

**Policy and Procedures**

**Department of Anesthesiology and Critical Care Medicine**

**University of New Mexico School of Medicine**

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**Based upon the 2013 ASA Manual for Anesthesia Department Organization and Management <http://www.asahq.org/>**

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## **SECTION I- ADMINISTRATION**

### **I. Scope of Services**

#### **A. PURPOSE:**

The Department of Anesthesiology will provide medical care in the specialty of anesthesiology for all patients. Members of the Department of Anesthesiology will continually look for ways to improve the process and outcomes of anesthesia care. All patients requiring anesthesiology services within the Scope of Services will be served.

#### **B. SCOPE OF SERVICES:**

The Department of Anesthesiology provides complete anesthesia services, including consultation for patients and other physicians, general anesthesia, spinal and regional anesthesia, obstetric anesthesia, sedation, and management of intensive care patients, and acute and chronic pain management. Service is available 24 hours a day, 7 days a week.

#### **C. SITES OF ANESTHESIA CARE:**

1. Main Hospital to include 14 OR's, interventional radiology, MRI & CT scanner, nuclear medicine, GI lab, Cath lab, interventional pulmonology and the Cancer Center to include radiation therapy, CT scanner and procedure room. Main OR's function 24/7.
2. BBRP: 6 OR's, Cath Lab, MRI & CT scanner. 7am-10pm. On Call Services available 24/7.
3. OSIS: 6 OR's and 3 OSIS Satelite Procedure Rooms. 7am-5pm.
4. SRMC: 6 OR's and GI procedure room. 7am-5pm. On Call Services available 24/7.
5. All general, regional and Monitored Anesthesia Care (MAC) anesthesia will only be performed by qualified and properly credentialed anesthesia personnel formally in the Department of Anesthesiology. Conscious and Deep sedation will only be performed by qualified individuals in accordance with respective department's policies, and within the guidelines of the hospital's sedation policy.

### **II. The Anesthesiology Service will provide anesthesia or administrative management for the following indications:**

#### **A. GENERAL OR REGIONAL ANESTHESIA OR SEDATION WITH MONITORING**

1. (MAC) for scheduled and/or emergency operative, invasive, or non-invasive procedures at UNM Hospital, including, but not necessarily limited to, minor and major orthopedics, vascular, cardiothoracic, plastic, general surgery, gynecology, ENT, burns, and ophthalmology cases.

#### **B. EMERGENCY AIRWAY MANAGEMENT**

#### **C. PAIN MEDICINE**

1. Providing diagnostic and therapeutic nerve blocks and advanced pain management techniques.

#### **D. ACUTE PERI-OPERATIVE PAIN MANAGEMENT**

1. Consultative service and postoperative anesthesia pain service

#### **E. INSERTION OF INVASIVE LINES**

1. Including arterial lines, pulmonary artery catheters, central venous catheters and intravenous lines. Arterial lines and pulmonary artery catheters will only be inserted in those areas where adequate assistance, equipment, and sterile conditions can be maintained.

F. CONSULTATION FOR RESPIRATORY CARE

G. ASSIST WITH PROBLEMS AS THEY ARISE IN THE ICU OR CCU

H. SUPERVISION OF POSTANESTHESIA CARE UNIT PATIENTS

### **III. Guidelines for Patient Care in Anesthesiology**

A. DEFINITION OF ANESTHESIOLOGY

Anesthesiology is a discipline within the practice of medicine dealing with but not limited to, and specializing in:

1. The preoperative, intraoperative and postoperative evaluation and treatment of patients who are rendered unconscious and/or insensible to pain and emotional stress during surgical, obstetrical, therapeutic and diagnostic or other medical procedures;
2. The protection of life functions and vital organs (e.g., brain, heart, lungs, kidneys, liver, endocrine, skin integrity, nerve [sensory and muscular]) under the stress of anesthetic, surgical and other medical procedures;
3. Monitoring and maintenance of normal physiology during the perioperative period;
4. Diagnosis and treatment of acute, chronic and cancer-related pain;
5. Clinical management of cardiac and pulmonary resuscitation;
6. Evaluation of respiratory function and application of respiratory therapy;
7. Management of critically ill patients;
8. Conduct of clinical, translational and basic science research;
9. Supervision, teaching and evaluation of performance of both medical and paramedical personnel involved in perioperative care and cardiac and pulmonary resuscitation.

B. ANESTHESIOLOGISTS' RESPONSIBILITIES:

Anesthesiologists are physicians who, after college, have graduated from an accredited medical school and have successfully completed an approved residency in anesthesiology. Anesthesiologists may have had additional training and certification in subspecialty areas such as critical care medicine or pain management. Areas of additional training may also include, but are not limited, to pediatric anesthesia, neuroanesthesia, obstetrical, vascular, regional, transplantation, or cardiothoracic anesthesia. Anesthesiologists' responsibilities to patients include:

1. Assessment of, consultation for and preparation of patients for anesthesia;
2. Medical management of patients and the anesthetic for the planned procedures;
3. Postanesthetic evaluation and treatment;
4. On-site medical direction of any nonphysician who participates in the delivery of anesthesia care to the patient;
5. Perioperative pain management.

C. GUIDELINES FOR ANESTHESIA CARE:

1. The same standards for and quality of anesthetic care should be available for:

- a. All patients, 24 hours a day, seven days a week;
  - b. Emergency as well as elective patients;
  - c. Obstetrical, medical and surgical patients.
2. Preanesthetic evaluation and preparation means that an anesthesiologist:
- a. Reviews the chart;
  - b. Interviews the patient, parents or guardians of a minor, next of kin if patient is unable to communicate, or reviews the available medical information if no information can be supplied by any of the above to:
    - (1) Discuss the medical history, including anesthetic experiences and drug therapy;
    - (2) Perform any examinations that would provide information that might assist in decisions regarding anesthetic risk and management;
  - c. Orders tests and medications necessary to the conduct of anesthesia;
  - d. Obtains consultations as necessary;
  - e. Records an assessment and an anesthetic plan on the patient's chart.
3. Perianesthetic care means:
- a. Re-evaluation of the patient immediately prior to induction;
  - b. Preparation and check of equipment, drugs, fluids and gas supplies;
  - c. Appropriate monitoring of the patient;
  - d. Selection and administration of anesthetic agents to render the patient insensible to pain, while providing a level of comfort and relaxation commensurate with the invasiveness and physiologic stress of the planned procedure;
  - e. Support of life functions under the stress of anesthetic, surgical, and obstetrical manipulations;
  - f. Recording the pertinent events of the procedure.
4. Postanesthetic care means:
- a. Availability of nursing personnel and equipment as required for safe postanesthetic care;
  - b. The anesthesia care provider gives to the healthcare receiver transfer of care information pertinent to the patient's specific needs and ensure a safe transition;
  - c. The anesthesia care team remains with the patient as long as medically necessary and until the receiving healthcare provider has all the information needed to assume care;
  - d. Assurance that the patient is discharged from the postanesthesia care unit in accordance with policies established by the Department of Anesthesiology.
  - e. The duration of surveillance in the postanesthesia care unit is determined by the status of the patient and the judgment of the anesthesiologist.

**D. ADDITIONAL AREAS OF EXPERTISE:**

- 1. Resuscitation procedures
- 2. Pulmonary care
- 3. Critical care medicine

4. Diagnosis and treatment of acute, chronic, and cancer-related pain
  5. Trauma and emergency care
  6. Management of cardiopulmonary bypass
  7. Management of preadmission clinics for patients undergoing surgical, diagnostic, or therapeutic procedures requiring care by an anesthesiologist
  8. Perioperative medicine
  9. Transesophageal and Transthoracic echocardiography
  10. Operating room management
  11. Regional anesthesia
  12. Other specialized diagnostic or therapeutic procedures including, but not limited, to somatosensory evoked potential monitoring and cardiopulmonary bypass
  13. Palliative Care Medicine
- E. QUALITY ASSURANCE:  
The anesthesiologist should participate in a planned program for evaluation of quality and appropriateness of the anesthetic care of patients and should participate in resolving identified problems.

#### **IV. Guidelines for the Ethical Practice of Anesthesiology**

- A. ANESTHESIOLOGISTS IN THE DEPARTMENT  
should be familiar with and adhere to the Guidelines for the Ethical Practice of Anesthesiology (Approved by House of Delegates on October 3, 1967 and last amended on October 15, 2003  
<http://www.asahq.org/publicationsAndServices/standards/10.pdf>).
- B. PREAMBLE  
Membership in the American Society of Anesthesiologists is a privilege of physicians who are dedicated to the ethical provision of health care. The Society recognizes the Principles of Medical Ethics of the American Medical Association (AMA) as the basic guide to the ethical conduct of its members which appear below.
- C. AMA PRINCIPLES OF MEDICAL ETHICS  
(Adopted By the AMA's House of Delegates June 17, 2001)  
The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility not only to patients but also to society, to other health professionals and to self. The following Principles adopted by the American Medical Association are not laws but standards of conduct which define the essentials of honorable behavior for the physician.
1. A physician shall be dedicated to providing competent medical care with compassion and respect for human dignity and rights.
  2. A physician shall uphold the standards of professionalism, be honest in all professional interactions, and strive to report physicians deficient in character or competence, or engaging in fraud or deception to appropriate entities.
  3. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements, which are contrary to the best interests of the patient.



4. A physician shall respect the rights of patients, colleagues and other health professionals and shall safeguard patient confidences within the constraints of the law.
5. A physician shall continue to study, apply and advance scientific knowledge, maintain a commitment to medical education, make relevant information available to patients, colleagues and the public, obtain consultation, and use the talents of other health professionals when indicated.
6. A physician shall, in the provision of appropriate patient care except in emergencies, be free to choose whom to serve, with whom to associate and the environment in which to provide medical care.
7. A physician shall recognize a responsibility to participate in activities contributing to improvement of the community and the betterment of public health.
8. A physician shall, while caring for a patient, regard responsibility to the patient as paramount.
9. A physician shall support access to medical care for all people. The practice of anesthesiology involves special problems relating to the quality and standards of patient care. Therefore, the Society requires its members to adhere to the AMA Principles of Medical Ethics and any other specific ethical guidelines adopted by this Society.

#### D. MEDICAL DIRECTION:

Medical Direction is anesthesia direction, management or instruction provided by an anesthesiologist whose responsibilities include:

1. Preanesthetic evaluation of the patient.
2. Prescription of the anesthesia plan.
3. Personal participation in the most demanding procedures in this plan, especially those of induction and emergence, if applicable.
4. Following the course of anesthesia administration at frequent intervals.
5. Remaining physically available for the immediate diagnosis and treatment of emergencies.
6. Providing indicated postanesthesia care. An anesthesiologist engaged in medical direction should not personally be administering another anesthetic and should use sound judgment in initiating other concurrent anesthetic and emergency procedures.

#### E. ASA ETHICAL GUIDELINES

There may be specific circumstances when elements of the following guidelines may not apply and wherein individualized decisions may be appropriate.

1. Anesthesiologists have ethical responsibilities to their patients.
  - a. The patient-physician relationship involves special obligations for the physician that include placing the patient's interests foremost, faithfully caring for the patient and being truthful.
  - b. Anesthesiologists respect the right of every patient to self-determination. Anesthesiologists should include patients, including minors, in medical decision-making that is appropriate to their developmental capacity and the medical issues involved.

