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Follow Whidden Hospital Policy/Protocols for the following:

DNR Policy
Fire and Safety Policy
Infection Control Policy
Informed Consent Policy
Latex Policy
Universal Protocol

For Malignant Hyperthermia follow the MHAUS (Malignant Hyperthermia Association of the United States) protocol.

Reviewed February 2018
1. **Scope of Service**

The Department of Anesthesiology provides anesthesia services under the supervision of the Chair of the Department. Anesthesia services may be provided for patients receiving diagnostic, therapeutic, invasive and surgical procedures throughout the medical facility. Anesthesia care will be provided by or under the medical direction of staff member physicians with privileges in anesthesia. The services may include general and regional anesthesia, monitored anesthesia care and acute and chronic pain control management.

Anesthesiology practices entail pre-operative assessments and educational preparation of patients and evaluation of applicable diagnostic tests and laboratory results as appropriate. Intraoperative anesthesia practice involves administering anesthetic agents and related drugs, performing procedures to render patients insensible to pain and supporting patients to facilitate surgery. Post-anesthesia care involves patient evaluation, support and analgesia.

Anesthesia may be administered in locations within the facility depending on contractual obligations in existence at a particular time.

Anesthesiologists possess knowledge and skills relevant to the care of a broad spectrum of patient care issues and problems, including airway management, analgesia and sedation support. The Department of Anesthesia is available for consultation as needed.

The goal of the Department of Anesthesia is to foster communication and coordination of safe anesthesia management. Other goals include providing ongoing education, practice guidelines and quality assurance programs designed to enhance patient care and safety.

2. **Integration of Service**

The Department of Anesthesia provides anesthesia services pursuant to the terms of its contract. Coordination of care involves integration of the needs of the Operating/Procedure Room and PACU while delivering anesthesia services.

3. **Department Chair**

The Chair of the Department of Anesthesia oversees the anesthesia care and personnel. The responsibilities of the Chair include coordinating anesthesia coverage, supervising anesthesia personnel and providing emergency anesthesia support. The Chair also develops, implements, and evaluates anesthesia practices to enhance the quality of patient care. Additional administrative duties include developing policies for safe patient care which incorporate regulatory and accreditation requirements.

4. **Availability of Qualified Staff**

Anesthesia services will be provided under the direction and supervision of an anesthesiologist. A staff anesthesiologist, with appropriate privileges, will be available at all times unless an unusual series of emergencies make this temporarily impossible.

Reviewed February 2018
5. Determining Adequate Resources Necessary to Provide Patient Care

The Chair of the Department of Anesthesia coordinates with the anesthesia staff, operating room staff and administration to assess and evaluate resources and needs. Plans for equipment and supplies will be developed and processed through appropriate facility channels.

6. Communication and Coordination of Internal Activities

The Department of Anesthesia has regular meetings to facilitate communication, education and standardization of practice. These meetings bring together physicians, nurse anesthetists, if applicable, nurses, technical staff and invited personnel to learn and discuss various topics, issues and concerns. Periodically, anesthesia management occurrences and practices are discussed and peer reviewed. This process encourages a supportive, proactive environment to provide patient care. Additional communication activities may include written correspondence and email. Direct communication and open discussion of concerns are encouraged.

7. Development of Policies, Procedures and Standards

The Anesthesia Department promotes safe patient care practices, referencing the standards of anesthesia care as set forth by the American Society of Anesthesiologists. Policies and procedures are developed, reviewed and implemented as needed to provide safe anesthesia services. The anesthesia staff, in accordance with the Department Chair, will be involved in the process of developing and evaluating new policies, procedures and guidelines.

8. Quality Control/Quality Assurance

The Department of Anesthesia is committed to quality assurance and quality improvement of patient care by providing an ongoing appraisal of anesthesia practices. Important aspects of care that focus on high risk, high volume and/or problem prone areas are identified and reviewed systematically. All of this work and related documents are considered part of the peer review process and are subject to all available state and federal legal protections and privileges.

Reviewed February 2018
ANAESTHESIA ASSOCIATES OF MASSACHUSETTS

SUBJECT: STANDARDS FOR PATIENT CARE

PREAMBLE:

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 high quality patient care, but observing them cannot guarantee any specific outcome. They are subject to revision from time to time, as warranted by the evolution of technology and practice. In certain rare or unusual circumstances:

1. Some of these methods may be clinically impractical, and
2. Appropriate use of the described methods may fail to detect untoward clinical developments.
   Brief interruptions of continual monitoring may be unavoidable.

DEFINITIONS:

1. Continual: Repeated regularly and frequently in steady rapid succession.
2. Continuous: Prolonged without any interruptions at any time.

