia services will be recovered by the primary nurse, under the supervision of the attending Anesthesiologist and/or CRNA.
5. Patients receiving anesthesia services outside the Surgical Suite or the Obstetrical Suite may be recovered in their respective procedural recovery area or transferred to the PACU under the supervision of a member of the Anesthesia Care Team.



6. The patient's post-anesthesia follow-up report will be written by an anesthesia provider within 48 hours and will document the following:
 - a. Respiratory function, including respiratory rate, airway patency, and oxygen saturation;
 - b. Cardiovascular function, including pulse rate and blood pressure;
 - c. Mental status;
 - d. Temperature;
 - e. Pain
 - f. Nausea and vomiting, and
 - g. Postoperative hydration
 - h. Any complications occurring during post-anesthesia recovery;
 - i. Any follow-up care and/or observations and/or patient instructions given;



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TITLE: INFECTION CONTROL RESPONSIBILITIES	
EFFECTIVE DATE: JANUARY 2012	NUMBER: 12
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1. Anesthesia personnel will follow all appropriate infection control measures for the Operating Suites (OR) and the Post Anesthesia Recovery Unit (PACU).
2. Strict hand-washing will be observed at all times between different patient contacts.
3. Anesthesia personnel will abide by the scrub suit dress code of the Operating Suites (OR).
4. Disposable anesthesia patient care supplies will be used whenever possible.
5. Reusable items will be properly high-level disinfected or steamed, gas or cold sterilized prior to reuse.
6. Anesthesia machines will be cleaned with a hospital approved germicide at the completion of each case and when soiled during a procedure.
7. Patients with active airborne communicable disease processes (MRSA, TB, Varicella, etc.) will be cared for and appropriately isolated, based on the specific organism suspected or diagnosed.
8. Standard precautions will be observed at all times and there will not be any direct contact with a patient's blood, body fluids and/or excretions.
9. Central Lines will be placed in accordance with CDC guidelines, as follows:
 - a. Appropriate Skin Preparation
 - i. Chlorhexidine gluconate (CHG) for patients \geq 2 months old (completely dry before Central Line insertion)
 - ii. Povidone iodine, alcohol, CHG or other specified for children $<$ 2 months old (completely dry before Central Line insertion)
 - b. Appropriate Hand Hygiene will be performed by provider
 - c. All 5 maximal sterile barriers will be used:
 - i. Sterile gloves
 - ii. Sterile gown
 - iii. Cap
 - iv. Mask
 - v. Large sterile body drape



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TITLE: THE SAFE ADMINISTRATION OF ANESTHETIC AGENTS	
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1. Anesthesia equipment will be inspected and tested by an anesthesia provider before patient use. If a defect that might materially affect the safe functioning of the equipment is observed, the equipment is not used until the fault is repaired. Equipment that might have a defect of this sort will be clearly tagged with the noted defect and the date, and the appropriate service individual (Biomed or Engineering) will be notified as soon as possible, and the repair effected as soon as possible.
2. No flammable anesthesia agents are to be used for anesthesia or the pre-operative preparation of the surgical field. If laser surgery is being performed, all the usual precautions to prevent unwanted combustion will be carried out within the limits of the equipment available.



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TITLE: ANESTHESIA APPARATUS CHECK RECOMMENDATIONS	
EFFECTIVE DATE: JANUARY 2012	NUMBER: 14
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1. It will be the responsibility of the anesthesia provider administering anesthesia to check all anesthesia equipment and supplies prior to use.
2. See attached checklist 14A – Anesthesia Apparatus Checklist.



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TITLE: ANESTHESIA APPARATUS CHECKLIST	
EFFECTIVE DATE: JANUARY 2012	NUMBER: 14A CHECKLIST
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ANESTHESIA APPARATUS CHECKLIST

Date: _____ Location/OR Room: _____

Anesthetist: _____ Anesthesia Machine #: _____

Emergency Ventilation Equipment:

- Backup ventilation equipment is available and functioning

High Pressure System:

- Check oxygen cylinder supply
 - Open O₂ cylinder and verify at least half full (about 1000 psi)
 - Close cylinder
 - Replace any cylinder with less than 600 psi
- Check central pipeline supplies
 - Hoses are connected and pipeline gauges read about 50 psi

Low Pressure System:

- Check initial status of low pressure system
 - Close flow control valves and turn vaporizers off
 - Check full level and tighten vaporizers' filler caps
- Perform leak check of machine low pressure system
 - Verify that machine master switch and flow control valves are OFF