- c. Anesthetized patients are particularly vulnerable, and anesthesiologists should strive to care for each patient's physical and psychological safety, comfort and dignity. Anesthesiologists should monitor themselves and their colleagues to protect the anesthetized patient from any disrespectful or abusive behavior.
  - d. Anesthesiologists should keep confidential patients' medical and personal information.
  - e. Anesthesiologists should provide preoperative evaluation and care and should facilitate the process of informed decision-making, especially regarding the choice of anesthetic technique.
  - f. If responsibility for a patient's care is to be shared with other physicians or nonphysician anesthesia providers, this arrangement should be explained to the patient. When directing nonphysician anesthesia providers, anesthesiologists should provide or ensure the same level of preoperative evaluation, care and counseling as when personally providing these same aspects of anesthesia care.
  - g. When directing nonphysician anesthesia providers or physicians in training in the actual delivery of anesthetics, anesthesiologists should remain personally and continuously available for direction and supervision during the anesthetic they should directly participate in the most demanding aspects of the anesthetic care.
  - h. Anesthesiologists should provide for appropriate postanesthetic care for their patients.
  - i. Anesthesiologists should not participate in exploitive financial relationships.
  - j. Anesthesiologists share with all physicians the responsibility to provide care for patients irrespective of their ability to pay for their care. Anesthesiologists should provide such care with the same diligence and skill as for patients who do pay for their care.
2. Anesthesiologists have ethical responsibilities to medical colleagues.
- a. Anesthesiologists should promote a cooperative and respectful relationship with their professional colleagues that facilitate quality medical care for patients. This responsibility respects the efforts and duties of other care providers including physicians, medical students, nurses, technicians and assistants.
  - b. Anesthesiologists should provide timely medical consultation when requested and should seek consultation when appropriate.
  - c. Anesthesiologists should cooperate with colleagues to improve the quality, effectiveness and efficiency of medical care.
  - d. Anesthesiologists should advise colleagues whose ability to practice medicine becomes temporarily or permanently impaired to appropriately modify or discontinue their practice. They should assist, to the extent of their own abilities, with the re-education or rehabilitation of a colleague who is returning to practice.
  - e. Anesthesiologists should not take financial advantage of other physicians, nonphysician anesthesia providers or staff members. Verbal

- and written contracts should be honest and understandable, and should be respected.
3. Anesthesiologists have ethical responsibilities to the health care facilities in which they practice.
    - a. Anesthesiologists should serve on health care facility or specialty committees. This responsibility includes making good faith efforts to review the practice of colleagues and to help develop departmental or health care facility procedural guidelines for the benefit of the health care facility and all of its patients.
    - b. Anesthesiologists share with all medical staff members the responsibility to observe and report to appropriate authorities any potentially negligent practices or conditions, which may present a hazard to patients or health care facility personnel.
    - c. Anesthesiologists personally handle many controlled and potentially dangerous substances and, therefore, have a special responsibility to keep these substances secure from illicit use. Anesthesiologists should work within their health care facility to develop and maintain an adequate monitoring system for controlled substances.
  4. Anesthesiologists have ethical responsibilities to themselves.
    - a. The achievement and maintenance of competence and skill in the specialty is the primary professional duty of all anesthesiologists. This responsibility does not end with completion of residency training or certification by the American Board of Anesthesiology.
    - b. The practice of quality anesthesia care requires that anesthesiologists maintain their physical and mental health and special sensory capabilities. If in doubt about their health, then anesthesiologists should seek medical evaluation and care. During this period of evaluation or treatment, anesthesiologists should modify or cease their practice.
  5. Anesthesiologists have ethical responsibilities to their community and to society.
    - a. A physician shall recognize a responsibility to participate in activities contributing to an improved community.
    - b. An anesthesiologist who serves as an expert witness in a judicial proceeding shall possess the qualifications and offer testimony in conformance with the ASA "Guidelines for Expert Witness Qualifications and Testimony."

## **V. The Organization of the Anesthesia Department**

(<http://www.asahq.org/publicationsAndServices/standards/25.pdf>).

### **A. PHYSICIAN RESPONSIBILITIES FOR MEDICAL CARE**

1. Anesthesiology is the practice of medicine. An anesthesiologist must be personally responsible to each patient for the provision of anesthesia care. An anesthesiologist exercises the same independent medical judgment on behalf of the patient as is exercised by other physicians. The anesthesiologist's responsibilities to the patient should include responsibility for preanesthetic evaluation and care, medical management of the anesthetic procedure and of

the patient during surgery, post anesthetic evaluation and care, and medical direction of any nonphysician who assists in providing anesthesia care to the patient. The anesthesiologist should fulfill these responsibilities to the patient in accordance with the ASA Guidelines for the Ethical Practice of Anesthesiology and Guidelines for Patient Care in Anesthesiology. As a member of the hospital medical staff, an anesthesiologist is subject to and must observe, as well as be accorded the benefits of, the medical staff bylaws, rules and regulations generally applicable to all physicians granted privileges in the hospital. Additional rights and responsibilities may arise from rules and regulations specifically applicable to physicians in the department of anesthesia. An anesthesiologist with full staff privileges must share on a fair and equitable basis in the responsibility for assuring 24-hour-a-day, 7-day-a-week availability of anesthesia care.

#### **B. ADMINISTRATIVE ORGANIZATION OF ANESTHESIOLOGISTS AND THEIR RESPONSIBILITIES**

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

#### **C. RESPONSIBILITIES OF DEPARTMENT CHAIR, ANESTHESIOLOGISTS, CERTIFIED REGISTERED NURSE ANESTHETISTS and ANESTHESIOLOGIST ASSISTANTS**

##### **1. Department Chair**

###### **a. Primary Function**

The Chair of the Department of Anesthesiology will be selected and appointed by the Dean, University of New Mexico School of Medicine in accordance with University policy. The Chair of the Anesthesia Department will serve as the hospital's CMS mandated director of

anesthesia services. The director of anesthesia services has the authority and responsibility for directing the administration of all anesthesia services, including anesthesia and analgesia, throughout the hospital (including all departments in all campuses and off-site locations where anesthesia services are provided), as well as responsibility for evaluating the quality and appropriateness of the anesthesia patient care as part of the hospital's Quality Assessment/performance Improvement program. The Chair shall be responsible for assuring that the following functions are performed, either by him/herself or by specific delegation to a qualified member of the department:

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

various departments or services of the hospital, including participating in the hospital's program of cardiopulmonary resuscitation. When requested, the Chair or Chair's designee should provide consultation in the management of problems of acute and chronic respiratory insufficiency as well as a variety of other diagnostic and therapeutic measures related to hospital patient care.

b. Specific Duties

The Chair will be responsible for:

- i. Seeing that the daily assignments of anesthesia for the surgical schedule are carried out in an equitable manner.
- ii. Seeing that the vacation schedule affords equal opportunity for time off for all department members, and encouraging them to take their vacation time.
- iii. Reporting as required to the Credentials Committee, Quality Improvement Committee, Safety Committee, Infection Control Committee, Operating Room Committee, and other such committees as appropriate.
- iv. The Chair shall not be responsible for the professional conduct of the individual anesthesiologists or other anesthetists, but shall have the responsibility and the necessary authority to establish quality standards for the anesthesia service.
- v. Specific duties as provided in appropriate sections of the Bylaws. In the absence of the Chair, the Vice Chairs of the Anesthesia Department as appointed by the Chair shall assume all the responsibilities of the Chair as provided in the Bylaws.

2. Anesthesiologists

a. Primary Function

- i. Perform accepted procedures commonly used to render patient insensible to pain during the performance of surgical, obstetrical, and other pain-producing clinical maneuvers, and to relieve pain-associated medical syndromes.
- ii. Support life functions during the period in which anesthesia is administered.
- iii. Provide consultation relating to various other forms of patient care, such as respiratory therapy and problems in pain relief.

b. Specific Duties

- i. Preoperative evaluation and reasonable explanation to the patient of the proposed anesthetic procedure.
- ii. Pre-medication of the patient if needed.
- iii. Administration of anesthesia to the patient on the basis of the ASA standards and guidelines;  
i.e., the anesthesiologist will be personally responsible for the conduct of the selected anesthetic and will be immediately available at all times to fulfill this responsibility.

- iv. Performance of a documented postoperative visit or visits as indicated.
  - c. Academic duties
    - i. Academic, administrative, research, and educational responsibilities as assigned by the Chair.
    - ii. Participation in the academic activities of the department in accordance with the UNM-SOM Faculty Handbook.
  - 3. Certified registered nurse anesthetists and anesthesiologist assistants
    - a. Delegation of functions to non-physician personnel should be based on specific criteria
    - b. The individual's education, training, and demonstrated skills shall be approved by the medical staff on the recommendation of the physician responsible for anesthesia care. Such criteria should include competence to follow the anesthesia plan prescribed by the anesthesiologist and the technical ability to:
      - i. Induce anesthesia under the direction of an anesthesiologist.
      - ii. Maintain anesthesia at prescribed levels.
      - iii. Monitor and support life functions during the perioperative period.
      - iv. Recognize and report to the anesthesiologist any abnormal patient responses during anesthesia.
      - v. Adherence to the Anesthesia Care Team Principles as outlined below (Approved by House of Delegates on October 26, 1982 and last amended on October 18, 2006 (<http://www.asahq.org/publicationsAndServices/standards/16.pdf>))
- Anesthesiology is the practice of medicine including, but not limited to, preoperative patient evaluation, anesthetic planning, intraoperative and postoperative care and the management of systems and personnel that support these activities. In addition, anesthesiology involves perioperative consultation, the prevention and management of untoward perioperative patient conditions, the treatment of acute and chronic pain, and the care of critically ill patients. This care is personally provided by or directed by the Anesthesiologist. In the interest of patient safety and quality of care, the American Society of Anesthesiologists believes that the involvement of an anesthesiologist in the perioperative care of every patient is optimal. Almost all anesthesia care is either provided personally by an anesthesiologist or is provided by a non-physician anesthesia provider directed by an anesthesiologist. The latter mode of anesthesia delivery is called the Anesthesia Care Team and involves the delegation of monitoring and appropriate tasks by the physician to non-physicians. Such delegation should be specifically defined by the anesthesiologist and should also be consistent with state law or regulations and medical staff policy. Although selected tasks of overall anesthesia care may be

delegated to qualified members of the Anesthesia Care Team, overall responsibility for the Anesthesia Care Team and the patients' safety rests with the anesthesiologist.

#### 4. Core Members of the Anesthesia Care Team

The Anesthesia Care Team includes both physicians and non-physicians. Each member of the team has an obligation to accurately identify themselves and other members of the team to patients and family members. Anesthesiologists should not permit the misrepresentation of non-physician personnel as resident physicians or practicing physicians. The nomenclature below is appropriate terminology for this purpose.

##### a. Physicians:

- i. Anesthesiologist – director of the anesthesia care team—a physician licensed to practice medicine who has successfully completed a training program in anesthesiology accredited by the ACGME, the American Osteopathic Association or equivalent organizations.
- ii. Anesthesiology Fellow— an anesthesiologist enrolled in a training program to obtain additional education in one of the sub disciplines of anesthesiology.
- iii. Anesthesiology Resident—a physician enrolled in an accredited anesthesiology residency program.

##### b. Nonphysician:

- i. Nurse Anesthetist – a registered nurse who has satisfactorily completed an accredited nurse anesthesia training program.
- ii. Anesthesiologist Assistant – a health professional who has satisfactorily completed an accredited anesthesiologist assistant training program.
- iii. Anesthesiologist Assistant Student – a health professions graduate student who has satisfied the required coursework for admission to an accredited school of medicine and is enrolled in an accredited anesthesiologist assistant training program.
- iv. Although not considered core members of the Anesthesia Care Team, other health care professionals make important contributions to the perianesthetic care of the patient (see **Addendum A**).

##### c. Definitions

- i. Anesthesia Care Team – Anesthesiologists supervising resident physicians in training and/or directing qualified non physician anesthesia providers in the provision of anesthesia care wherein the physician may delegate monitoring and appropriate tasks while retaining overall responsibility for the patient.

d. Supervision And Direction – Terms used to describe the physician work required to oversee, manage and guide both residents and non physician anesthesia providers in the Anesthesia Care Team. For the purposes of this statement, supervision and direction are interchangeable and have no relation to the billing, payment or regulatory definitions that provide



distinctions between these two terms (see Section VI, Anesthesia Billing and Compliance).

e. Safe Conduct of the Anesthesia Care Team

In order to achieve optimum patient safety, the anesthesiologist who directs the Anesthesia Care Team is responsible for the following:

- f. Management of personnel – Anesthesiologists should assure the assignment of appropriately skilled physician and/or non-physician personnel for each patient and procedure.
- g. Preanesthetic evaluation of the patient – A preanesthetic evaluation allows for the development of an anesthetic plan that considers all conditions and diseases of the patient that may influence the safe outcome of the anesthetic. Although non-physicians may contribute to the preoperative collection and documentation of patient data, the anesthesiologist is responsible for the overall evaluation of each patient.
- h. Prescribing the anesthetic plan – The anesthesiologist is responsible for prescribing an anesthesia plan aimed at the greatest safety and highest quality for each patient. The anesthesiologist discusses with the patient (when appropriate), the anesthetic risks, benefits and alternatives, and obtains informed consent. When a portion of the anesthetic care will be performed by another qualified anesthesia provider, the anesthesiologist should inform the patient that delegation of anesthetic duties is included in care provided by the Anesthesia Care Team.
- i. Management of the anesthetic – The management of an anesthetic is dependent on many factors including the unique medical conditions of individual patients and the procedures being performed. Anesthesiologists should determine which perioperative tasks, if any, may be delegated. The anesthesiologist may delegate specific tasks to qualified non anesthesiologist members of the ACT providing that quality of care and patient safety are not compromised, but should participate in critical parts of the anesthetic and remain immediately physically available for management of emergencies regardless of the type of anesthetic (see Section VI, Anesthesia Billing and Compliance).
- j. Postanesthesia care – Routine postanesthesia care is delegated to postanesthesia nurses. The evaluation and treatment of postanesthetic complications are the responsibility of the anesthesiologist.
- k. Anesthesia consultation – Like other forms of medical consultation, this is the practice of medicine and should not be delegated to non physicians.

**ADDENDUM A:**

Other personnel involved in perianesthetic care:

- Postanesthesia Nurse – a registered nurse who cares for patients recovering from anesthesia.
- Perioperative Nurse – a registered nurse who cares for the patient in the operating room.