A. PRE-OPERATIVE TESTING

Preanesthetic laboratory and diagnostic testing is often essential; however, no laboratory or diagnostic screening test is routinely necessary for the preanesthetic evaluation of all patients. Individual surgeons and anesthesiologists should order test(s) when, in their judgment, the results may influence decisions regarding risks and management of the anesthesia and surgery.

Because it is not always possible or required for a patient to be evaluated by a physician during the pre-admission testing visit, and to minimize the risk of delay of surgery waiting for lab results that the physician might request, it is common for hospitals and surgery centers to develop pre-surgery testing guidelines for nurses to follow to make sure testing the physician might want is available if requested on the day of surgery. Such guidelines are not intended to be viewed as inflexible mandates, standards or absolute requirements and may be adopted, modified, or rejected according to clinical needs and constraints. The anesthesiologist must use his/her professional judgment in assessing patients pre-procedure and will review all applicable data and determine immediately before surgery if sufficient information is available to proceed with the anesthetic or if further testing and assessment is indicated based on the individual patient’s presentation and situation.

B. BASIC STANDARDS FOR PREANESTHESIA EVALUATION AND PLAN

3. An anesthesiologist shall be responsible for determining the medical status of each patient who receives general, regional, or monitored anesthesia, developing a plan of anesthesia care, and acquainting the patient or the responsible adult with the proposed plan. The performance of a pre-anesthesia evaluation and development of an appropriate plan of anesthesia care includes at a minimum:

Reviewed and Revised February 2018
i. Reviewing the medical record, including anesthesia, drug and allergy history;
ii. Performing a directed interview and exam of the patient pertinent to the anesthetic;
   - Discuss the medical history, previous anesthetic experience and drug therapy
   - Assess those aspects of the physical condition that might affect decisions regarding perioperative risk and management
   - Documentation of pertinent positive findings of the directed history and physical
iii. Notation of anesthesia risk according to established standards of practice (e.g., ASA classification of risk);
iv. Identification of potential anesthesia problems, particularly those that may suggest potential complications or contraindications to the planned procedure (e.g., difficult airway, ongoing infection, limited intravascular access);
v. Identification of additional pre-anesthesia data or information, if applicable and as required in accordance with standard practice prior to administering anesthesia (e.g., stress tests, additional specialist consultation);
vi. Development of the plan for the patient’s anesthesia care, including the type of medications for induction, maintenance and post-operative care and discussion with the patient (or the patient’s representative) of the risks and benefits of the delivery of anesthesia;
vii. Obtaining and/or reviewing tests and consultations necessary to manage the anesthetic plan;
viii. Determining the appropriate prescription of preoperative medications as necessary for the management of anesthetic care;
ix. Reevaluation of the patient immediately before the administration of anesthesia.

C. BASIC STANDARDS FOR INTRA-OPERATIVE MONITORING

1. Qualified anesthesia personnel shall be present in the room throughout the provision of all general anesthetic, regional anesthetics and monitored anesthesia care. 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 temporary absence.

During all anesthetics, the patient’s oxygenation, ventilation, and circulation shall be continually evaluated.
1. Oxygenation: To ensure adequate oxygen concentration in the inspired gas and the blood during all anesthetics.
   a) 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.
b) 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.

c) Adequate illumination and exposure of the patient is necessary to assess color.

d) Ventilation: To ensure adequate ventilation of the patient during all anesthetics. 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.*

e) 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.*

f) 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.

g) 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.

2. Circulation: To ensure adequacy of the patient’s circulatory function during all anesthetics.

   a) Every patient receiving anesthesia shall have the electrocardiogram continuously displayed from the beginning of anesthesia until preparing to leave the anesthetizing location.

   b) Patients receiving anesthesia, where applicable, shall have arterial blood pressure and heart rate determined and evaluated at least every five minutes.

   c) 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 the heart sounds, monitoring of tracing of intra-arterial pressure, ultrasound peripheral pulse monitoring, or pulse plethysmography or oximetry.

Reviewed and Revised February 2018
3. **Body Temperature:** To aid in the maintenance of appropriate body temperature during all anesthetics.
   a) There shall be readily available a means to continuously measure the patient’s temperature. When changes in blood temperature are intended, anticipated or suspended, the temperature shall be measured.

**D. BASIC STANDARDS FOR POST-ANESTHETIC CARE**

1. All patients who received general anesthesia, regional anesthesia, or monitored anesthesia care shall receive appropriate post-anesthesia management.
   a. A Post Anesthesia Care Unit (PACU) or an area, which provides equivalent post-anesthesia care, shall be available to receive patients after anesthesia care. All patients who receive anesthesia shall be admitted to the PACU or its equivalent except by specific order of the anesthesiologist responsible for the patient’s care.
   b. The medical aspects of care in the PACU (or equivalent area) 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.

