Anesthesia Services Policy
Clark Memorial Hospital

Purpose

The purpose of this policy is to establish the standards and expectations for all patients receiving anesthesia services at Clark Memorial Hospital (CMH), including but not limited to, topical or local anesthesia, minimal sedation, moderate sedation/analgesia, deep sedation/analgesia, Monitored Anesthesia Care, regional anesthesia and general anesthesia.

Scope

Anesthesia services throughout the hospital system must be organized into one anesthesia service. The anesthesia services must be under the direction of one individual who is a qualified doctor of medicine (MD) or doctor of osteopathy (DO). This policy applies to all locations where anesthesia services are provided, including but not limited to, the Operating Room Suites (both inpatient and outpatient), Emergency Department, Critical Care Areas, Obstetrical Suite, Radiology Department, Psychiatry Department, Recovery Rooms, Clinics, Outpatient Surgery areas, and Special Procedure areas, e.g. Endoscopy Suite and Pain Management Clinics, including all departments in all campuses and off-site locations where anesthesia services are provided. (see attached “Job Description – Director of Anesthesia Services”).

Information

Our hospital is vitally interested in the safe administration of all anesthesia services. Anesthesiology is the practice of Medicine. CMH shall appoint a Director of Anesthesia Services who shall be qualified for that position by being a licensed physician (MD or DO) on the medical staff who has completed an accredited Residency Program in Anesthesiology. The Director of Anesthesia has the responsibility and the authority for developing policies and procedures governing the provision of all categories of anesthesia services, including specifying the minimum qualifications for each category of practitioner who is permitted to provide anesthesia services. The hospital’s governing body approves the specific anesthesia service privileges, including the type and complexity of procedures, for
each practitioner who furnishes anesthesia services, addressing the type of supervision required, if applicable.

Hospital anesthesia services policies and procedures will also address the minimum qualifications and supervision requirements for each category of practitioner who is permitted to provide analgesia services, particularly moderate and deep sedation. The hospital is required to assure that any staff administering drugs for analgesia must be appropriately qualified and that the drugs are administered in accordance with accepted standards of practice.

When the hospital permits operating practitioners to supervise a CRNA administering anesthesia, the medical staff bylaws or rules and regulations must specify for each category of operating practitioner, the type and complexity of procedures the practitioner may supervise. However, the individual operating practitioners do not need to be granted specific privileges to supervise a CRNA.

Clinical privileges in Anesthesiology are granted to physicians and Registered Nurses qualified to administer anesthesia by having completed an accredited Residency Program in Anesthesiology or an accredited post-graduate training program in Nurse Anesthesia (CRNA). At CMH, CRNAs may only administer anesthesia under the Medical Direction of an Anesthesiologist or under the Supervision of an Anesthesiologist.

Clinical privileges are also granted to practitioners who are not anesthesia professionals to administer sedative and analgesic drugs to establish a level of moderate, or deep sedation (analgesia).

Clinical privileges for Moderate Sedation/Analgesia shall be granted to licensed physicians (MD or DO) on the medical staff who have not completed an accredited Residency program in Anesthesiology but who have been specifically trained to personally administer or to supervise the administration of moderate sedation.

Clinical privileges for Deep Sedation/Analgesia shall only be granted to licensed physicians (MD or DO) on the medical staff who have completed accredited Residency Programs in either Anesthesiology or Emergency Medicine. (See attached document “STATEMENT ON GRANTING PRIVILEGES TO NONANESTHESIOLOGIST PHYSICIANS FOR PERSONALLY ADMINISTERING OR SUPERVISING DEEP SEDATION”).
Analgesia and anesthesia comprise a continuum of states ranging from minimal sedation to general anesthesia; CMS adds the category of topical and local anesthesia. The following are definitions of various levels of sedation/analgesia and anesthesia as defined by the American Society of Anesthesiologists:

**Minimal Sedation** is a drug-induced state during which patients respond normally to verbal commands. Although cognitive function and physical coordination may be impaired, airway reflexes and ventilatory and cardiovascular functions are unaffected. Minimal Sedation is considered Anxiolysis, and is considered neither Anesthesia nor Analgesia.

**Moderate Sedation/Analgesia** is a drug-induced depression of consciousness during which patients respond purposefully (reflex withdrawal from a painful stimulus is NOT considered a purposeful response) to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained. At CMH, Moderate Sedation is considered Analgesia.