- Critical Care Nurse – a registered nurse who cares for patients in a special care area such the intensive care unit.
- Obstetric Nurse – a registered nurse who provides care to Laboring patients.
- Neonatal Nurse – a registered nurse who provides cares to neonates in special care units.
- Respiratory Therapist – an allied health professional who provides respiratory care to patients.
- Medical Students- a health professions graduate student who has satisfied the required coursework for admission to an accredited school of medicine and is enrolled in an accredited medical school.

Support personnel whose efforts deal with technical expertise, supply and maintenance:

- Anesthesia Technologists And Technicians
- Anesthesia Aides
- Blood Gas Technicians
- Respiratory Technicians
- Monitoring Technicians

## **VI. Anesthesia Billing and Compliance**

### **A. INTRODUCTION:**

The Department of Anesthesiology and Critical Care Medicine at the University of New Mexico, functions as a Group Practice. The Anesthesia Care Team is comprised of Anesthesiologist, Anesthesiology Residents, Certified Nurse Anesthetists (CRNA), and Anesthesiology Assistants (AA). The department requires that all members comply with the following patterns of practice and guidelines for billing and compliance. It is a condition of employment that all department members comply with and act in accordance with all billing and compliance policies and procedures issued by the UNM Faculty Practice Organization. A departmental compliance officer will be appointed by the Chair and will coordinate all departmental compliance activities required under Center for Medicare and Medicaid Services (CMS) Guidelines.

### **B. THE ANESTHESIA CARE TEAM: (based on ASA Statement on the Anesthesia Care Team updated October 16, 2013)**

#### **1. Personally Performed:**

The following criterion applies to anesthesia services personally performed:

- a. The anesthesiologist personally performs the entire anesthesia service alone
- b. The anesthesiologist is a teaching physician and is personally and continuously involved with a single anesthetic performed by an anesthesiology resident.
- c. The anesthesiologist is personally and continuously is involved in a single anesthetic performed by a medical student or CRNA/AA student

2. Medical Direction:

Medical direction occurs if the physician medically directs qualified individuals in two, three, or four concurrent cases. Qualifies individuals include:

- a. Anesthesiology Resident
- b. Certified Nurse Anesthetist
- c. Anesthesiology Assistant: In New Mexico, licensure of AA allows for medical direction of a maximum of four concurrent cases. Due to the complexity of patients at University of New Mexico hospitals, we limit medical direction to three AA with an option for four in the event of a life-threatening emergency.

3. Medical Supervision:

When an anesthesiologist is involved in more than four procedures concurrently or is performing other services while directing concurrent procedures, the anesthesia services are considered medically supervised. This may occur when the rules of medical direction are broken.

C. THE SEVEN STEPS OF MEDICAL DIRECTION

Medical direction occurs when the anesthesiologist medically directs qualified individuals in two, three, or four concurrent cases. Documentation of medical direction is required in the form of an attestation. The medically directing physician must perform the following activities:

- 1. Perform a pre-anesthesia examination and evaluation
  - a. Obtain and document medical and anesthetic history on the day of surgery or document review of a previously obtained evaluation
  - b. Perform appropriate physical exam including vital signs
  - c. Assign an ASA physical status
- 2. Prescribes the anesthesia plan
  - a. Document plan
  - b. Discuss risks and benefits
- 3. Personally participates in the most demanding procedures of the anesthesia plan, including induction and emergence, if applicable
  - a. Induction
    - i. General: drug administration and intubation
    - ii. Regional: performance of actual procedure
    - iii. MAC: no induction applicable
  - b. Emergence
    - i. Time span from discontinuing anesthetic to sign-off in PACU
    - ii. Emergence is not applicable for MAC or regional blocks
- 4. Ensures that any procedures in the anesthesia plan that he/she does not perform are performed by a qualified individual
- 5. Monitors the course of anesthesia administration at frequent intervals
  - a. The physician may use best clinical judgment pertinent to each patient
  - b. Indicators of presence
    - i. Initials on timeline
    - ii. Note in comments section

6. Remains physically present and available for immediate diagnosis and treatment of emergencies
  - a. Additional services that may be provided while medically directing concurrent cases include
    - i. Addressing an emergency of short duration in the immediate area
    - ii. Administer an epidural anesthetic to a patient in labor
    - iii. Performing periodic, rather than continuous monitoring of an obstetric patient
    - iv. Receiving patients entering the operating suite for the next surgery.
    - v. Checking on or discharging patients in PACU
    - vi. Coordinating scheduling matters
    - vii. Placing lines (including CVP and A-line) in the Holding Area
    - viii. Placing epidurals catheter for post-operative analgesia or in preparation for subsequent surgery
    - ix. Placing a peripheral nerve block prior to subsequent surgery
7. Provides indicated post-anesthesia care
  - a. Patient evaluation on admission
  - b. Address any complications
  - c. A post-operative note indicating that the patient has recovered from anesthesia

As a group practice, one member of the group may complete one of the steps while another member of the group provides the other component parts of the anesthesia service. The medical record shall reflect the identity of the physicians providing the differing steps.

#### D. MEDICAL DIRECTION AND TEMPORARY RELIEF

Medically directing anesthesiologists must be immediately available at all times. Temporary relief of a resident, CRNA or AA is accomplished under the following conditions without disrupting immediate availability as follows:

1. The relieved provider will remain in the immediate area and be available to immediately return to his/her case in the event the relieving anesthesiologist is required elsewhere.
2. A second anesthesiologist, not medically directing more than three concurrent rooms may assume temporary medical direction.

#### E. REIMBURSEMENT FOR ANESTHESIA SERVICES AND DOCUMENTATION

Anesthesia services are billed as follows:

**(Base Units + Time Units + Modifying units/procedure) X Conversion Factor (CF)**

##### 1. Base Units

- a. All services are billed using a procedure code listed in the Current Procedural Terminology (CPT). These codes are required to determine the base units.
- b. ASA Relative Value Guide may also be used.
- c. Included in the base unit is:
  - i. Usual pre-operative and post-operative visits
  - ii. Interpretation of non-invasive monitoring (ECG, temperature, blood pressure, oximetry, capnography, and mass spectrometry)

2. Time Units
  - a. Reporting:
    - i. Record exact time
    - ii. Report time in exact minutes
  - b. Anesthesia Start Time
    - i. Start time begins when the anesthesiologist begins to prepare the patient for anesthesia care in the operating room or in an equivalent area.
    - ii. Start time for all cases is “In the Room Time” with the following exceptions:
      1. Patients brought directly to the OR from the ICU, start time occurs when patient is sedated and transported by the anesthesia team
      2. Time when the anesthesia team provides continuous care to the patient. Example, a regional block placed in the holding area as the primary anesthetic.
      3. Discontinuous Times: Multiple start and stop times may be recorded if there is a disruption in the continuous care of the patient
  - c. Anesthesia End of Stop Time
  - d. End time occurs when transfer of care is complete and the anesthesiologist is no longer in attendance of the patient
    - i. Transfer of care usually occurs to a PACU or ICU nurse.
3. Modifying Units
  - a. ASA physical status codes may add units
  - b. Emergency: defined as a situation in which a delay in treating the patient would lead to a significant increase in threat to life or body part
4. Conversion Factor
  - a. Medicare rates determined yearly
  - b. Rates differ with third party payers
5. Other Billable Services
  - a. Arterial and Central Lines
    - i. Documentation shall include anesthesia team member placing the line. A procedure note will be completed on the anesthesia record.
    - ii. May be placed in the holding area
    - iii. No time units added
  - b. Transesophageal Echocardiography (TEE)
    - i. Probe placement only
    - ii. Probe placement and routine monitoring
    - iii. Probe placement and personally perform a diagnostic interpretation with written report
  - c. Post-operative Analgesia
    - i. Post-operative pain management is usually bundled into the surgeon’s global fee

- ii .A written request by the surgeon or a documentation of such request by the anesthesiologist must be noted
- iii. Peripheral nerve blocks and epidural catheter insertion may be performed for post-operative analgesia and billed as a pain procedure, if they are not used as the primary anesthetic.
- iv. A procedure note/form must be filled out including the time of insertion
- v. If used as the primary anesthetic, time units may be added
- vi. Post-operative visit (starting on post-op day 1)
  - 1. Continuous epidural catheter: one daily charge with proper documentation irrespective of the number of visits
  - 2. Peripheral nerve blocks with catheter: daily visits bundled with original catheter placement
- d. Ultrasound guided placement of peripheral nerve blocks and vascular lines
  - i. Document a timed procedure note
  - ii. Include ultrasound image in medical record

## **VII. Delineation of Clinical Privileges**

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

[http://hospitals.unm.edu/policies\\_and\\_procedures/index.cfm?fuseaction=policies\\_and\\_procedures.main](http://hospitals.unm.edu/policies_and_procedures/index.cfm?fuseaction=policies_and_procedures.main)

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

### **A. ANESTHESIOLOGIST**

1. Must be Board certified by the American Board of Medical Specialties or board eligible
2. Must have completed residency program of anesthesiology that is approved by the Accreditation Council of Graduate Medical Education (ACGME) and the American Board of Anesthesiology (or the Osteopathic equivalents).
3. Must have a current medical license and registration to practice
4. Must have Federal and, where applicable, state narcotics registration
5. Must have relevant training and clinical experience
6. Must have demonstrated current competence and ability to recognize and manage anesthetic related complications
7. Must be in good mental and physical health
8. Must provide references and recommendations from credible sources

### **B. CERTIFIED REGISTERED NURSE ANESTHETIST (CRNA)**

1. Must have graduated from an accredited school of nursing and an accredited school of nurse anesthesia.
2. Must be certified or eligible to be certified by the appropriate nursing specialty organization
3. Must be credentialed by the Medical Staff.
4. Must have a current state RN license.

5. Must meet the American Association of Nurse Anesthetists (AANA) requirements for New Mexico for CME for re-licensure and recertification.
6. Continual recertification by the AANA is mandatory unless the AANA grants an exemption or additional time to meet the requirement.

**C. CERTIFIED ANESTHESIOLOGIST ASSISTANT (AA-C)**

1. AA training programs must include a minimum of 24 months in a Master's level program accredited by the Commission for the Accreditation of Allied Health Educational Programs (CAAHEP). The programs must be based at, or in collaboration with, a university that has a medical school and academic anesthesiologist physician faculty.
2. Upon completion of an accredited AA program and in order to practice a student must become certified by passing the NCCAA examination, which is co-validated by the National Board of Medical Examiners.
3. In order to re-certify, an AA must meet the requirements for New Mexico for CME for re-licensure and recertification.
4. Additionally, AAs must take the Continuing Demonstration of Qualification Exam every six years. This exam follows the same format as the initial certification exam.

**VIII. Classes of Clinical Privileges**

**A. PRIVILEGES IN ANESTHESIOLOGY**

Privileges are granted by the University of New Mexico Hospital and approved by the Chairman of the Department of Anesthesiology.

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

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

**B. BOARD CERTIFICATION**

Anesthesiologists at UNM Hospital Must be Board certified by the American Board of Medical Specialties or board admissible.

**C. CERTIFIED REGISTERED NURSE ANESTHETISTS (CRNA) AND CERTIFIED ANESTHESIOLOGIST ASSISTANTS (AA-C)**

These practitioners shall practice only under the supervision of the anesthesiologist. They are members of the medical staff and shall be reappointed in accordance with the hospital bylaws.

D. "QUALIFIED SUPERVISION"

These rules and regulations shall not preclude the administration of anesthesia under "qualified supervision" as part of a training program. The term, "qualified supervision" shall apply only to members of the Attending Staff in the Department of Anesthesiology and such other individuals specifically designated by the chair.

E. GUIDELINES FOR DELINEATION OF CLINICAL PRIVILEGES IN ANESTHESIOLOGY

Anesthesiology is the practice of medicine. Clinical privileges in anesthesiology are granted to physicians who are qualified by training to render patients insensible to pain and to minimize stress during surgical, obstetrical and certain medical procedures using general anesthesia, regional anesthesia or monitored anesthesia care. Performance of preanesthetic, intra-anesthetic and postanesthetic evaluation and management are essential components of the practice of anesthesiology. The granting, reappraisal and revision of clinical privileges are awarded on a time-limited basis in accordance with Medical Staff Bylaws of UNMH and governmental rules and regulations, as applicable.

F. CRITERIA TO BE CONSIDERED FOR DELINEATION OF CLINICAL PRIVILEGES IN ANESTHESIOLOGY

1. Education

- a. Graduation from a medical school accredited by the Liaison Committee on Medical Education (LCME), from an osteopathic medical school or program accredited by the American Osteopathic Association (AOA), or from a foreign medical school that provides medical training acceptable to and verified by the Educational Commission on Foreign Medical Graduates (ECFMG).
- b. Completion of an anesthesiology residency training program approved by the Accreditation Council for Graduate Medical Education (ACGME) or by the AOA.
- c. Permanent certification by the American Board of Anesthesiology (ABA), current recertification within the time interval required by the ABA, or in the Board process.
- d. Current Physician's Recognition Award of the American Medical Association or completion of continuing medical education (CME) as required to maintain a valid New Mexico license to practice medicine. (see Section VI- Education)

2. Licensure

- a. Current, active, unrestricted medical or osteopathic license in New Mexico.
- b. Current, unrestricted DEA registration (schedules II-V) or no history of revocation of DEA registration (schedules II-V) within the past five years.