2. A member of the anesthesia care team who is knowledgeable about the patient’s condition shall accompany a patient transported to the PACU. The patient shall continually be evaluated and treated during transport with monitoring and support appropriate to the patient’s condition.

3. 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. The following information should be communicated to the PACU staff:
      1. diagnosis and current condition of the patient (including pre-operative condition and the surgical/anesthetic course)
      2. recent changes in the patient’s condition
      3. anticipated changes in the patient’s condition
      4. what to watch for in the next interval of care
   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.

4. 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, level of consciousness 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. Assessment and monitoring shall be done of temperature, respiratory rate, airway patency, pulse and BP, mental status, pain, nausea and vomiting and post-op hydration and additional parameters if required by the applicable surgery and/or the patient’s condition.

Reviewed and Revised February 2018
Such information shall be documented by the PACU nurse and reviewed and assessed by a member of the anesthesia care team as part of the post-anesthesia evaluation.

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 shall be the responsibility of an anesthesiologist.

5. A post-anesthesia evaluation must be completed and documented no later than 48 hours after surgery or a procedure requiring anesthesia services involving general, regional, or monitored anesthesia.

a. The calculation of the 48 hour timeframe begins at the point the patient has moved into the designated recovery area. The evaluation should generally not be performed immediately at the point of transfer from the operating area to the PACU and should not begin until the patient is sufficiently recovered from the acute administration of anesthesia so as to participate in the evaluation, e.g., answer questions appropriately, perform simple tasks, etc.

b. For those patients who are unable to participate in the post-anesthesia evaluation (e.g., postoperative sedation, mechanical ventilation, etc.), a post-anesthesia evaluation should be completed and documented within 48 hours with notation that the patient was unable to participate, and include the reason for the patient’s inability to participate as well as expectations for recovery time, if applicable. An example of such a patient would be one who is transferred following the procedure from the ambulatory surgery center to the hospital for inpatient admission.

c. For those patients who require long-acting regional anesthesia and whose acute effects will last beyond the 48-hour timeframe, a post-anesthesia evaluation must still be completed and documented within 48 hours. However, there should be a notation that the patient is otherwise able to participate in the evaluation, but full recovery from regional anesthesia has not occurred and is not expected within the stipulated timeframe for the completion of the evaluation.

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

a. 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, the Intensive Care Unit, to a short stay unit or home.

b. In the absence of the 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.

*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 reasons) in a note in the patient’s record.

Reviewed and Revised February 2018
I. Responsibilities of the Chief or his/her designee to the Department of Anesthesia

A. Personnel Management
   i. Long term department schedule
   ii. Daily personnel assignments
   iii. Resource calculations and planning

B. Subspecialty Coverage
   i. Develop appropriate departmental daily and on-call coverage

C. Daily Operations
   i. Early morning review of schedule
   ii. Morning clinical conference
   iii. Assignment changes during the day
   iv. Chief arbiter of clinical and inter – staff problems

D. Participative Roles
   i. Pre-operative evaluation and pre-admission testing procedure
   ii. Anesthesia equipment monitoring

II. Responsibilities of the Chief or his/her designee to the Operating Room/Hospital/Medical Staff

A. Scheduling and Data Collection
   i. Daily review of the OR schedule
   ii. Enforce scheduling policy in conjunction with OR Leadership Committee or applicable committee
   iii. May include review of OR utilization data and submission of reports to appropriate governing bodies.

B. Communication Center (OR front desk)
   i. Work in conjunction with OR Leadership Committee, if any, to establish procedural practices that provide expeditious service

C. Liaison to:
   i. Facility administration
   ii. Nursing administration
   iii. OR Leadership Committee, if any (may serve as Chairman of the OR Committee); authority must be delegated from the facility administration

Reviewed February 2018
Job Title: Certified Registered Nurse Anesthetist
Location: Various
Date: July 2013

General Objectives:
Administers intravenous, inhalation and regional anesthetics to render persons insensible to pain during surgical procedures, obstetrical deliveries or other medical and dental procedures. Provides airway management services as needed throughout hospital.