- Attach “suction bulb” to common fresh gas outlet
- Squeeze bulb repeatedly until fully collapsed
- Verify bulb stays collapsed for at least 10 seconds
- Open one vaporizer at a time and repeat the last two (2) steps above
- Remove suction bulb and reconnect fresh gas hose

Turn on Machine Master Switch and All Other Necessary Electrical Equipment:

- Inspired gas analyzer unit
- Pulse oximetry
- EKG/BP monitor, etc.
- Electrical equipment requiring warm-up
- Ensure undamaged flowmeters, vaporizers, gauges, breathing system and supply hoses

Test Flow Meters:

- Adjust flow of all gases through their full range, checking for smooth operation of floats and undamaged flowtubes
- Attempt to create a hypoxic O₂/N₂O mixture and verify correct changes in flow and/or alarms
- Check that the float is at the bottom of the tube with flow control valves closed (or at a minimum oxygen flow if so equipped)

Adjust and Check Scavenging System:

- Ensure proper connections between scavenging systems and both APL (pop-off) valve and ventilator relief valve
- Adjust waste gas vacuum (if possible)
- Fully open APL valve and occlude Y-piece
- With minimum O₂ flow, allow scavenger reservoir bag to collapse completely and verify that absorber pressure gauge reads about zero
- With O₂ flush activated, allow the scavenger reservoir bag to distend fully, and then verify that absorber pressure gauge reads less than 10 cm H₂O

Calibrate O₂ Monitor:

- Calibrate oxygen monitor to read 21% room air

- Low O₂ alarm is enabled and functioning
- Reinstall sensor in circuit and flush breathing system with 100% O₂
- Verify that monitor now reads greater than 90%

Check Initial Status Breathing System:

- Set selector switch to “bag” mode
- Check the breathing circuit is complete, undamaged, unobstructed
- Verify that CO₂ absorbent is adequate
- Install breathing circuit accessory equipment (i.e., humidifier, PEEP valve) to be used during the case
- Ensure correct mounting of cylinders in yokes and presence of cylinder wrench

Perform Leak Check of the Breathing System:

- Set all gas flows to zero (or minimum)
- Close APL (pop-off) valve and occlude Y-piece
- Pressurize breathing system to about 30 cm H₂O with O₂ flush
- Ensure that pressure remains fixed at least 10 seconds
- Open APL (pop-off) valve and ensure that pressure decreases

Test Ventilation Systems and Unidirectional Valves:

- Place a second breathing bag on Y-piece
- Set appropriate ventilator parameters for next patient
- Switch to automatic ventilation (ventilator) mode
- Fill bellows and breathing bag with O₂ flush and then turn ventilator ON
- Set O₂ flow to minimum, other gas flows to zero
- Verify that during inspiration, bellows delivers appropriate tidal volume and that during expiration, bellows fills completely
- Set fresh gas flow to about 5 liters per mm
- Verify that the ventilator bellows and simulated lungs fill and empty appropriately without sustained pressure at end expiration

- Check for proper action of unidirectional valves
- Exercise breathing circuit accessories to ensure proper function
- Turn ventilator OFF and switch to manual ventilation (Bag/APL) mode
- Ventilate manually and assure inflation and deflation of artificial lungs and appropriate feel of system resistance and compliance
- Remove second breathing bag from Y-piece

Check, Calibrate and/or Set Alarm Limits of All Monitors:

- Capnometer
- Oxygen analyzer
- Pulse oximeter
- Respiratory volume monitor (spirometer)
- Pressure monitor with high and low airway alarms
- Temperature monitor

Check Final Status of Machine:

- Vaporizers off
- APL valve open
- Selector switch to “bag”
- All flowmeters to zero
- Patient suction level adequate
- Breathing system ready to use

Note: If an anesthesia provider uses the same machine in successive cases, these steps need not be repeated or may be abbreviated after the initial checkout.

Anesthesia Equipment/Supplies:

- Appropriate masks, breathing system, head strap available
- Appropriate airways
- Laryngoscopes and blades tested
- Appropriate tracheal tubes available with functioning cuffs
- Stylet available

- Availability of bottled inhalation anesthetics
- Appropriate hypnotics and muscle relaxants available
- Availability of emergency medications
- Availability of appropriate IV fluids
- Stethoscope

Problems: _____

Follow-up: _____

Reference: FDA "Anesthesia Apparatus Checkout Recommendations" 1993



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TITLE: ANESTHESIA QUALITY IMPROVEMENT	
EFFECTIVE DATE: JANUARY 2012	NUMBER: 15
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OBJECTIVE:

To define the process for identifying, evaluating and trending adverse anesthesia events.
To monitor adverse events/reversal cases from areas where Sedation Analgesia is administered.

