HENDRICKS REGIONAL HEALTH

# ANESTHESIA SERVICE RULES AND REGULATIONS

A. Scope of Anesthesia Availability and Services

1. The anesthetist on call shall be within thirty minutes of the hospital to provide care in the event of an emergency requiring anesthesia intervention.

2. Staffing for the provision of anesthesia services is related to the scope and complexity of the services offered. Anesthesia services are available "on call" during non-scheduled hours. Anesthesia will be notified of emergency cases by the house supervisor. Response time for emergency c-sections shall meet the ACOG Standard; for other emergency cases, response time shall be no longer than 30 minutes.

3. Surgical and anesthesia procedures are performed only when the necessary equipment, personnel, technical support and space are available.

4. Scope of anesthesia services include:

   Types of patients treated are: adult, pediatric, and OB. Physicians and Nurse Anesthetists are the providers of anesthesia.

   The modalities of anesthesia are: general, spinal, epidurals, nerve blocks, post-op analgesia, pain management procedures, conscious sedation, and monitored anesthesia care.

B. Requirements for Preanesthetic Evaluation

1. Every patient undergoing anesthesia will be evaluated preoperatively.

   The evaluation includes the gathering of information necessary to determine the capacity of the patient to undergo anesthesia and then formulate an anesthetic plan.

2. The preanesthetic evaluation is to include:

   a. Patient interview to assess medical history, anesthetic history and medication history.
   b. Appropriate physical exam that includes a pulmonary exam to include auscultation of the lungs and a cardiovascular exam.
   c. Review of objective diagnostic data.
   d. Assignment of ASA physical status.
   e. Anesthesia plan and discussion of the risks/benefits of the plan with the patient or the patient's legal representative.

3. Prior to anesthesia, there is a determination that the patient is an appropriate candidate to undergo the planned anesthesia. This determination is made by a licensed independent practitioner with appropriate clinical privileges and is based on the results of the preanesthetic evaluation. Qualified anesthesia personnel shall be present in the room throughout the conduct of all general anesthetics, regional anesthetics and monitored anesthesia care. Exception: labor epidural and postoperative pain management.

4. Immediately prior to induction of anesthesia, the patient is re-evaluated and all equipment and supplies are checked.

5. Intraoperatively, there must be documentation of:

    a. Immediate review prior to initiation of anesthetic procedures including patient re-evaluation and a check of equipment, drugs, and gas supply.
    b. The monitoring of the patient (e.g. recording of vital signs)
    c. The dosage of all anesthetic drugs and agents used and times of administration
    d. The type and amount of all fluids, blood, and blood products administered and times of administration
    e. The technique or techniques used
    f. Unusual events during the administration of anesthesia
    g. The status of the patient at the conclusion of anesthesia
    h. Estimated Blood Loss

    During all anesthetics, there will be the capacity to continuously evaluate the patient's oxygenation, ventilation, circulation, and temperature. Minimal monitoring in the patient having general anesthesia shall include inspiratory oxygen analysis, pulse oximetry, electrocardiogram, blood pressure, readily available temperature monitoring, and quantitative monitoring of end tidal carbon dioxide.

6. Every patient who received an anesthetic will have a postoperative evaluation by a person who is qualified to administer anesthesia that is written within 24 hours after surgery; with respect to outpatients, a post-anesthesia evaluation for proper anesthesia recovery will be completed.

    The anesthesia event record should also include any unusual events or postoperative complications, and the management of those events or complications.

7. When the surgeon is a dental or podiatric (non physician) practitioner, and the anesthesia provider is non-physician, an anesthesiologist responsible for management of medical crises is immediately available to provide intervention.

8. Discharge from the PACU/OPSU Area

A licensed independent practitioner who has appropriate clinical privileges and who is familiar with the patient is responsible for the decision to discharge a patient from the post anesthesia recovery area or, when the anesthesia services are provided on an ambulatory basis, from the hospital.

When the responsible practitioner is not personally present to make the decision to discharge or does not sign the discharge order:

a. The name of the practitioner responsible for the discharge is recorded in the patient's medical record, and
b. Relevant discharge criteria are rigorously applied to determine the readiness of the patient for discharge

When anesthesia services are performed on an ambulatory basis, the patient is provided with written instructions for follow-up care.

Patients who receive other than local anesthesia on an ambulatory basis are accompanied at discharge by a designated adult who is responsible for the patient.

C. Ownership of Anesthetic Machines and Maintenance

The anesthesia machines are the property of Hendricks Regional Health and are maintained daily by anesthesia staff according to the anesthesia apparatus checkout recommendation.

D. Medical Direction of Anesthesia Same Day Surgery – PACU

The Department of Anesthesia is directed by a physician member of the Medical Staff with appropriate clinical and administrative experience relevant to anesthesia services.

The Medical Director of the department of anesthesia shall have the following responsibilities:

1. Making recommendations regarding the clinical privileges of all independent practitioners in the department.

2. Assuring that anesthesia services are consistent with patient needs and with current anesthesia practice.

3. Assuring the effective monitoring and evaluation of the quality and appropriateness of anesthesia care provided by individuals in any area of the hospital.

4. Recommending the type and amount of physical resources necessary for administering quality anesthesia and providing any necessary resuscitative measures.

5. Developing guidelines for anesthesia safety.

6. Assuring that a program of continuing education is available for all individuals who provide anesthesia services.

7. Participate in the development of policies relating to the activities and individuals providing anesthesia.

8. Serve as the medical director for same day surgery and PACU.

E. Dress Code

Street clothes may be worn only in the immediate front office area to posted sign entering the clean outer corridor.

No person attired in street clothes will be permitted to enter the clean outer corridor of surgery without first donning a cap and clean cover gown. After donning the proper attire, the person may then proceed down the clean outer corridor. See posted red overhead sign.

To enter inner core, scrub attire/jumpsuit and cap will be required.

To enter the operating rooms with an open case, scrub attire, mask and cap are required.

To enter PACU, everyone must have on a cap, scrub attire/cover. Once inside the unit, caps may be removed.

F. Personal Conduct in the Operative Suite

The proper function of the OR requires teamwork and the optimal functioning of all involved in patient care. If a caregiver with a vital role in patient care is distracted by non-medical interests; his/her performance in the OR may be affected. As advocates for the patient, the surgeon, anesthesiologist and other allied health professionals must take personal responsibility to ensure that the OR environment is conducive to the safe conduct of anesthesia and the performance of surgery. The use of laptop computers, PDA's, and other electronic devices for non-medical activity is prohibited. Music may be permitted with the consent of the surgical team. Eating and drinking in the OR violates the hospital-wide infection control policy and is not permitted.

Approved by Surgery Committee: 02/07/2022
Approved by MEC: 02/14/2022
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