- c. Disclosure of any disciplinary action (final judgments) against any medical or osteopathic license or by any federal agency, including Medicare/Medicaid, in the last five years.
- 3. Performance Improvement
  - a. Member of an organization that conducts peer review of its members.
  - b. Active participation in an ongoing process that evaluates clinical performance and patient care results of the physician through continuous quality improvement (CQI).
- 4. Personal Qualifications
  - a. Agreement to abide by the ASA “Guidelines for the Ethical Practice of Anesthesiology.”
  - b. Disclosure of any adjudicated violation of ASA “Guidelines for the Ethical Practice of Anesthesiology” or of any adjudicated ethical violation reported by any medical society or medical or osteopathic licensing organization.
  - c. Agreement to abide by the HSC Code of Conduct.  
([http://hospitals.unm.edu/policies\\_and\\_procedures/docs/Administration/General/HSC/CodeofConduct/Organizatioin/Ethics/Policy.pdf](http://hospitals.unm.edu/policies_and_procedures/docs/Administration/General/HSC/CodeofConduct/Organizatioin/Ethics/Policy.pdf))
  - d. Certification in writing that “I am in good health and have no physical or mental limitation, including alcohol or drug use that could impair my ability to render quality patient care.”
  - e. Disclosure of record of felony or fraud conviction.
- 5. Practice Pattern
  - a. Site of practice within UNMH that is currently accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) the Accreditation Association for Ambulatory Health Care (AAAHC), the American Association for the Accreditation of Ambulatory Surgical Facilities (AAAASF) a state licensing or accrediting body, or that complies with the ASA “Guidelines for Ambulatory Anesthesia and Surgery.”
  - b. Medical liability claims experience (based on final judgments), risk-adjusted for frequency and severity with respect to specialty, years in practice and jurisdiction of practice, that is judged acceptable by the institution’s medical staff or peer review group.
  - c. Disclosure of any disciplinary action recorded by the National Practitioner Data Bank (NPDB) within the past five years.
  - d. Scope and quality of clinical skills, as evidenced by ongoing peer review, that are deemed appropriate by UNMH.

**G.PRIVILEGES FOR THE MEDICAL STAFF IN THE DEPARTMENT OF ANESTHESIOLOGY**

The granting, reappraisal and revision of clinical privileges shall be in accordance with Medical Staff Bylaws of UNMH.

**H. ANESTHESIOLOGY SECTION DELINEATION OF PRIVILEGES GUIDELINES FOR DELINEATION OF CLINICAL PRIVILEGES IN ANESTHESIOLOGY**

The granting, reappraisal and revision of clinical privileges shall be in accordance with Medical Staff Bylaws of UNMH.

## I. DEPARTMENT OF ANESTHESIOLOGY DELINATION OF PRIVILEGES

The following guidelines have been adopted for delineation of privileges for members of the Hospital Staff in the Department of Anesthesiology. The Department of Anesthesiology evaluates each applicant's training and previous experience using these guidelines for appointment and reappointment to the Department. These guidelines are subject to revision upon appropriate departmental and Medical Staff approval.

1. Physicians beginning the first year of postgraduate medical training on or after May 1, 1985 or the CA-1 year on or after May 1, 1986 must have satisfactorily completed an ACGME-approved Anesthesiology residency program of at least 4 years duration. A physician will be required to attain certification by the American Board of Anesthesiology or its equivalent within 5 years of satisfactory completion of the clinical Anesthesia (CA) third year.
2. The following procedures are considered intrinsic to the discipline of Anesthesiology and as such should not be considered special procedures:
  - a. Administration of general and regional anesthetics
  - b. Peripheral vascular cannulation
  - c. Pulmonary artery catheter placement\*
  - d. Fiberoptic bronchoscopy\*
  - e. Insertion of arterial lines
  - f. Tracheal intubation
  - g. Respiratory mechanical support
  - h. Acute respiratory care
  - i. Cardio pulmonary resuscitation
  - j. Spinal and epidural narcotic administration
  - i. Use of ultrasound technologies including Echocardiography
3. Emergency Situations:
  - a. All members of the Department of Anesthesiology, in an emergency, shall be authorized to treat any medical or surgical disease or condition and/or perform any medical or surgical procedures dictated by the situation. An emergency, for these purposes, is defined as a situation in which delay in instituting treatment would, in the judgment of the affected physician, result in serious harm to the patient or present an immediate threat to the life of the patient and no other more qualified person is available. Examples of such situations include, but are not limited to:
  - b. Cardio respiratory arrest, hemorrhage, tension pneumothorax. In all other situations, the clinical privileges will be limited to those requested by the candidate and recommended by the departmental committee on delineation of privileges and approved by the Chairman.

## J. DEPARTMENT OF ANESTHESIOLOGY QUALIFICATIONS FOR PRIVILEGES IN CRITICAL CARE MEDICINE

1. The critical care physician should be able to provide clinical, administrative, and educational direction in the Intensive Care Unit. In addition to regularly providing patient care, he/she should be regularly involved in unit management

including formulation and enforcement of unit policies and procedures, and in staff education.

2. The critical care physician must have successfully completed hospital-based training in an ACGME-approved anesthesiology, internal medicine or surgical program. In addition, the physician must have successfully completed at least one year of hospital-based training in Critical Care Medicine. Alternatively, a physician may qualify for privileges by demonstrating a high level of competence and knowledge of critical care medicine through participation in special courses, scholarly activities and equivalent experience.
3. Management of the following are considered intrinsic to critical care medicine: airway management for obstruction, protection, and respiratory failure; ventilatory management, including CPAP, mechanical ventilation, PEEP; treatment of shock/low cardiac output states; management of coma and intracranial hypertension, including hyperventilation and drug therapy; management of complex fluid electrolyte, acid-base, metabolic disturbances; and nutritional support, including parenteral and enteral techniques.
4. The following procedures are considered intrinsic to critical care medicine and as such should not be considered special procedures:
  - a. Insertion of central venous line, percutaneous
  - b. Insertion of arterial line, percutaneous
  - c. Insertion of pulmonary artery catheter
  - d. Diagnostic and therapeutic bronchoscopy
  - e. Endotracheal intubation
  - f. Abdominal paracentesis
  - g. Lumbar puncture
  - h. Insertion of transvenous cardiac pacemaker

#### **K. DEPARTMENT OF ANESTHESIOLOGY RESPONSIBILITIES OF NURSE ANESTHETISTS AND ANESTHESIOLOGY ASSISTANTS (C-AA)**

1. All nurse anesthetists credentialed in Nurse Anesthesia and all C-AA shall agree to abide by the Medical Staff Bylaws, as they apply to other practitioners, specifically nurse anesthetists or C-AA and the Rules and Regulations of UNMH as specified in Section XII of the Medical Staff Rules and Regulations: Non-Physician Medical Staff Members.
2. Nurse anesthetists and C-AA perform their activities as delegated by the supervising anesthesiologist. The experience and training of the nurse anesthetist, the condition of the patient, and the nature of the surgical procedure being performed determine the degree of participation of the supervising anesthesiologists.

#### **L. ANESTHESIOLOGY SERVICE DELINEATION OF PRIVILEGES**

Clinical privileges on the Anesthesiology Service are granted according to principles set forth in the UNM Hospital Medical Staff Bylaws. The Chairman of the Department of Anesthesiology will have the final approval.

#### **M. ANESTHESIOLOGY PRIVILEGES ON OTHER SERVICES**

Anesthesiology privileges are granted to members of the Medical Staff on services other than Anesthesiology according to criteria defined by the Chief of Anesthesiology. The Chief of Anesthesiology delegates the responsibility for granting

privileges for monitoring quality of anesthesia care to the chiefs of each clinical service, but the Chief of Anesthesiology will participate with the representatives of other services that provide anesthesia services in the formulation of mechanisms and material that help to provide uniform quality of anesthesia services throughout the institution.

1. The applicant must possess an M.D., D.O. or D.D.S. degree.
2. Skills will be monitored through informal, periodic observation by members of the Medical Staff who have occasion to observe the Medical Staff members administering the types of anesthesia covered by these privileges. More formal documentation will appear in Quality Assurance evaluations of the Medical Staff member's Service.
3. Capability of the Medical Staff member to manage procedurally related complications will be documented through certification in Basic Life Support CPR and through Quality Assurance evaluations of the Medical Staff member's Service.
4. Only Moderate and Deep Sedation Privileges will be granted to members of the medical staff outside of the Department of Anesthesiology. All general anesthetics will be performed by members of the Department of Anesthesiology.

## **SECTION II- PERFORMANCE IMPROVEMENT AND PEER REVIEW**

### **I. PURPOSE**

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

### **II. SCOPE AND RESPONSIBILITY**

The Department of Anesthesiology is composed of anesthesiologists, CRNAs, AAs (Anesthesiologist Assistants) and anesthesia residents who are responsible for the anesthesia and pain management services provided in the hospital. The hospital includes the Health Sciences Center, the Children's Hospital of New Mexico, the Richardson Pavilion and OSIS (Outpatient Surgery and Imaging Services). The Chair of Anesthesiology is ultimately responsible for all of the activities of the Department. To assure that the care provided is in accordance with recognized standards of practice, the Department of Anesthesiology continues to maintain an ongoing Quality Improvement Program which incorporates concurrent surveillance, objective peer review, and meaningful continuing education. Although the Chair of Anesthesiology is ultimately responsible for assuring that this is carried out effectively, the day-to-day activities of surveillance, peer review, and education are delegated to the Anesthesia Quality Improvement Committee.

### **III. REVIEW METHODOLOGY**

#### **A. ALL ANESTHETIC CARE PROVIDED BY THE DEPARTMENT OF ANESTHESIOLOGY**

Is concurrently monitored. Input into the system may be received from any source including, but not limited to, members of the medical and dental staff, nursing staff, administrative staff, risk management, medical records, and quality improvement and utilization review. This includes the preoperative, intraoperative, and postoperative phases and applies to both inpatients and outpatients on the obstetrical and surgical services. The Department of Anesthesiology maintains a longitudinal Quality Improvement database that includes all patient encounters involving an attending anesthesiologist. It serves to identify the anesthesiologist(s), resident(s) or mid-level provider(s) involved with each case. Data are collected from the Quality Assurance sheet filled in by the anesthesia provider at the conclusion of every case. The data fall into three categories: patient demographics, operative procedures and care providers as well as morbidity and mortality indicators. The database spans over ten years and includes over 148,000 patient encounters. The data are used to generate biannual summary reports and track patient care and provider trends.

1. Sources of data used in departmental QI include the following:
2. Quality Assurance sheets derived from each case
3. Requests for Peer Review generated from Laura Cicarella (Risk Manager, UNMH Quality outcomes Management Department) and/or from any clinician including surgeons, physicians, nurses and midlevel providers

4. Requests for Peer Review generated from the UNMH Trauma Care Coordinator Communications through the UHC-Patient Safety Net
5. Reports of Perioperative Death
6. Other concerned individuals.

**B. REGARDLESS OF THE SOURCE OF THE INCIDENT,**

The peer review process proceeds in the same way. Every reported incident is analyzed by the Quality Assurance Chairman. Data used to analyze each event include some or all of the following:

1. The (self-reporting) QA sheet
2. The Request for Peer Review letter
3. The anesthetic preoperative evaluation
4. The anesthetic record
5. The Post-Anesthetic Care Unit record
6. The medical record, including progress notes and consultations
7. Interviews with health care providers involved with the care of the patient
8. The patient and/or the patient's family

**C. THE DISPOSITION OF EACH INCIDENT INCLUDES ONE OR MORE OF THE FOLLOWING:**

1. Review by the Peer Review Committee. This committee consists of the Quality Assurance Chairman, three attending physicians, the Pediatric Fellow, the Chronic Pain fellow, and two resident anesthesiologists. Cases are reviewed by individual committee members and then reviewed by the committee as a whole at its scheduled meetings. Meetings are called on an *ad hoc* basis.
2. Presentation at Morbidity and Mortality Conference
3. Creation and participation in a Root Cause Analysis in the case of complicated, system-wide problems
4. Presentation at the Departmental QI Update
5. A letter is written to the appropriate source(s)
6. Development of ongoing education initiatives to address care issues
7. Resolution without the need for further follow-up
  - a. The first step of the peer review process is carried out the Quality Assurance Chairman .The first review is made to determine if, in fact, the event was anesthesia-related. No further action is necessary on those deemed to be non-anesthesia related, except possible referral to another service if deemed appropriate.
  - b. Those found to be anesthesia-related undergo in-depth medical record review, and the attending Anesthesiologist is contacted in writing, requesting his/her input in answering questions or providing undocumented information.
  - c. The Quality Assurance Committee at its regular or special meetings reviews all of these cases in-depth. Those found to be acceptable are so noted in both the minutes and related statistics.
  - d. Those cases which are deemed unacceptable undergo further analysis by the Committee, as it begins to apply numerical equivalents to the genesis of the problem and apply outcome scores.