Duties and Responsibilities:
- Performs pre-anesthetic and post anesthetic assessment and evaluation of the patient and documents findings. This includes obtaining an informed consent from the patient and requesting consultations and/or diagnostic studies.
- In collaboration with the anesthesiologist, determines the appropriate anesthetic plan of management, manages all aspects of anesthesia care to include preoperative, perioperative and immediate postoperative care.
- Maintains complete and accurate documentation of care for all procedures.
- Provides airway management and/or intubations for emergent, and non-emergent and resuscitation situations throughout the hospital.
- Provides consultation for ventilatory care throughout the hospital.
- Checks all equipment and agents to be used in the administration of the anesthetic to be sure it is in safe working order. Reports all malfunctioning equipment to the appropriate personnel.
- Checks all resuscitative anesthesia equipment prior to the beginning of the first surgery of the day. Any malfunctioning or missing equipment will be reported to the appropriate personnel.
- Records all pertinent events taking place during the induction of, maintenance of and emergence from anesthesia, including the dosage and duration of all anesthetic agents, other drugs, intravenous fluids and blood or blood components on all patients that have received anesthesia care.
- Insures safe transport of patient to PACU and provides complete report to PACU RN.
- Maintains currency of clinical privileges, RN license, state specialty certification, ACLS and CRNA re-certification.
• Assumes some teaching responsibilities for medical students and nurse anesthesia students.

• May be assigned other responsibilities by the Chief and Assistant of Anesthesia, the Anesthesiologist in Charge and/or the CRNA Site Manager.

Reports to:
For clinical matters: Chief of Anesthesia.
For all other matters: CRNA Site Manager

Position Characteristics:

• Graduation from an accredited school of nursing, with current licensure to practice in Massachusetts as a Registered Nurse in the expanded role of nurse anesthetist.

• Graduation from a school of anesthesia accredited by the AANA.

• Certification to practice as a Nurse Anesthetist and maintenance of that certification as required by guidelines established by the Council on Recertification of the AANA and by the State of Massachusetts.

• Ability to make sound judgments, analytical and physical abilities and manual dexterity to function as an anesthesia care provider.

• Ability to administer all types of anesthetics, using a variety of techniques and function with minimal direction and guidance.

• Ability to work harmoniously in a collaborative situation with anesthesiologist, CRNA’s, other health care providers and office staff.

• Ability to work at a variety of locations serviced by AAB and AAM and work is generally in the operating room but can be in Radiology, ICU, ECT or wherever nurse anesthesia services are required by specific hospital.

NOTE: This job description may not include all of the duties assigned to the associate and may be updated and modified according to the operational dynamics and needs of the company.

Reviewed February 2018
ANESTHESIA ASSOCIATES OF MASSACHUSETTS
SUBJECT: CRNA PRACTICE GUIDELINES

Introduction:

Certified Registered Nurse Anesthetist (CRNA) requirements:
1. Satisfactory completion of a formal education program in addition to generic nursing preparation which meets the standards of the Council on Accreditation of Nurse Anesthesia Programs and which has as its objective the preparation of nurses to perform as nurse anesthetists.
2. Current certification by a nationally recognized accrediting body approved by the Board for nurse anesthetists.
3. Current licensure as a registered professional nurse by the State in which the nurse practices.
4. Successful completion of a certification examination of the Council on Certification of Nurse Anesthetists or the Council on Recertification of Nurse anesthetists or has not yet received the results of the first examination given for certification for which he/she is eligible. Should a person fail to take or fail to pass such an examination, he/she shall immediately cease practicing in an expanded role as a nurse anesthetist.

These requirements encompass applicable state and federal regulations, and accreditation standards.

Guidelines:

1. The CRNA will be able to provide anesthesia services and deliver anesthesia care under the medical supervision of an anesthesiologist assigned and in charge of a case.
2. The delivery of anesthesia care and management of a patient under anesthesia will be the primary responsibility of the anesthesiologist assigned and in charge of that case. The CRNA will be accountable to the anesthesiologist that the patient will receive appropriate anesthesia care during the time he/she will be assigned to that case.
3. General anesthesia will be administered by the CRNA under the direct, personal and continuous supervision of the anesthesiologist. An anesthesiologist must be continuously physically present in the immediate vicinity of the operating room suite and is immediately available, although is not required to be in the operating room at all times.
4. CRNAs may perform procedures consistent with their credentialing under supervision. The anesthesiologist will be physically present during the establishment of anesthesia and fully satisfied that the desired anesthetic level has been obtained and the patient is stable and comfortable.
5. Where standby monitored anesthesia care is requested by a physician, a CRNA may perform this duty under the guidelines described in #3.
6. The CRNA should review the patient’s condition immediately prior to the induction of anesthesia, using the medical record, pertinent laboratory data, type, dosage and time of administration of pre-anesthetic medications, together with an appraisal of any changes in the patient’s condition as compared with that noted previously.
7. The CRNA is expected to discuss with the supervising anesthesiologist the choice of agents and other anesthetic management to be used in the case. The final decision on the choice of anesthetic agents, techniques and management will be the responsibility of each individual anesthesiologist. The CRNA and supervising anesthesiologist will work together and make a team effort to provide the appropriate anesthesia care for the patient.