**Deep Sedation/Analgesia** is a drug-induced depression of consciousness during which patients cannot easily be aroused but respond purposefully (reflex withdrawal from a painful stimulus is NOT considered a purposeful response) following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained. At CMH, Deep Sedation is considered Analgesia.

**General Anesthesia** is the drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive-pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired. If the patient loses consciousness and the ability to respond purposefully, the anesthesia care is a general anesthetic, irrespective of whether airway instrumentation is required. Clearly, General Anesthesia is considered Anesthesia.

**Rescue:** Because sedation is a continuum, it is not always possible to predict how an individual patient will respond. Hence, practitioners intending to produce a given level of sedation should be able to rescue patients whose level of sedation becomes deeper than initially intended. “Rescue” from a deeper level of sedation than
intended requires an intervention by a practitioner with expertise in airway management and advanced life support. The qualified practitioner must be able to correct adverse physiologic consequences of the deeper than intended level of sedation and return the patient to the originally intended level of sedation.

This policy also defines the following, specifically as practiced at Clark Memorial Hospital:

**Topical and/or Local Anesthesia** is the application or injection of a drug or combination of drugs to stop or prevent painful sensation to a circumscribed area of the body where a painful procedure is to be performed. There are generally no systemic effects to these medications. These procedures are NOT considered anesthesia for the purposes of this policy, despite the name.

**Regional Anesthesia** is the delivery of anesthetic medication to a specific level of the spinal column (central neuraxial anesthesia) including spinal and epidural anesthesia, as well as the delivery of anesthetic medications to peripheral nerves, when a loss of consciousness is not necessarily required but sufficient analgesia and a loss of voluntary and involuntary movement is required. The potential exists that a regional anesthetic may require an extension to general anesthesia in certain circumstances. For the purposes of this policy, these procedures are considered Anesthesia.

**Monitored Anesthesia Care** (MAC) is a specific anesthesia service for a diagnostic or therapeutic procedure. Indications for MAC include the nature of the procedure, the patient’s clinical condition, and/or the potential need to convert to a general or regional anesthetic. Monitored Anesthesia Care may include varying levels of sedation, analgesia and anxiolysis as necessary. The provider of Monitored Anesthesia Care must be prepared and qualified to convert to general anesthesia when necessary, and therefore MAC is Anesthesia.

**Anesthesia for Labor and Delivery** (Obstetric Anesthesia) For the purposes of this policy, at Clark Memorial Hospital, central neuraxial anesthetic techniques, including spinal, epidural, combined spinal-epidural, and caudal blocks, performed for the relief of the pain of labor or for Caesarian Section, are considered to be Regional Anesthesia.
Medical Sedation in the ICUs
Medical Sedation in the ICUs is purposely not addressed in this policy. However, procedural sedation provided in the ICU is included, and must follow this policy regarding the level of anesthesia/analgesia that is intended.

Anesthesia

The Pre-Anesthesia Evaluation

A pre-anesthesia evaluation must be performed for each patient who receives general anesthesia, regional anesthesia, or monitored anesthesia care, by a practitioner qualified to administer Anesthesia. This evaluation shall be completed and documented within the 48 hours immediately prior to the induction of anesthesia.

The patient shall be interviewed, if possible, given the patient’s condition, and be physically examined by the practitioner.

The following elements shall be reviewed, updated, and documented, at a minimum:

- A review of the patient’s medical history, including history of prior anesthetics, current medications, and allergies.
- Confirmation of the intended procedure, including the surgical site location, if applicable.
- Time and nature of last oral intake.
- A focused physical examination, including vital signs, auscultation of the heart and lungs, with concentration on those areas pertinent to the patient’s history, the anesthetic, and the proposed procedure (e.g. examination of the airway, cardiopulmonary system, and vascular access).
- Pertinent laboratory data.
- Pertinent pre-operative testing (e.g. stress test, echocardiogram, radiologic studies).
- Any pertinent pre-operative consultations.
- Identification of potential anesthetic complications.
- Development of an anesthetic plan.
- Discussion of that plan with the patient, or the patient’s representative, when appropriate, including a discussion of the risks and benefits of the delivery of anesthesia care.
- Informed consent for Anesthesia shall be obtained and documented in the medical record prior to the procedure.
Preoperative Fasting: Patients undergoing anesthesia for elective procedures should not drink fluids or eat solid foods for a sufficient period of time to allow for gastric emptying before their procedure, as recommended by the ASA “Guidelines for Preoperative Fasting”:

<table>
<thead>
<tr>
<th>Ingested Material</th>
<th>Minimum Fasting Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clear Liquids</td>
<td>2 h</td>
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<tr>
<td>Breast Milk</td>
<td>4 h</td>
</tr>
<tr>
<td>Infant Formula</td>
<td>6 h</td>
</tr>
<tr>
<td>Nonhuman Milk</td>
<td>6 h</td>
</tr>
<tr>
<td>Light meal</td>
<td>6 h</td>
</tr>
<tr>
<td>Heavy (fatty) meal</td>
<td>8 h</td>
</tr>
</tbody>
</table>

In urgent, emergent, or other situations in which gastric emptying may be impaired, the potential for pulmonary aspiration of gastric contents must be considered in determining (1) the target level of sedation, (2) whether the procedure should be delayed, or (3) whether the trachea should be protected by intubation.

**Intraoperative Anesthesia Record**

There must be an intraoperative anesthesia record or report for each patient who receives general anesthesia, regional anesthesia, or monitored anesthesia care.

Current standard of care stipulates that an intraoperative anesthesia record, at a minimum, includes:

- Name and hospital identification number of the patient;
- Name(s) of practitioner who administered anesthesia, and as applicable, the name and profession of the supervising anesthesiologist or operating practitioner;
- Name, dosage, route and time of administration of drugs and anesthesia agents;
- Techniques(s) used and patient position(s), including the insertion/use of any intravascular or airway devices;
- Name and amounts of IV fluids, including blood or blood products if applicable;
- Timed-based documentation of vital signs as well as oxygenation and ventilation parameters;
• 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.

“Time-out”: A Time-out must be performed prior to the Induction of Anesthesia or prior to the initiation of any procedure (e.g. spinal, epidural, peripheral nerve block, or invasive vascular access such as an arterial line or central venous line placement). This “time-out” will be led by the anesthesia provider, include the patient and the surgical team, and will include at a minimum the identification of the patient by 2 patient identifiers, the procedure to be performed, and the surgical site location. The performance of the time-out must be documented in the medical record.

Post-Anesthesia Evaluation

A post-anesthesia evaluation must be completed and documented by an individual qualified to administer anesthesia, no later than 48 hours after a procedure requiring general, regional or monitored anesthesia services. The qualified individual performing the post-anesthesia evaluation need not be the same individual who administered the anesthetic.

The 48-hour timeframe begins at the point the patient is moved into the PACU/ICU or other designated recovery area. The evaluation should not occur until the patient has sufficiently recovered from the acute effects of the administered anesthetic, to allow the patient’s participation (e.g., answer questions appropriately, perform simple tasks, etc.) and to adequately assess the essential elements of the evaluation. In some cases, it may be appropriate to perform and document the evaluation immediately upon arrival in the recovery area, when these conditions have been met. While the evaluation should begin in the PACU/ICU or other designated recovery location, it may be completed after the patient has been moved to another location.

For outpatients, if permitted by State law and hospital policy, the evaluation may be completed after the patient is discharged, provided this occurs within the 48-hour timeframe. This timeframe is intended to define the maximum acceptable period for completion and documentation of the post-anesthesia evaluation.

The elements of an adequate post-anesthesia evaluation should be clearly documented and include:
• Respiratory function, including respiratory rate, airway patency, and oxygen saturation;
• Cardiovascular function, including pulse rate and blood pressure;
• Mental status;
• Temperature;
• Pain;
• Nausea and vomiting; and
• Postoperative hydration status.

Depending on the specific surgery or procedure performed, additional types of monitoring and assessment may be necessary.

For patients unable to participate in the post-anesthesia evaluation, due to intentional prolonged sedation, underlying physiologic conditions, or other reasons, an evaluation must still be completed and documented within the 48-hour timeframe. Documentation should include reasons for the patient’s nonparticipation and expectations for recovery time, if applicable.

For patients receiving long-acting regional anesthesia, the post-anesthesia evaluation must be completed and documented within the 48-hour timeframe. Documentation should include the patient’s participation in the evaluation to the extent appropriate, and assessment of the ongoing regional anesthetic.