- e. These cases and the Committee's recommendations are then presented at the monthly departmental meetings where they are thoroughly discussed and final decisions rendered. Decisions are communicated to all members of the department via email as needed.
- f. The Chair of Anesthesiology reviews the result of all peer review activity with every faculty member during annual meetings.

#### **IV. RELATIONSHIPS WITH HOSPITAL-WIDE PROGRAMS**

In addition to the comprehensive program described above, the Anesthesia Department also participates in those other medical staff functions that are carried out on a hospital-wide basis. Pertinent information relative to the Anesthesia staff is communicated from these committees to the Chief of Service for information and any follow-up deemed necessary. In addition, the Department actively participates in the hospital's Quality Improvement Program through the Associate Chief's participation on the Medical Subcommittee and the Chair's participation on the Incident Review Subcommittee.

#### **V. REPORTING AND REAPPRAISAL**

Quarterly Monitoring Reports, summarizing the Department's quality improvement activities are submitted to the Quality Improvement Department for approval by the Medical Subcommittee. At least annually, the Quality Improvement Program will be evaluated and revised as necessary. Copies of the most recent plan will be filed with the Anesthesia Department and the Quality Improvement Department.

#### **VI. CORRECTIVE ACTION**

When indicated, a plan of correction will be formulated and implemented. All correction plans will be evaluated for effectiveness using methodology described in Chapter 4.

#### **VII. AUTHORITY**

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

## **SECTION III-DEPARTMENT RESPONSIBILITIES**

### **I. Anesthesia Coverage/Availability**

The Department of Anesthesiology provides complete anesthesia services, including general, spinal, regional, conscious sedation, and pain management. Service is available 24 hours a day, 7 days a week at the main OR, in obstetrics and in the pediatric operating room. The OSIS operates Monday through Friday 6am-6 pm.

### **II. ASA Physical Status Definition**

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

#### **CLASSIFICATION OF PHYSICAL STATUS**

P-1 - A normal healthy patient.

P-2 - A patient with mild systemic disease.

P-3 - A patient with severe systemic disease. P-4 - A patient with severe systemic disease that is a constant threat to life.

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

P-6 - A declared brain-dead patient whose organs are being removed for donor purposes. The Patient requires emergency procedure.

### **III. Emergency Service Coverage**

Adequate and timely availability of anesthesia services when emergent or urgent need for operating room services must be provided. Weekday call coverage begins at 1630. Weekend call coverage begins at 0700. Two anesthesiologists are on restricted call duty (in-house) and immediately available on weekdays and weekends. The pediatric anesthesiologist on-call for the children's OR is to be available within thirty (30) minutes of notification. A SRMC anesthesiologist is available on unrestricted (beeper) call 24/7.

Availability of anesthesiologists is documented on a monthly call schedule, which is posted and available on a daily basis in all operating rooms.



## SECTION IV- INFECTION CONTROL GUIDELINES

### I. PERSONNEL

#### A. CERTAIN BASIC CONSIDERATIONS

Govern good practice behavior of all personnel in the operating room suite. These are outlined in the *Operating Room Policies* and all anesthesia personnel will adhere to same.

#### B. SOME ANESTHETIC PROCEDURES REQUIRE

"Aseptic technique" and the procedures for same is outlined in the *Hospital Policies and Procedures*.

#### C. HAND WASHING AND/OR DECONTAMINATION

With suitable materials by anesthesia personnel, should be done before and after each patient exposure. This shall be in accordance with the hospital policy on "Standard Precautions and Isolation".

[http://hospitals.unm.edu/policies\\_and\\_procedures/index.cfm?fuseaction=policies\\_and\\_procedures.main](http://hospitals.unm.edu/policies_and_procedures/index.cfm?fuseaction=policies_and_procedures.main)

#### D. GOWNING, GLOVES, AND MASK

Are mandatory to wear for insertion of invasive lines.

### II. EQUIPMENT

#### A. EQUIPMENT THAT HAS BECOME "SOILED"

Or potentially contaminated during the procedure (e.g. intubation and suction equipment) should be kept separate from the clean working area of the anesthesia cart or machine.

#### B. IT IS ROUTINE PRACTICE

That the parts of the anesthesia circuit, which come into direct contact with the patient, will be disposable and used only for a single patient.

#### C. SOILED BLOOD PRESSURE CUFFS AND HEAD STRAPS

Should be washed in a detergent and dried. Forceps and laryngoscope blades should be rinsed to remove debris, washed and scrubbed with a brush and a germicide detergent.

#### D. ANESTHESIA MACHINES

Equipment carts and monitors need to be surface cleaned each day by a cloth soaked in a germicide. The horizontal surfaces of the machine and cart should be cleaned between cases.

#### E. KNOWN INFECTIOUS HAZARDS

For patients who present known infectious hazards, the specific Operating Room Policies and Procedures will apply.

### III. RESOURCES AND REFERENCES

The most recent publication of the *ASA's Recommendations for Infection Control for the Practice of Anesthesiology, second edition* should be utilized as a resource

<http://www.asahq.org/publicationsAndServices/infectioncontrol.pdf>

As well as OSHA guidelines referenced in the Federal Register, “Occupational Exposure to Blood Borne Pathogens,” 29 CFR; Part 1910.1030; Vol. 56:235; Dec 1991; p64175-82.

## **SECTION V- SAFETY GUIDELINES**

### **A. Equipment and Facility**

#### **1. ANESTHETIC APPARATUS**

Must be inspected and tested before use. If a leak or other defect is observed, the equipment must not be used until the fault is repaired.

#### **2. ONLY NON-FLAMMABLE AGENTS**

Shall be used for the preoperative preparation of the surgical field, when electrical equipment employing an open spark is to be used during an operation, for example, cautery or coagulation equipment.

#### **3. NON-FLAMMABLE ANESTHETIC AGENTS**

Will be used in all anesthetizing locations.

**4. THE CONDITION OF ALL OPERATING ROOM** Electrical equipment shall be inspected at prescribed intervals and a written report of the results and any required corrective action shall be maintained.

#### **5. ANNUAL CONDUCTIVITY TESTING**

The results of any required annual conductivity testing shall be made known to personnel who work primarily in these areas.

#### **6. ANESTHESIA PERSONNEL**

Shall familiarize themselves with the rate, volume, and mechanism of air exchange within the surgical and obstetrical suites, as well as with humidity control.

#### **7. ALL WASTE GAS**

From the anesthesia machine is disposed by connection to the vacuum system in each operating room.

#### **8. LASER SURGERY**

a. All personnel must wear protective goggles.

b. All patients will wear protective eye coverings.

c. Laser-safe endotracheal tubes will be used when performing head and neck laser procedures for patients receiving a general anesthetic.

9. There shall be readily available to each anesthetizing location, an emergency cart with a defibrillator, emergency drugs and other resuscitation equipment equivalent to that used in the operating room.

### **B. Patient Safety Goals ORYX**

1. Goal 1 - Improve the accuracy of patient identification.

#### **Requirement 1A**

Use at least two patient identifiers when providing care, treatment or services.

At UNMH we use patient name and birth date.

#### **Requirement 1B**

Prior to the start of any invasive procedure, conduct a final verification process, (such as a “time out,”) to confirm the correct patient, procedure and site using active—not passive—communication techniques. The time out should involve the entire procedural team. There should be no barrier to anyone speaking up if there is a concern about a possible error. There should be oral affirmation that the patient, procedure, and site are correct.

2. Goal 2 - Improve the effectiveness of communication among caregivers.

Requirement 2A

For verbal or telephone orders or for telephonic reporting of critical test results, verify the complete order or test result by having the person receiving the order or test result "read-back" the complete order or test result.

Requirement 2B

Adhere to UNMH list of abbreviations, acronyms and symbols that are not to be used throughout the organization

Requirement 2C

Measure, assess and, if appropriate, take action to improve the timeliness of reporting, and the timeliness of receipt by the responsible licensed caregiver, of critical test results and values.

Requirement 2D

Implement a standardized approach to "hand-off" communications, including an opportunity to ask and respond to questions. The primary objective of a "hand off" is to provide accurate information about a patient's care, treatment, and services, current condition and any recent or anticipated changes.

3. Goal 3 - Improve the safety of using medications.

Requirement 3A

1. Standardize the drug concentrations used by the organization.
2. When more than one concentration of a drug is necessary, the number of concentrations is limited to the minimum required to meet patient care needs.

Requirement 3B

Label all medications, medication containers (for example, syringes, medicine cups, basins), or other solutions on and off the sterile field.

Implementation Expectations for Requirement 3B

1. Medications and solutions both on and off the sterile field are labeled even if there is only one medication being used.
2. Labeling occurs when any medication or solution is transferred from the original packaging to another container.
3. Labels include the drug name, strength, amount (if not apparent from the container), expiration date when not used within 24 hours, and expiration time when expiration occurs in less than 24 hours.
4. All labels are verified both verbally and visually by two qualified individuals when the person preparing the medication is not the person administering the medication.
5. No more than one medication or solution is labeled at one time.
6. Any medications or solutions found unlabeled are immediately discarded.
7. All original containers from medications or solutions remain available for reference in the perioperative area until the conclusion of the procedure.
8. All labeled containers on the sterile field are discarded at the conclusion of the procedure.

9. At shift change or break relief, all medications and solutions both on and off the sterile field and their labels are reviewed by entering and exiting personnel.

*Clearly, these implementation expectations could create hardship for anesthesiologists, but the hard work of the ASA resulted in the Standards*

*Interpretation Group saying that this does not apply to medication drawn up and administered by the same caregiver. As a result, an anesthesiologist who draws up and administers an antibiotic or performs a spinal anesthetic, for example, is exempt from the labeling requirement.*

4. Goal 4 - Reduce the risk of health care-associated infections.

Requirement 4A

Comply with current Centers for Disease Control and Prevention (CDC) hand hygiene guidelines.

Requirement 4B

Manage as sentinel events all identified cases of unanticipated death or major permanent loss of function associated with a health care-associated infection.

5. Goal 5 - Accurately and completely reconcile medications across the continuum of care.

Requirement 5A

There is a process for comparing the patient's current medications with those ordered for the patient while under the care of the organization.

Rationale for Requirement 5A

Patients are most at risk during transitions in care (hand offs) across settings, services, providers, or levels of care. The development, reconciliation and communication of an accurate medication list throughout the continuum of care are essential in the reduction of transition-related adverse drug events.

1. The organization, with the patient's involvement, creates a complete list of the patient's current medications at admission/entry.

2. The medications ordered for the patient while under the care of the organization are compared to those on the list and any discrepancies (e.g., omissions, duplications, potential interactions) are resolved.

Requirement 5B

A complete list of the patient's medications is communicated to the next provider of service when a patient is referred or transferred to another setting, service, practitioner or level of care within or outside the organization. The complete list of medications is also provided to the patient on discharge from the facility.

6. Goal 6 - Reduce the risk of patient harm resulting from falls.

Requirement 6A

Implement a fall reduction program including an evaluation of the effectiveness of the program.

Rationale for Requirement 6A

Falls account for a significant portion of injuries in hospitalized patients, long term care residents, and home care recipients. In the context of the population it serves, the services it provides, and its environment of care, the organization should evaluate its patients' risk for falls and take action to reduce the risk of falling and to reduce the risk of injury, should a fall occur. The evaluation could include fall history, medications and alcohol consumption review, gait and balance screening walking aids, assistive technologies and protective devices assessment, and environmental assessments.

7. Goal 7 - Encourage patients' active involvement in their own care as a patient safety strategy.

Requirement 7A

Define and communicate the means for patients and their families to report concerns about safety and encourage them to do so.

Implementation Expectation for Requirement 7A

1. Patients and families are educated on methods available to report concerns related to care, treatment, services and patient safety issues.

2. The organization encourages patients and their families to report concerns about safety.

8. Goal 8 - The organization identifies safety risks inherent in its patient population.

Rationale for Goal 8

Probabilistic risk assessment has been used to assess the designs of high hazard systems such as chemical engineering plants and space initiatives. Probabilistic risk assessment looks at events that contributed to adverse outcomes. Health care has the ability to identify those areas of high risk potential based on previous sentinel events and other data.