Reviewed February 2018
8. Precautions for patient safety will include appropriate forms of continuous monitoring and observance of physical safety regulations. The CRNA will use discretion to determine the extent of non-invasive monitoring and appropriate care in each individual case. The extent to which invasive monitoring of a patient during anesthesia should be used will be determined following consultation with the supervising anesthesiologist. It will be at the discretion of the anesthesiologist to allow a CRNA to perform cannulation of a peripheral artery for blood gases and pressure measurements.

9. The CRNA has the expertise and is permitted to:
   a. Induce general anesthesia, including endotracheal intubation procedures
   b. Maintain anesthesia at the desired level and support life function during the administration of an anesthetic during the course of surgery, including infusion of fluids and blood products
   c. Recognize and take appropriate corrective actions for abnormal patient response to anesthesia or to any adjunctive medications or other forms of therapy. The CRNA should exert judgment as to the seriousness of the patient’s condition at any time and request consultation when deemed necessary
   d. Provide professional observation and resuscitative care during the immediate postoperative period and until a patient has regained control of his/her vital functions. The CRNA will immediately notify the surgeon and anesthesiologist in charge of life threatening conditions such as cardiovascular collapse or cardiac arrest.

10. Upon delivery of the patient to the PACU or other recovery area, it will be the duty of the CRNA to report to the PACU or other recovery personnel the following: a brief account of the patient’s pre-operative conditions, any problems encountered during anesthesia and surgery, estimated blood loss during surgery, extent of fluid and blood products replacement, type, dose and time of additional forms of therapy administered during anesthesia such as antibiotics, steroids, vasoactive agents etc. In the PACU, pain management is the responsibility of the supervising anesthesiologists.

11. The CRNA will attend regular meetings of the Department of Anesthesia to review and discuss the quality and appropriateness of anesthesia services. The CRNAs are encouraged to provide input in establishing guidelines for better anesthesia care as part of the overall facility quality improvement program.

12. CRNAs are encouraged to attend continuing education programs and to participate in in-service programs.

13. The Department of Anesthesia Chief is the supervising physician for all CRNAs at the hospital. Requests for clinical privileges are made using the hospital’s medical staff application form.

14. Privileges in accordance with the Scope of Patient Care Services for the Certified Registered Nurse Anesthetist (CRNA) are as follows:
   a. Provision of general anesthesia and/or sedation under supervision for surgical and other therapeutic and diagnostic procedures.
   b. Monitoring and management of anesthetized patients, under supervision.
   c. Performance of spinal anesthesia and selected regional anesthetic techniques, under supervision.

Reviewed February 2018
Anesthesiologist:

Minimally acceptable continuing medical education requirements in a given time period are those established by applicable state Boards of Registration in Medicine. Each physician must complete the minimum amount of continuing medical education requirements, including in selected areas if applicable, as exist at any given point in time in each state in which he/she is licensed.

Certified Registered Nurse Anesthetist:

Minimally acceptable continuing education requirements are those established by the American Association of Nurse Anesthetists (AANA).
The granting, reappraisal and revision of clinical privileges shall be in accordance with applicable medical staff bylaws, 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
   a. Must be board certified by the American Board of Medical Specialties or board eligible.
   b. 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 (or the Osteopathic equivalents).
   c. Must have a current medical license and registration to practice.
   d. Must have Federal and, where applicable, state narcotics registration.
   e. Must have relevant training and clinical experience.
   f. Must have demonstrated current competence and ability to recognize and manage anesthetic-related complications.
   g. Must provide references and recommendations from credible sources.

B. Certified Registered Nurse Anesthetist
   a. Must have graduated from an accredited school of nursing and an accredited school of nurse anesthesia.
   b. Must have passed a certification examination of the Council of Nurse Anesthetists or the Council on Recertification of Nurse Anesthetists or has not yet received the results of the first examination given for certification for which he/she is eligible.
   c. Must be credentialed by the Medical Staff.
   d. Must have a current state RN license.
   e. Must meet the American Association of Nurse Anesthetists (AANA) continuing education requirements for re-licensure and re-certification.
   f. Continual re-certification by the AANA is mandatory unless the AANA grants an exemption or additional time to meet the requirement.

Reviewed February 2018
ANAESTHESIA ASSOCIATES OF MASSACHUSETTS

SUBJECT: DOCUMENTATION

PURPOSE:

To establish guidelines for the documentation of anesthesia services.