POLICY STATEMENT:

The managing anesthesia person or PACU nurse completes an Anesthesia Quality Improvement forms for all patients.

RESPONSIBLE PERSON(S):

Anesthesia staff, Quality Management staff and PACU staff

PROCEDURE:

1. Anesthesia Quality Improvement sheet to be filled out on all cases.
2. Completed sheets sent to the Quality Improvement Manager (QIM).
3. Prior to the scheduled anesthesia meeting, completed sheets are sent to the Chair of Anesthesia or a QI designed physician (QIP) for review.
4. QIP notifies the responsible anesthesia provider about the review.
5. QIP or designee (not the responsible provider) reviews the cases and writes an account of the event.
6. QIP sends the completed, reviewed sheets back to the QIM.
7. QIM places these on the agenda and will bring the charts selected to the Quarterly Anesthesiology QI Meeting.
8. Selected cases are discussed in an educational forum at the QI meeting and the QIM is responsible for the minutes of the meeting.



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TITLE: ANESTHESIA QUALITY ASSURANCE INDICATOR SHEET PROCESS	
EFFECTIVE DATE: JANUARY 2012	NUMBER: 16
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PURPOSE STATEMENT: To establish a consistent procedure for tracking and trending anesthesia quality indicators in the operative area.

RESPONSIBLE PERSON(S): Anesthesia staff and PACU nursing staff.

PROCEDURE:

1. The Commonwealth Anesthesia Associates Quality Assurance sheet will be printed on bright orange paper to indicate it is NOT a permanent part of the medical record.
2. A patient identification label is to be placed at the upper right hand corner.
3. The location should also be indicated by circling the appropriate campus.
4. A Quality Assurance sheet will be placed with the pre-op forms on each patient undergoing any type of anesthesia.
5. This includes: **inpatients, outpatients, patients that come from inpatient beds, and same day surgery patients.**
6. A CRNA or Anesthesiologist can fill out the sheet. A sheet should be filled out on every patient, whether there is an adverse event or not.
7. Mark the corresponding box if there was "No Adverse Event".
8. After the patient has been signed out of the PACU, the sheet is to be removed from the chart and sent via interoffice mail with corresponding billing paperwork to the RESULT office, for processing.



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TITLE:	MALIGNANT HYPERTHERMIA	
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PURPOSE STATEMENT: Malignant Hyperthermia is a rare but potentially fatal complication of anesthesia. Prompt and aggressive therapy with Dantrolene Na and established protocols may produce, but cannot guarantee a favorable outcome.

RESPONSIBLE STAFF: Anesthesiologists, CRNAs, Surgery Staff with the case (RN, SA, Scrub Tech), Anesthesia Technicians and any other available surgery staff

POLICY STATEMENT: Anesthesia practitioners will make every attempt to reduce the likelihood of malignant hyperthermia, and should it occur, to manage the impact of malignant hyperthermia for the patient.

PROCEDURE:

An adequate supply of Dantrolene Na will be immediately available. The treatment protocol will be kept with the supply of Dantrolene Na. The equipment, drugs, and necessary fluids needed for reconstitution and administration will be kept together. All resuscitation drugs and equipment shall be readily available.

- Refrigerated saline solutions will be immediately available.
- Operating Suite and PACU personnel should be familiar with MHS protocol.
- Stop inhalation agents/succinylcholine and terminate surgery as quickly as possible.
- Hyperventilate the patient with 100% oxygen at high flows.
- As quickly as possible, administer Dantrolene Na 2.5 mg/kg IV, repeat dose up to 1-mg/kg. Dissolve Dantrolene with 60 ml sterile water without preservatives for each vial.
- Cool the patient:
 - IV iced normal saline solution (not Ringers Lactate) to maintain urine output > 2ml/kg/hr.
 - Surface cooling with iced/hypothermia blanket.
 - Lavage stomach, rectum, peritoneal cavity, with iced saline (3-6 liters)
 - Correct acidosis in accordance with ABG's with NaHCO₃ or changes in ventilation
 - Procainamide 15 mg/kg IV for treatment of arrhythmias
 - Insulin 10 units/50%D/W to reduce serum K⁺



- **Secure Monitoring:** EKG, B/P, Foley Cath., ETCO₂, SAO₂, A-Line, CVP if possible, temperature, large bore IV's
- MH will be diagnosed and managed according to the latest guidelines or recommendations of MHAUS. Questions regarding MH management should be referred to the MH Hotline (1-800-MH-HYPER) or on the Web at 222.mhaus.org.