*C. Preoperative Evaluation*

1. Review patient medical records for potential risk factors

- Substance use or abuse
- Previous episode of intraoperative awareness
- History of difficult intubation or anticipated difficult intubation
- Chronic pain patients using high doses of opioids
- ASA physical status IV or V
- Limited hemodynamic reserve

2. Interview patient

- Assess level of anxiety
- Obtain information regarding previous experiences with anesthesia

3. Determine other potential risk factors

- Cardiac surgery
- Cesarean delivery
- Trauma surgery
- Emergency surgery
- Reduced anesthetic doses in the presence of paralysis
- Planned use of muscle relaxants during the maintenance phase of general anesthesia
- Planned use of nitrous oxide–opioid anesthesia

4. Patients whom the individual clinician Intraoperative Awareness Guidelines From ASA considers to be at substantially increased risk of intraoperative awareness should be informed of the possibility of intraoperative awareness when circumstances permit

#### *D. Preinduction Phase of Anesthesia*

1. Adhere to a checklist protocol for anesthesia machines and equipment to assure that the desired anesthetic drugs and doses will be delivered
2. Verify the proper functioning of intravenous access, infusion pumps, and their connections, including the presence of appropriate backflow check valves
3. 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)

#### *E. Intraoperative Monitoring*

1. 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.*, electrocardiogram, blood pressure, heart rate, end-tidal anesthetic analyzer, capnography)
    - Brain function monitoring
  - Not routinely indicated for general anesthesia patients
  - The decision to use a brain function monitor should be made on a case-by-case basis by the individual practitioner for selected patients (*e.g.*, light anesthesia)

#### *F. Intraoperative and Postoperative Management*

1. The decision to administer a benzodiazepine intraoperatively after a patient unexpectedly becomes conscious should be made on a case-by-case basis
2. Speak with patients who report recall of intraoperative events to obtain details of the event and to discuss possible reasons for its occurrence
3. A questionnaire or structured interview may be used to obtain a detailed account of the patient's experience
4. Once an episode of intraoperative awareness has been reported, an occurrence report regarding the event should be completed for the purpose of quality management
5. Offer counseling or psychological support to those patients who report an episode of intraoperative awareness

## SECTION VI- EDUCATION

The Department of Anesthesia will participate in continuing education programs for the OR and PACU nursing staff. Each anesthesiologist is responsible for participating in a program of continuing medical education consistent with the ASA “Guidelines for a Minimally Acceptable Program of Any Continuing Education Requirement”. (Approved by House of Delegates on October 4, 1972, and last amended on October 25, 2005)

<http://www.asahq.org/publicationsAndServices/standards/05.pdf>).

Each anesthesiologist is responsible for submitting documentation of fulfillment of CME requirements to the Department Office. Since each member of the Department of Anesthesiology must hold a valid license to practice, he/she must also be in compliance with the New Mexico Medical Board requirements for continuing medical education.

<http://www.nmmb.state.nm.us/continuingmedicaleducation.htm>

## VII. PHYSICIAN CONTINUING MEDICAL EDUCATION

### A. HOURS REQUIRED

1. Seventy-five hours of continuing medical education are required for each licensed physician during each triennial renewal cycle. CME may be earned at any time during the licensee's three year renewal period, July 1 through June 30, immediately preceding the triennial renewal date.

### B. EXCEPTIONS

1. CME is not required until the physician has been licensed in NM for consecutive years. The first license renewal occurs no later than 13 months after initial licensure, so CME is not required at the first renewal.
2. CME is not required for federal emergency, telemedicine, postgraduate training, public service, or temporary teaching, youth camp, or school licenses.
3. Physician assistants fulfill their CME requirements through the NCCPA and are required to submit any CME documentation directly to the Medical Board.
4. A physician practicing or residing outside the United States is not required to fulfill the CME requirements for the period of the absence. However, the Board must be notified of the absence prior to license expiration. Once the physician returns to the US, the required CME must be completed for the months or years of practice within the US during the renewal cycle.

### C. FULFILL YOUR COMPLETE TRIENNIAL CME REQUIREMENT BY OBTAINING:

1. AMA PRA Category 1 Credit™. Clinical courses certified by an accredited sponsor of the *AMA PRA Category 1 Credit™* are acceptable for credit.
2. NM category 1. Clinical courses certified by the New Mexico medical society medical education committee as meeting the criteria for *AMA PRA Category 1 Credit™*, but certified as New Mexico category 1 specific, are acceptable for credit. New Mexico specific CME issued by the Medical Board for service on an Impaired Physician Committee are also acceptable.
3. Post graduate education. Forty (40) credit hours per year are allowed for participation in a postgraduate education program, which has been approved by



the Board or by the AMA liaison committee on graduate medical education. This category includes internships, residencies and fellowships.

4. Advanced degrees. Forty (40) credit hours are allowed for each full academic year of study toward an advanced degree in a medical field or a medically-related field as approved by the board.
5. Self assessment tests. Self-assessment examinations certified for *AMA PRA Category 1 Credit™*, by an accredited sponsor of continuing medical education are acceptable if the examination is scored by an educational entity approved by the board.
6. Teaching. One credit hour is allowed for each hour of teaching medical students or physicians in a United States medical school, an approved internship or residency, or for teaching in other programs approved by the Board, for a maximum of forty (40) credit hours in any three-year reporting period.
7. Physician preceptors. A maximum of thirty (30) hours of credit during a three-year reporting period is acceptable for licensed physicians who are acting as preceptors for students enrolled in an accredited medical or physician assistant school.
8. Papers and publications. Ten (10) hours of credit are allowed for each original scientific medical paper or publication written by a licensee. For acceptance, papers must have been presented to a recognized national, international, regional or state society, or organization whose membership is primarily physicians; or must have been published in a recognized medical or medically-related scientific journal. Material used in a paper or publication may be given credit one time. A maximum of thirty (30) hours credit may be claimed during each three-year reporting period.
9. Cardio-pulmonary resuscitation. Credit may be claimed during each three-year reporting period for successful completion of ACLS (advanced cardiac life support), PALS (pediatric advanced life support), ATLS (advanced trauma life support), NALS (neonatal advanced life support), and ALSO (advanced life support in obstetrics) courses.
10. During each renewal cycle credit will be given for CME that has been obtained using the Internet. Hours obtained online must be approved by the AMA or state equivalent as *AMA PRA Category 1 Credit™*.

#### D. VERIFICATION OF CME AND ANNUAL CME AUDIT

1. Each physician renewing a license shall attest that they have obtained the required hours of CME. Documentation of CME is not required unless you are selected for the annual CME compliance audit. If you are selected for audit, you will be notified and provided with instructions for compliance. The Board may audit CME records at any time, so CME records must be maintained for at least one year following the renewal cycle in which they are earned.
2. *Physicians who attest on their renewal application that they have obtained the required hours of CME but are then unable to provide documentation of those hours face possible disciplinary action by the Board.*

#### E. ACCEPTABLE DOCUMENTATION OF CME INCLUDES:

1. Photocopies of original certificates or official letters from course sponsors or online
2. Postgraduate CME hours must be documented and attested either by the dean of the medical school, the chief of service, the course director, or an equivalent authority.
3. Advanced degree studies must be documented and attested either by the dean of the medical school, the chief of service, the course director, or an equivalent authority.
4. Teaching hours must be documented and attested either by the dean of the medical school, the chief of service, the course director, or an equivalent authority.
5. Preceptor hours must be documented and attested either by the dean of the medical school, the chief of service, the course director, or an equivalent authority.
6. Papers or publications must be documented by submission of an official, printed copy, with reference citation, to the Board.

#### F. EMERGENCY DEFERRAL

1. A physician who is unable to fulfill the CME requirements prior to the date of license expiration may apply to the Board for an emergency deferral of the requirements. The request for deferral must be received no later than July 1 of the renewal year. NOTE: all physicians who are granted an emergency deferral will be automatically included in the CME audit at their next license renewal.
2. In case of illness or other documented circumstances, the Board may grant an additional extension of time in which the necessary credits may be earned. The request must be made in writing prior to the end of the emergency deferral, and must be approved by the Board

#### G. CRNA AND AA CONTINUING MEDICAL EDUCATION

1. Each CRNA or AA is required to maintain the level of continuing medical education required by their respective licensure board. Each practitioner will submit documentation of their CME to the department office.
2. Certified Registered Nurse Anesthetist CME requirements are as follows: ([http://www.bon.state.nm.us/cont\\_ed.php](http://www.bon.state.nm.us/cont_ed.php))
  - a. RNs and LPNs are required to complete 30 hours of approved CE within the 24 months immediately preceding expiration of license. Certification and/or recertification granted by a national professional organization, which uses criteria designed to recognize competence in a specialized area of nursing practice may be used as, approved CE. Certified nurse practitioners and Clinical Nurse Specialist must complete a total of 50 hours of approved CE each renewal. Thirty (30) contact hours shall meet the requirements for licensure as an RN and an additional twenty (20) contact hours, fifteen (15) of which must be pharmacology and five (5) in the area of practice. Certified registered anesthetists must submit a copy of the recertification card issued by AANA Council on Recertification for renewal of the CRNA license.
  - b. AANA National Board on Certification and Recertification of Nurse Anesthetists criteria for recertification require “completion of 40 hours

of approved continuing education within the two-year period prior to the applicant's recertification date".

([http://www.aana.com/Credentialing.aspx?ucNavMenu\\_TSMenuTargetID=116&ucNavMenu\\_TSMenuTargetType=4&ucNavMenu\\_TSMenuID=6&id=150](http://www.aana.com/Credentialing.aspx?ucNavMenu_TSMenuTargetID=116&ucNavMenu_TSMenuTargetType=4&ucNavMenu_TSMenuID=6&id=150))

3 Anesthesia Assistant CME requirements are as follows:

([http://www.nmmb.state.nm.us/pdffiles/Rules/NMAC16.10.19\\_AnesthAsst.pdf](http://www.nmmb.state.nm.us/pdffiles/Rules/NMAC16.10.19_AnesthAsst.pdf))

16.10.19.15 CONTINUING EDUCATION:

- a. Proof of forty hours of continuing education are required for each bi-annual renewal.
- b. Current certification in Advanced Cardiac Life Support is also required for license renewal and the hours spent in refresher courses count as part of the required education hours.
- c. Required continuing education will be prorated during the initial licensing period. Individuals licensed less than one year will require no continuing education for the initial renewal. Individuals licensed more than one year, but less than two years must submit proof of twenty hours of continuing education, including ACLS certification.

[16.10.19.15 NMAC - N, 8/11/01]

## **SECTION VII- CARE OF PATIENTS**

### **A. INFORMED CONSENT**

It is the policy of the University of New Mexico Health Sciences Center that the patient must be given the opportunity to give an “informed consent” prior to the administration of anesthesia by an anesthesiologist and prior to the performance of operative and/or invasive procedure, diagnostic or therapeutic procedures or situations when it is deemed advisable to have formal documentation of the patient’s consent for treatment. Written verification of the informed consent discussion (where appropriate) must be entered on the patient’s chart by the attending anesthesiologist prior to the initiation of anesthesia or any of the above stated procedures. .

### **B. DO-NOT-RESUSCITATE ORDERS**

A patient’s right to accept or refuse medical treatments is fundamental, particularly when faced with a terminal illness. The aim of this policy statement is to preserve and make known this right as it pertains to the patient in the operating room.

These guidelines apply to competent patients and also to incompetent patients who have previously expressed their preferences.

#### **1. GIVEN THE DIVERSITY**

Of published opinions and cultures within our society, an essential element of preoperative preparation and perioperative care for patients with Do-Not Resuscitate (DNR) orders or other directives that limit treatment is communication among involved parties. It is necessary to document relevant aspects of this communication.

#### **2. POLICIES AUTOMATICALLY SUSPENDING DNR**

Orders or other directives that limit treatment prior to procedures involving anesthetic care may not sufficiently address a patient's rights to self determination in a responsible and ethical manner. Such policies, if they exist, should be reviewed and revised, as necessary, to reflect the content of these guidelines.

#### **3. THE ADMINISTRATION OF ANESTHESIA**

Necessarily involves some practices and procedures that might be viewed as "resuscitation" in other settings. Prior to procedures requiring anesthetic care, any existing directives to limit the use of resuscitation procedures (that is, do-not-resuscitate orders and/or advance directives) should, when possible, be reviewed with the patient or designated surrogate. As a result of this review, the status of these directives should be clarified or modified based on the preferences of the patient. One of the three following alternatives may provide for a satisfactory outcome in many cases:

- a. Full Attempt at Resuscitation: The patient or designated surrogate may request the full suspension of existing directives during the anesthetic and immediate postoperative period, thereby consenting to the use of any resuscitation procedures that may be appropriate to treat clinical events that occur during this time.
- b. Limited Attempt at Resuscitation Defined with Regard to Specific Procedures: The patient or designated surrogate may elect to continue to refuse certain specific resuscitation procedures (for example, chest compressions, defibrillation or tracheal intubation). The

anesthesiologist should inform the patient or designated surrogate about which procedures are 1) essential to the success of the anesthesia and the proposed procedure, and 2) which procedures are not essential and may be refused.

- c. Limited Attempt at Resuscitation Defined with Regard to the Patient's Goals and Values: The patient or designated surrogate may allow the anesthesiologist and surgical team to use clinical judgment in determining which resuscitation procedures are appropriate in the context of the situation and the patient's stated goals and values. For example, some patients may want full resuscitation procedures to be used to manage adverse clinical events that are believed to be quickly and easily reversible, but to refrain from treatment for conditions that are likely to result in permanent sequelae, such as neurologic impairment or unwanted dependence upon life sustaining technology.