POLICY:

1. The anesthesiologist and/or CRNA will document anesthesia care in attendance for all types of anesthesia including general, regional, and monitored anesthesia care.

2. The following will be documented in the medical record: airway assessment, vital signs immediately prior to anesthesia (the first set of vital signs on the Anesthesia Record constitute this), medications given, intravenous fluids given, blood and/or blood components given, unusual events and/or complications and management of these events/complications and postoperative vital signs and level of consciousness.

3. A post-operative evaluation note will be written according to the Standards for Patient Care.

4. The anesthetist in attendance will complete and sign the anesthesia record.

Reviewed February 2018
PURPOSE:

To provide guidance to AAM staff in minimizing the risks of awareness under general anesthesia and provide guidance in making clinical decisions to respond to it.

ISSUE:

Intraoperative unintended awareness is a rare situation involving the patient having some recollection of events during his or her surgery while under general anesthesia, including possibly hearing sounds and feeling sensations or pain and is an issue of concern.

The anesthesiologist must balance the risks and benefits of alternative anesthetic techniques and dosing in each individual patient. The psychological risks of anesthesia awareness must be considered against the physiological risks of deeper anesthesia in a critical situation.

IMPLEMENTATION:

A. Preoperative Evaluation

Where applicable, consider possible risk factors for anesthesia awareness when conducting the preoperative evaluation.

B. Preinduction Phase of Anesthesia

- Adhere to a checklist protocol for anesthesia machines and equipment to assure that the desired anesthetic drugs and doses will be delivered.
- Verify the proper functioning of intravenous access, infusion pumps and their connections, including the presence of appropriate back-flow check valves.
- The decision to administer a benzodiazepine prophylactically should be made on a case-by-case basis for selected patients (e.g., patients requiring smaller dosages of anesthetics).

C. Intraoperative Monitoring

- Use multiple modalities to monitor depth of anesthesia
- Clinical techniques (i.e., checking for purposeful or reflex movement)
  - Neuromuscular blocking drugs may mask purposeful or reflex movement
- Conventional monitoring systems (e.g., ECG, BP, HR, end-tidal anesthetic analyzer, capnography)
- Brain function monitoring
  - not routinely indicated for general anesthesia patients

The general clinical applicability of these monitors in the prevention of intraoperative awareness has not been established.

Reviewed February 2018
D. Intraoperative and Postoperative Management

- The decision to administer a benzodiazepine intraoperatively after a patient unexpectedly becomes conscious should be made on a case-by-case basis.
- When, due to the unique circumstances of the case, you have noticed that a patient may be experiencing awareness, advise the patient that you are aware that he/she may feel pain and not be able to move, or not be fully asleep, and that as soon as it is safe you will put the patient to sleep.
- Speak with patients who report recall of intraoperative events to obtain details of the event and to discuss possible reasons for its occurrence. Apologize to the patient if intraoperative awareness has occurred, reassure the patient and provide support.
- Offer counseling or psychological support to the patient who reports an episode of intraoperative awareness.
- Complete an occurrence report for the purposes of performance improvement/patient safety and document in the patient’s record.

Reference: American Society of Anesthesiologists, “Practice Advisory for Intraoperative Awareness and Brain Functioning Monitoring”, October 25, 2005
I. PURPOSE

The purpose of the Performance Improvement Program is to promote safe and effective anesthesia care, of events, education and implementation of patient safety initiatives.

II. COMPONENTS

- Participation in the peer review protected quality improvement program of each hospital/facility contracting with AAM
- Development and implementation a program to measure quality/safety outcomes through the collection of data and
- Implementation of improvements with measurement of results
- Development of an occurrence review system that consistently and reliably evaluates clinician performance
- Training on strategies to improve patient safety, including simulation and performance assessments
- Management of patient complaints to enhance patient satisfaction, identify opportunities for improvements and promote patient safety
- Auditing of compliance with, and success of, safety initiatives through the collection and analysis of data
- Participate in accreditation/regulation of hospitals/facilities for which AAM provides anesthesia services
- Maintenance of event data for tracking and trending purposes.
- Aggregation of adverse event data by facility for analysis and reporting to the applicable facility Chief.
- Performance of OPPE and FPPE as set forth below.

III. AUTHORITY/RESPONSIBILITY

- AAM’s Medical Practice Committee shall provide oversight and direction for the Performance Improvement Program.
- AAM’s Chief Medical Officer shall supervise staff in the performance of the Program.
- Anesthesia providers shall participate in performance improvement initiatives as indicated and report incidents/occurrences as appropriate through AAM’s reporting program. Manager of Performance Improvement shall implement and coordinate performance improvement initiatives and serve as a resource to the Chiefs and other AAM clinicians.