Reference: MHAUS Emergency Therapy for Malignant Hyperthermia.



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ANESTHESIOLOGY POLICIES & PROCEDURES

TITLE: SENTINEL EVENT	
EFFECTIVE DATE: JANUARY 2012	NUMBER: 18
REVISION DATES:	PAGE 1 OF 1

Unexpected events or occurrences involving death or serious physical or psychological injury, or the risk thereof (i.e., sentinel events), are to be reported to the Quality Management Department immediately upon identification. Any sentinel event requires immediate action to examine, in-depth, the event to determine why the incident occurred and how to reduce the likelihood of recurrence.



ANESTHESIOLOGY POLICIES AND PROCEDURES

TITLE:	CAA'S AUDIT AND REVIEW PROCESS	
EFFECTIVE DATE: JANUARY 2012	NUMBER: 19	
REVISION DATES:	PAGE 1 OF 1	

PURPOSE STATEMENT: Define Audit and Review Process

RESPONSIBLE STAFF: All CAA Personnel

PROCEDURES:

Commonwealth Anesthesia Associates shall:

- Hold an annual compliance meeting for all employees
- Provide routine compliance updates at every Board meeting
- Have a compliance board available to all employees
- Perform an annual audit on each physician and employee and provide the results of the audit
- Maintain an open door policy and respond as appropriate to information received by the corporation.
- Review the compliance plan and policies within 60 days of hiring a new employee



ANESTHESIOLOGY POLICIES AND PROCEDURES

TITLE: CAA EMPLOYEES' RESPONSIBILITIES FOR COMPLIANCE	
EFFECTIVE DATE: JANUARY 2012	NUMBER: 20
REVISION DATES:	PAGE 1 OF 2

PURPOSE STATEMENT: To define responsibilities of CAA employees in providing accurate and complete patient information

RESPONSIBLE STAFF: All CAA Employees

PROCEDURE:

Commonwealth Anesthesia Associates' employees shall provide accurate and sufficient documentation by the following:

1. Accurately record beginning and ending times of all procedures
2. Record all diagnoses and procedures
3. Perform all seven steps for medical direction
 - a. Perform the pre-anesthetic examination
 - b. Prescribe the anesthetic plan
 - c. Personally participate in the most demanding portions of the case including induction and emergence, if applicable
 - d. Ensure any procedures not performed by the anesthesiologist are performed by a qualified individual
 - e. Monitor at frequent intervals
 - f. Remain physically present and immediately available. Immediate area for John Randolph Medical Center shall be defined as present on the campus.
 - g. Provide indicated post-anesthetic care
4. Bill for items and services actually provided to the patient
5. Provide diagnosis, procedure and patient information for coding by **RESULT**
6. Not providing medically unnecessary services
7. Not routinely waiving patient's co-payments and deductibles
8. Not conducting improper marketing activities



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CAA Employees' Responsibilities for Compliance Page 2 of 2

9. All contracts will comply with federal and state regulations
10. Proper retention of records for seven (7) years for non-medical records including safe storage and the ability to retrieve records. After seven years non-medical records will be shredded prior to disposal. Incorporate compliance evaluation as part of the performance evaluation

I have read the Employee Responsibilities and will comply with the responsibilities that pertain to my duties.

Printed Name: _____

Signature: _____

Date: _____



ANESTHESIOLOGY POLICIES & PROCEDURES

TITLE: COMMONWEALTH ANESTHESIA ASSOCIATES CODE OF CONDUCT	
EFFECTIVE DATE: JANUARY 2012	NUMBER: 21
REVISION DATES:	PAGE 1 OF 1

POLICY:

Commonwealth Anesthesia Associates will maintain an appropriate level of care, service and confidentiality for our patients. The organization is guided at all times by the value of compassion, mercy and respect for the dignity of every patient. It is the responsibility of every person affiliated with Commonwealth Anesthesia Associates to observe all applicable laws and regulations in practice business dealings. Commonwealth Anesthesia Associates is committed to the accurate and proper submission of all insurance claims.

I have read and understand CAA's Code of Conduct

Name: _____

Signature: _____

Date: _____