#### C. ANY CLARIFICATIONS OR MODIFICATIONS

Made to the patient's directive should be documented in the medical record. In cases where the patient or designated surrogate requests that the anesthesiologist use clinical judgment in determining which resuscitation procedures are appropriate, the anesthesiologist should document the discussion with particular attention to the stated goals and values of the patient.

#### D. PLANS FOR POSTOPERATIVE CARE

Should indicate if or when the original, pre-existent directive to limit the use of resuscitation procedures will be reinstated. This occurs when the patient leaves the postanesthesia care unit or when the patient has recovered from the acute effects of anesthesia and surgery. Consideration should be given to whether continuing to provide the patient with a time- limited or event-limited postoperative trial of therapy would help the patient or surrogate better evaluate whether continued therapy would be consistent with the patient's goals.

#### E. IT IS IMPORTANT TO DISCUSS AND DOCUMENT

Whether there are to be any exceptions to the injunction(s) against intervention should there occur a specific recognized complication of the surgery or anesthesia.

#### F. CONCURRENCE

On these issues by the primary physician (if not the surgeon of record), the surgeon and the anesthesiologist is desirable. If possible, these physicians should meet together with the patient (or the patient's legal representative) when these issues are discussed. This duty of the patient's physicians is deemed to be of such importance that it should not be delegated. Other members of the health care team who are (or will be) directly involved with the patient's care during the planned procedure should, if feasible, be included in this process.

#### G. SHOULD CONFLICTS ARISE

The following resolution processes are recommended:

1. When an anesthesiologist finds the patient's or surgeon's limitations of intervention decisions to be irreconcilable with one's own moral views, then the anesthesiologist should withdraw in a nonjudgmental fashion, providing an alternative for care in a timely fashion.

2. When an anesthesiologist finds the patient's or surgeon's limitation of intervention decisions to be in conflict with generally accepted standards of care, ethical practice or institutional policies, then the anesthesiologist should voice such concerns and present the situation to the appropriate institutional body.
3. If these alternatives are not feasible within the time frame necessary to prevent further morbidity or suffering, then in accordance with the American Medical Association's Principles of Medical Ethics, care should proceed with reasonable adherence to the patient's directives, being mindful of the patient's goals and values.

#### H. A REPRESENTATIVE

From the hospital's anesthesiology service should establish a liaison with surgical and nursing services for presentation, discussion and procedural application of these guidelines. Hospital staff should be made aware of the proceedings of these discussions and the motivations for them.

#### I. MODIFICATION OF THESE GUIDELINES

May be appropriate when they conflict with local standards or policies, and in those emergency situations involving incompetent patients whose intentions have previously expressed.

### **VIII. STANDARDS FOR PATIENT CARE**

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

#### A. PRE-OPERATIVE TESTS

1. Preanesthetic laboratory and diagnostic testing is often essential; however, no routine laboratory or diagnostic screening test is necessary for the preanesthetic evaluation of patients. Appropriate indications for ordering tests include the identification of specific clinical indicators or risk factors (e.g. age, pre-existing disease, and magnitude of the surgical procedure). The Department of Anesthesiology has developed appropriate guidelines for preanesthetic screening tests in selected populations after considering the probable contribution of each test to patient outcome. Anesthesiologists will order test(s) when, in their judgment, the results may influence decisions regarding risks and management of the anesthesia and surgery. Relevant abnormalities will be noted and action taken, if appropriate.

#### B. BASIC STANDARDS FOR PREANESTHESIA CARE

1. An anesthesiologist will be responsible for determining the medical status of the patient, developing a plan of anesthesia care, and acquainting the patient or the responsible adult with the proposed plan. The development of an appropriate plan of anesthesia care is based upon:
  - a. Reviewing the medical record.
  - b. Interviewing and examining the patient to:
    - i. Discuss the medical history, previous anesthetic experience and drug therapy.

- ii. Assess those aspects of the physical condition and concurrent health problems that might affect decisions regarding perioperative risk and management.
- c. Obtaining and/or reviewing tests and consultations necessary to the conduct of anesthesia.
- d. Determining the appropriate prescription of preoperative medications as necessary to the conduct of anesthesia.

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

### C. STANDARD FOR BASIC ANESTHETIC MONITORING

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

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

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

- a. **Oxygenation Objective:** To ensure adequate oxygen concentration in the inspired gas and the blood during all anesthetics.
  - i. **Inspired gas:** During every administration of general anesthesia using an anesthesia machine, the concentration of oxygen in the patient breathing system shall be measured by an oxygen analyzer with a low oxygen concentration limit alarm in use.
  - ii. **Blood oxygenation:** During all anesthetics a quantitative method of assessing oxygenation such as pulse oximetry shall be employed. 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 is necessary to assess color.
- b. **Ventilation Objective:** To ensure adequate ventilation of the patient during all anesthetics.
  - i. Every patient receiving general anesthesia shall have the adequacy of ventilation continually evaluated. While qualitative clinical signs such as chest excursion, observation of the reservoir breathing bag and auscultation of breath sounds may be useful, quantitative monitoring of the carbon dioxide content and/or volume of expired gas is strongly encouraged.
  - ii. When an endotracheal tube or laryngeal mask is inserted, its correct positioning must be verified by clinical assessment and by identification of carbon dioxide in the expired gas. Continual end-tidal carbon dioxide analysis, in use from the time of endotracheal tube/laryngeal mask placement, until extubation/removal or initiating transfer to a postoperative care location, shall be performed using a quantitative method such as capnography, capnometry or mass spectroscopy.
  - iii. When ventilation is controlled by a mechanical ventilator, there shall be a continuous use of a device that is capable of detecting disconnection of components of the breathing system. The device must give an audible signal when its alarm threshold is exceeded.
  - iv. During regional anesthesia and monitored anesthesia care, the adequacy of ventilation shall be evaluated, at least, by continual observation of qualitative clinical signs and/or monitoring for the presence of exhaled carbon dioxide.
- c. **Circulation-Objective:** To ensure the adequacy of the patient's circulatory function during all anesthetics.
  - i. Every patient receiving anesthesia shall have the electrocardiogram continuously displayed from the beginning of anesthesia until preparing to leave the anesthetizing location.
  - ii. Every patient receiving anesthesia shall have arterial blood pressure and heart rate determined and evaluated at least every five minutes.



- iii. Every patient receiving general anesthesia shall have, in addition to the above, circulatory function continually evaluated by at least one of the following: palpation of the pulse, auscultation of heart sounds, monitoring of tracing of intra-arterial pressure, ultrasound peripheral pulse monitoring, or pulse or oximetry.
- d. Body temperature Objective: To aid in the maintenance of appropriate body temperature during all anesthetics.
  - i. There shall be readily available a means to continuously measure the patient's temperature. When changes in body temperature are intended, anticipated or suspected, the temperature shall be measured.

#### D. STANDARDS FOR POSTANESTHESIA CARE

These standards apply to postanesthesia care in all locations.

1. Standard I: All patients who received general anesthesia, regional anesthesia, or monitored anesthesia care shall receive appropriate postanesthesia management.
  - a. A Postanesthesia Care Unit (PACU) or an area, which provides equivalent post-anesthesia care, shall be available to receive patients after surgery and anesthesia. All patients who receive anesthesia shall be admitted to the PACU except by specific order of the anesthesiologist responsible for the patient's care.
  - b. The medical aspects of care in the PACU shall be governed by policies and procedures, which have been reviewed and approved by the Department of Anesthesiology.
  - c. The design, equipment and staffing of the PACU shall meet requirements of the facility's accrediting and licensing bodies.
2. Standard II: A patient transported to the PACU shall be accompanied by a member of the Anesthesia Care team who is knowledgeable about the patient's condition. The patient shall be continually evaluated and treated during transport with monitoring and support appropriate to the patient's condition.
3. Standard III: Upon arrival in the PACU, the patient shall be re-evaluated and a verbal report provided to the responsible PACU nurse by the member of the anesthesia care team who accompanied the patient.
  - a. The patient's status on arrival in the PACU shall be documented.
  - b. Information concerning the preoperative condition and the surgical/anesthetic course shall be transmitted to the PACU nurse. The handoff communication will be documented in the PACU nursing flow sheet.
  - c. A 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. Standard IV: The patient's condition shall be evaluated continually in the PACU.
  - a. The patient shall be observed and monitored by methods appropriate to the patient's medical condition. Particular attention will be given to

monitoring oxygenation, ventilation, circulation and temperature. During recovery from all anesthetics, a quantitative method of assessing oxygenation such as pulse oximetry shall be employed in the initial phase of recovery. This is not intended for application during the recovery of the obstetrical patient in whom regional anesthesia was used for labor and vaginal delivery.

- b. An accurate written report of the PACU period shall be maintained. Use of the Modified Aldrete Scoring System shall be used 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.
- d. There shall be a policy to assure the availability in the facility of a physician capable of managing complications and providing cardiopulmonary resuscitation for patients in the PACU.

5. Standard V: A physician is responsible for the discharge of the patient from the postanesthesia care unit.

- a. Discharge criteria shall be used to assess readiness for discharge as approved by the Department of Anesthesiology and the medical staff. They may vary depending upon whether the patient is discharged to a hospital room, to the ICU, to a short stay unit or home.
- b. All patients shall be signed out, from PACU, by a physician on the anesthesiology team after appropriate evaluation.

#### E. DOCUMENTATION OF ANESTHESIA CARE:

It is the policy of this hospital to set legibility standards for medical record documentation and medical error reduction activities. Documentation is a factor in the provision of quality care and is the responsibility of an anesthesiologist. While anesthesia care is a continuum, it is usually viewed as consisting of preanesthesia, perianesthesia and postanesthesia components. Anesthesia care shall be documented to reflect these components and to facilitate review. The record should include documentation of the following:

##### 1. Preanesthesia Evaluation

- a. Patient interview to review:
  - i. Medical history
  - ii. Anesthesia history
  - iii. Medication history
- b. Appropriate physical examination.
- c. Review of objective diagnostic data (e.g., laboratory, ECG, X-ray).
- d. Assignment of ASA physical status.
- e. Formulation and discussion of an anesthesia plan with the patient or the patient's legal representative.

#### F. INTRAOPERATIVE/PROCEDURAL RECORD (TIME-BASED RECORD OF EVENTS).

- 1. Immediate review prior to initiation of anesthetic procedures:
  - a. Patient reevaluation
  - b. Check of equipment, drugs and gas supply

2. Monitoring of the patient (e.g., recording of vital signs)
3. Amounts of all drugs and agents used, and times of administration
4. Type and amounts of all intravenous fluids used, including blood and blood products, and times given
5. Anesthetic technique(s) used
6. Unusual events during the administration of anesthesia
7. Status of the patient at the conclusion of anesthesia
8. Should anesthesia providers change for any reason during the case documentation of an appropriate handoff communication shall occur between the anesthesia providers.

#### G. POSTANESTHESIA

1. Documentation of an appropriate handoff communication shall occur between the anesthesia provider and the PACU RN
2. Patient evaluation on admission and discharge from the postanesthesia care unit
3. Time-based record of vital signs and level of consciousness
4. Time-based record of drugs administered their dosage and route of administration.
5. Type and amounts of intravenous fluids administered, including blood and blood products.
6. Any unusual events including postanesthesia or post procedural complications
7. Postanesthesia visits

#### H. GENERAL CARE

It is expected that all practitioners credentialed through the Dept of Anesthesiology will conform to the hospital policies and guidelines as listed below:

1. Procedural Policy on Procedural Sedation- Conscious-Moderate-  
[http://hospitals.unm.edu/policies\\_and\\_procedures/index.cfm?fuseaction=policies\\_and\\_procedures.main](http://hospitals.unm.edu/policies_and_procedures/index.cfm?fuseaction=policies_and_procedures.main)
2. Procedure Policy on Procedural Sedation-Deep-  
[http://hospitals.unm.edu/policies\\_and\\_procedures/docs/Patient\\_Care/General\\_Patient\\_Care/Procedural\\_Sedation-Deep.pdf](http://hospitals.unm.edu/policies_and_procedures/docs/Patient_Care/General_Patient_Care/Procedural_Sedation-Deep.pdf)
3. Guidelines for Handoff Communication -  
[http://hospitals.unm.edu/policies\\_and\\_procedures/docs/Patient\\_Care/General\\_Patient\\_Care/HandOff\\_Communication.pdf](http://hospitals.unm.edu/policies_and_procedures/docs/Patient_Care/General_Patient_Care/HandOff_Communication.pdf)
4. Guidelines for the avoidance of intraoperative awareness
  - a. Intraoperative Awareness Guidelines  
*Preoperative Evaluation*
    - i. Review patient medical records for potential risk factors
    - ii. Substance use or abuse
    - iii. Previous episode of intraoperative awareness
    - iv. History of difficult intubation or anticipated difficult intubation
    - v. Chronic pain patients using high doses of opioids
    - vi. ASA physical status IV or V
    - vii. Limited hemodynamic reserve
  - b. Interview patient
    - i. Assess level of anxiety