IV. EVALUATION

The Chiefs Committee shall review and approve the Performance Improvement Program to assure that it is comprehensive and enhances the provision of quality patient care.

Reviewed and Revised February 2018
V. CONFIDENTIALITY AND EVIDENTIARY PROTECTIONS

The Program is structured to provide all available evidentiary protections from discovery to AAM and its clinicians in the event of a lawsuit. Peer review protection pursuant to G.L.c.111, sec 204 and all applicable state and federal law is afforded to the work done by the Department of Anesthesia of each hospital/facility for which AAM provides anesthesia services as a participant in the respective institution’s risk management and quality improvement programs. AAM’s General Counsel/Director of Risk Management, AAM’s Director/Manager of Performance Improvement and any other individuals working under the direction and control of AAM’s AAM’s General Counsel/Director of Risk Management are deemed part of the Anesthesia Department of each of these hospitals/facilities and, therefore participate in their risk management and quality improvement programs with all applicable protections. In addition, work done by AAM counsel on potentially compensable events and actual litigation matters, and under her direction and control, is deemed to be attorney work product done in anticipation of litigation and not discoverable. Finally, AAM’s General Counsel provides legal advice to AAM and its clinicians concerning risk management, claims and litigation, in addition to other legal matters. All related written and verbal communications with AAM counsel are deemed confidential attorney client communications prohibited from discovery.

Policy: Anaesthesia Associates of Massachusetts Provider Evaluation Process

Overview: Anaesthesia Associates of Massachusetts (AAM) has a long-standing commitment to clinical excellence and patient safety. In service to this goal, AAM has developed an extensive event reporting and risk management system that allows for continuous and focused monitoring of the care provided by its practitioners. As a result, AAM is able to quickly identify patient care issues and trends, both for individual providers and for our affiliate hospitals and facilities, thus facilitating early interventions designed to maintain high quality anesthesia care. In compliance with regulatory, legal, and accreditation mandates, this policy is designed to provide an evidence-based system to monitor provider competency as outlined below.

Ongoing Professional Practice Evaluation and Focused Professional Practice Evaluation

Policy: Anaesthesia Associates of Massachusetts evaluates on a continuous basis the professional practice and competence of its anesthesia providers. On-going evaluation is used to timely:

- identify provider-specific practice issues and to develop appropriate interventions
- identify trends in patient outcomes that require review and possible modification of clinical practices
- utilized as a performance improvement tool

Scope: All AAM anesthesia providers

Procedure: AAM monitors the care delivered by AAM providers on an on-going basis to assure safe, high quality health care for all its patients. It does so by the following process:

- Medical record review
- Direct observation
- Web Based Event Reporting System: Adverse events, outcomes of known risks of anesthesia, patient/family complaints, and other patient care or practice related issues are entered into a web based event reporting system by AAM providers and risk managers. An extensive list of events and sub-categories allow for documentation of the occurrence of practice issues and patterns, even when there is no patient harm or the event was not preventable.

Reviewed and Revised February 2018
Real Time Evaluation: AAM’s in-house risk managers view every event entered into the reporting system in real time. If a significant event occurs, they have immediate post-event communication with the provider, the Chief of Anesthesia of the involved facility and its risk management staff. The anesthesia record is immediately reviewed for standard of care and documentation compliance. Major issues are initially addressed at this time.

M&M review: Each AAM Chief of Anesthesia and M&M Physician Coordinator receives notification of all cases submitted into the system for review at their facility’s ongoing M&M meetings. Case review, discussion, and education are designed to improve anesthetic practices in a peer review forum. A member of the hospital’s quality/risk department is invited to attend these meetings.

Performance Profile: Performance data for each provider is available through AAM’s event reporting and billing systems and is documented in a Performance Profile that is reviewed every six months by the Chief of Anesthesia at each of AAM’s facilities. The billing data provides the Chief with information on the number of specific anesthetics administered by each anesthesia provider in that six-month period. The Performance Profile includes evaluation of the following general competencies:

1. **Patient Care:** (Provision of care that is compassionate, appropriate, and effective for the promotion of health, prevention of illness, treatment of disease, and care at the end of life)
2. **Medical/Clinical Knowledge:** (Knowledge of established and evolving biomedical, clinical, and social sciences, and the application of this knowledge to patient care and the education of others)
3. **Practice-based learning and development:** (Use of scientific evidence and methods to investigate, evaluate, and improve patient care practices)
4. **Interpersonal/communication skills:** (Demonstration of interpersonal and communication skills that enable providers to establish and maintain professional relationships with patients, families, and other members of health care teams)
5. **Professionalism:** (Demonstration of behaviors that reflect commitment to continuous professional development, ethical practice, an understanding and sensitivity to diversity, and a responsible attitude toward patients, the profession, and society)
6. **Systems Based Learning:** (Demonstration of an understanding of the contexts and systems in which health care is provided, and the ability to apply this knowledge to improve and optimize health care)

Occurrence Screens: In addition to the above competencies, the Performance Profile for each provider includes frequency and volume data for six particular occurrence screens:

1. difficult airway resulting in preventable unplanned tracheotomy
2. intraoperative death or immediate postoperative death in a healthy patient related to anesthetic
3. awareness under general anesthesia
4. medication administration error
5. family/patient complaints.
6. severe CVC complications

Focused Professional Practice Evaluation:

Policy: AAM uses a Focused Professional Practice Evaluation when the performance of a given provider requires documented evidence of competence in a given area or areas. It occurs when:

1. There is concern about a currently privileged AAM provider’s ability to provide safe, high quality patient care as identified through the Ongoing Professional Practice Evaluation. This evaluation is performed “for cause.”
2. An evaluation of privilege-specific competency is needed for all new AAM providers, existing AAM providers requesting new privileges, and existing providers who have been newly privileged at an AAM facility at which they have never practiced.

Reviewed and Revised February 2018
Procedure:
1. When a “For Cause” Focused Evaluation May be Performed:

Triggers: A “for cause” evaluation may be triggered by any of the underlying reasons:
- information gained from ongoing M&M and other peer review related forums
- evidence suggesting the provider’s care does not fall within the standard of care or practice guidelines
- staff or patient/family complaints
- incident reports
- evidence of behavioral, physical health, or impairment issues
- a sentinel/adverse event, a non-optimal trend in clinical practice, or any other issue suggesting patient care may have been compromised
- repeated disregard for known policies, protocols, and safety-related interventions designed to protect patients from harm
- unethical practices impacting quality of care
- disruptive behaviors

Upon review of performance data, the following will trigger an FPPE if determined to fall below the standard of care:
- More than one preventable death related to anesthesia care within 6 months
- More than one preventable tracheostomy related to anesthesia care within 12 months
- Preventable awareness under anesthesia occurring more than one within 12 months
- More than one medication error within 6 months
- More than two serious substantiated patient/family complaints within one year
- One or more severe CVC complication within 12 months

Authority: In most instances, the Chief of Anesthesia in conjunction with AAM’s Chief Medical Officer will determine who will conduct the evaluation, the method(s) to be used and the time period of evaluation. The terms of all FPPE shall be communicated to the affected practitioner. In some instances, these decisions will be made by the hospital’s Institutional Peer Review Committee, Medical Executive Committee, Credentials Committee, or other body delineated by its Medical Staff Bylaws or other such document.

Methods of Evaluation: To ascertain competency related to an identified issue, a focused practice evaluation may include any of the following methods of assessment or a combination thereof:
- Comparison of the provider’s inpatient/outpatient complications/outcomes in relation to those of his/her peers
- Monitoring of clinical competency or practice patterns
- Proctoring
- Retrospective or prospective chart review
- External peer review (may be used when there is no appropriately privileged in-house provider or competition or bias may color the evaluation)
- Simulation
- Discussion with other individuals involved in the care of the practitioner’s patients

Time Period: The period of evaluation is time limited and will be determined at the discretion of the Chief of Anesthesia, AAM’s Chief Medical Officer, or the hospital’s Institutional Peer Review Committee or other such Committee noted in the hospital’s Medical Staff Bylaws or other such document.

Issue Specific Competencies: The Chief of Anesthesia or designee will determine the specific competencies to be evaluated and document them on the appropriate focused review form.

Reviewed and Revised February 2018
2) When a Focused Evaluation of Privilege-Specific Competency is Needed for All New AAM Providers, Existing Providers Requesting New Privileges, and Existing Providers Newly Privileged at an AAM Facility at Which They Have Never Practiced

Authority: the Chief of Anesthesia or designee will conduct the focused evaluation.

Time Period: The focused review will be for 3 months or a period of time determined by the Chief of Anesthesia.

Facility Specific Orientation: Anesthesia providers new to an AAM facility must undergo an orientation to the facility prior to engaging in the delivery of services.

Facility Specific Competencies: The provider must meet competencies required for practice at each specific facility at which s/he has privileges, i.e., HemoCue testing, etc.

Reviewed and Revised February 2018

The information contained in On-going and Focused Professional Evaluations and all the accompanying and related documents and correspondence are deemed confidential and are created by, for, or as a result of the work product, proceedings and reports of a medical staff peer review committee and are subject to all privileges and protections established pursuant to applicable law.