- ii. Obtain information regarding previous experiences with anesthesia
- c. Determine other potential risk factors
  - i. Cardiac surgery
  - ii. Cesarean delivery
  - iii. Trauma surgery
  - iv. Emergency surgery
  - v. Reduced anesthetic doses in the presence of paralysis
  - vi. Planned use of muscle relaxants during the maintenance phase of general anesthesia
  - vii. Planned use of nitrous oxide–opioid anesthesia
- d. Patients whom the individual clinician considers to be at substantially increased risk of intraoperative awareness should be informed of the possibility of intraoperative awareness when circumstances permit
- e. *Preinduction Phase of Anesthesia*
  1. Adhere to a checklist protocol for anesthesia machines and equipment to assure that the desired anesthetic drugs and doses will be delivered
  2. Verify the proper functioning of intravenous access, infusion pumps, and their connections, including the presence of appropriate backflowcheck valves
  3. 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)
- f. *Intraoperative Monitoring*
  1. Use multiple modalities to monitor depth of anesthesia  
Clinical techniques (*i.e.*, checking for purposeful or reflex movement)
  2. Neuromuscular blocking drugs may mask purposeful or reflex movement
- g. Conventional monitoring systems (*e.g.*, electrocardiogram, blood pressure, heart rate, end-tidal anesthetic analyzer, capnography)
- h. Brain function monitoring
  1. Not routinely indicated for general anesthesia patients
  2. The decision to use a brain function monitor should be made on a case-by-case basis by the individual practitioner for selected patients (*e.g.*, light anesthesia)
- i. *Intraoperative and Postoperative Management*
  1. The decision to administer a benzodiazepine intraoperatively after a patient unexpectedly becomes conscious should be made on a case-by-case basis
  2. Speak with patients who report recall of intraoperative events to obtain details of the event and to discuss possible reasons for its occurrence
  3. A questionnaire or structured interview may be used to obtain a

detailed account of the patient's experience

4. Once an episode of intraoperative awareness has been reported, an occurrence report regarding the event should be completed for the purpose of quality management

5. Offer counseling or psychological support to those patients who report an episode of intraoperative awareness

5. Joint Practice Procedure - Epidural Analgesia-

[http://hospitals.unm.edu/policies\\_and\\_procedures/index.cfm?fuseaction=policies\\_and\\_procedures.main](http://hospitals.unm.edu/policies_and_procedures/index.cfm?fuseaction=policies_and_procedures.main)

6. Procedure Policy- Post-Caesarian Neuraxial Opioids Procedure-

[http://hospitals.unm.edu/policies\\_and\\_procedures/docs/Patient\\_Care/Women's\\_Services/Post-Cesarean\\_Neuraxial\\_Opioids\\_Procedure.pdf](http://hospitals.unm.edu/policies_and_procedures/docs/Patient_Care/Women's_Services/Post-Cesarean_Neuraxial_Opioids_Procedure.pdf)

7. Procedure Policy- Controlled Substance OR Satellite Pharmacy Services-

[http://hospitals.unm.edu/policies\\_and\\_procedures/docs/PatientServices/Pharmacy/Controlled\\_Substance\\_OR\\_Satellite\\_Pharmacy\\_Services.pdf](http://hospitals.unm.edu/policies_and_procedures/docs/PatientServices/Pharmacy/Controlled_Substance_OR_Satellite_Pharmacy_Services.pdf)

8. Procedure Policy- Transport of Monitored and/or Mechanically-ventilated Patient-

[http://hospitals.unm.edu/policies\\_and\\_procedures/docs/Patient\\_Care/Adult\\_Critical\\_Care/Transport\\_of\\_Monitored\\_and.or\\_Mechanically\\_Ventilated\\_Patient.pdf](http://hospitals.unm.edu/policies_and_procedures/docs/Patient_Care/Adult_Critical_Care/Transport_of_Monitored_and.or_Mechanically_Ventilated_Patient.pdf)

## **SECTION IX- POSTANESTHESIA CARE UNIT**

### **A. PURPOSE**

The function of the Post anesthesia Care Unit (PACU) is to provide the concentrated and comprehensive care necessary in the immediate post anesthetic period for patients who have had surgical, obstetric, diagnostic or therapeutic procedures. All UNM PACU's ( i.e.- Main OR, Pediatric OR, Labor and Delivery OR, OSIS) will conform to these guidelines.

### **B. ORGANIZATION**

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

#### **1. Medical Supervision**

2. The Chair of the Department of Anesthesia, or Chair's designee, shall assume overall medical responsibility.

3. Individual post anesthetic patient care shall be the responsibility of the anesthesiologist and the physician performing the procedure.

### **C. Nursing Supervision**

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

### **D. ADMISSION CRITERIA**

The anesthesiologist or physician in charge of the PACU shall determine which patients shall be admitted to the PACU. This may include patients who have had general, regional, or local anesthesia. A suggested ratio of recovery room beds to anesthetizing locations is 1.5 recovery beds to every active anesthetizing location.

### **E. DISCHARGE CRITERIA**

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

### **F. POSTANESTHESIA RECOVERY SCORE**

(a variety of scores for assessing patients' readiness for discharge from the PACU are successfully employed. A sample one developed by Aldrete is published herein.)

MODIFIED ALDRETE SCORE

	<b>Activity</b>	<b>Respiration</b>	<b>Circulation</b>	<b>Consciousness</b>	<b>Color</b>
<b>2</b>	Able to move 4 extremities voluntarily or on command	Able to deep breathe and cough freely	Blood pressure varies +/- 20% of preanesthetic level	Fully awake	Pink
<b>1</b>	Able to move 2 extremities voluntarily or on command	Dyspnea or limited breathing	Blood pressure varies +/- 20%-50% of preanesthetic level	Arousable on calling	Pale, dusky, blotchy, jaundiced, other
<b>0</b>	Able to move 0 extremities voluntarily or on command	Apnea	Blood pressure varies +/- 50% of preanesthetic level	Not responding	cyanosis

## SECTION X- STATE CODE SECTION

Regulations specific to Anesthesia Assistant Practice are as follows:

([http://www.nmmb.state.nm.us/pdf/files/Rules/NMAC16.10.19\\_AnesthAsst.pdf](http://www.nmmb.state.nm.us/pdf/files/Rules/NMAC16.10.19_AnesthAsst.pdf))

### TITLE 16 OCCUPATIONAL AND PROFESSIONAL LICENSING

#### CHAPTER 10 MEDICINE AND SURGERY PRACTITIONERS

#### PART 19 QUALIFICATIONS & LICENSURE FOR ANESTHESIOLOGIST ASSISTANTS

**16.10.19.1 ISSUING AGENCY:** New Mexico Medical Board, hereafter called the board.

[16.10.19.1 NMAC - N, 8/11/01; A, 10/5/03]

**16.10.19.2 SCOPE:** This part applies anesthesiologist assistants and their supervising anesthesiologists.

[16.10.19.2 NMAC - N, 8/11/01]

**16.10.19.3 STATUTORY AUTHORITY:** These Rules are promulgated pursuant to and in accordance with the Anesthesiologist Assistants Act, Session Laws of 2001, Ch. 311, Sections 1 through 11.

[16.10.19.3 NMAC - N, 8/11/01]

**16.10.19.4 DURATION:** Permanent.

[16.10.19.4 NMAC - N, 8/11/01]

**16.10.19.5 EFFECTIVE DATE:** 8/11/01, unless a different date is cited at the end of a section.

[16.10.19.5 NMAC - N, 8/11/01]

**16.10.19.6 OBJECTIVE:** This part regulates the licensing and practice of anesthesiologist assistants and their supervision by anesthesiologists.

[16.10.19.6 NMAC - N, 8/11/01]

#### **16.10.19.7 DEFINITIONS:**

**A. “Supervising Anesthesiologist”** means an anesthesiologist currently and actively licensed in the State of New Mexico who meets the requirements of the Act, who will function as the supervisor of the anesthesiologist assistant, and whose application to do so is accepted by the Board.

**B.** [Reserved]

[16.10.19.7 NMAC - N, 8/11/01]

#### **16.10.19.8 QUALIFICATIONS FOR LICENSURE:**

**A.** Completion of a graduate level training program for anesthesiologist assistants accredited by the Committee on Allied Health Education and Accreditation (CAHEA) of the American Medical Association or its successor agency, and

**B.** Successful completion of the certification examination of the National Commission on Certification of Anesthesiologist Assistants (NCCAA).

**C.** Current ACLS certification.

**D.** Be of good moral and professional character.

**E.** Not have had a anesthesiologist assistant registration or license refused, suspended, or revoked by any other state for reasons that relate to the ability to perform skillfully and safely.

[16.10.19.8 NMAC - N, 8/11/01]

**16.10.19.9 LICENSURE PROCESS:** Each applicant for licensure as an anesthesiologist assistant shall submit the required fees as defined in Subsection A of 16.10.9.10 NMAC and following documentation:

**A.** A completed application for which the applicant has supplied all information and correspondence requested by the Board on forms and in a manner acceptable to the Board. Applications are valid for 1 year from the date of receipt.

**B.** Two letters of recommendation from board certified anesthesiologists licensed to practice medicine in the United States who have served as a supervisor of the applicant or Anesthesiologist Assistant Program Directors who have personal knowledge of the applicant’s moral character and competence to practice. Letters of recommendation must be sent directly to the Board from the individual recommending the applicant.

**C.** Verification of licensure in all states where the applicant holds or has held a license to practice as an anesthesiologist assistant, or other health care profession. Verification must be sent directly to the Board from the other state board(s). Verification must include an original seal; attest to current status, issue date, license number, 16.10.19 NMAC 1 and all other related information.

**D.** Applicants may be required to personally appear before the Board or the Board’s designee for an interview and may present original documents, as the Board requires.



E. The initial license is valid until July 1 of the next odd-numbered year.

[16.10.19.9 NMAC - N, 8/11/01]

**16.10.19.10 SUPERVISION REQUIREMENTS:**

A. Pursuant to Session Laws of 2001, Ch. 311, Section 9, an anesthesiologist may not supervise more than three (3) anesthesiologist assistants, except in emergency cases. An anesthesiologist shall not supervise, except in emergency cases, more than four anesthesia providers if at least one is an anesthesiologist assistant.

B. The supervising anesthesiologist shall submit written notice of intent to supervise an anesthesiologist assistant on forms prescribed by the board. These forms must be submitted and approved before the anesthesiologist assistant begins work. Supervising anesthesiologists who are notifying the board of their intent to supervise an anesthesiologist assistant with less than one year of experience will include a plan for providing enhanced supervision during the first year of practice.

C. An anesthesiologist assistant shall only work under the supervision of an anesthesiologist approved by the Board.

D. Failure of the supervising anesthesiologist to comply with the Medical Practice Act and the Rules may result in denial of approval for current or future anesthesiologist assistant supervision.

E. Except in cases of emergency, the supervising anesthesiologist must be present in the operating room during induction of a general or regional anesthetic and during emergence from a general anesthetic, and the presence of the supervising anesthesiologist must be documented in the patient record.

F. The supervising anesthesiologist must be present within the operating suite and immediately available to the operating room when an anesthesiologist assistant is performing anesthesia procedures.

G. The supervising anesthesiologist shall ensure that all activities, functions, services and treatment measures are properly documented in writing and that all anesthesia records are reviewed, countersigned and dated.

[16.10.19.10 NMAC - N, 8/11/01; A, 1/20/03; A, 10/5/03]

**16.10.19.11 TEMPORARY DELEGATION OF SUPERVISION:** For periods of time not to exceed fourteen days a supervising anesthesiologist may delegate supervisory responsibilities to another anesthesiologist who meets the same requirements specified under "Definitions" in the Act and who is familiar with the Rules governing the supervision of an anesthesiologist assistant.

[16.10.19.11 NMAC - N, 8/11/01]

**16.10.19.12 RESPONSIBILITY OF ANESTHESIOLOGIST ASSISTANT:**

A. To identify themselves to patients and others as an anesthesiologist assistant, and to wear a name-tag or other identification when on duty clearly stating that they are an anesthesiologist assistant.

B. Register annually with the Board on or before July 1.

C. Work only when under the supervision of a Board approved anesthesiologist, or as delegated under the provisions of 16.10.19.11 NMAC.

D. Immediately report to the supervising anesthesiologist any unexpected or adverse peri-operative events, or incidents when the prescribed anesthetic deviates from its expected course.

E. Assure that except in cases of emergency, the supervising anesthesiologist is present in the operating room during induction of a general or regional anesthetic and during emergence from a general anesthetic, and the presence of the supervising anesthesiologist is documented in the patient record.

F. Practice within the defined Scope of Authority and all provisions of Session Laws of 2001, Ch. 311, Sections 1 through 11.

[16.10.19.12 NMAC - N, 8/11/01]

**16.10.19.13 LICENSE EXPIRATION AND RENEWAL:**

A. Anesthesiologist assistant licenses expire on July 1 of each odd-numbered year.

B. A completed renewal application, post-marked on or before July 1 of the renewal year, shall include the required fees as defined in Subsection B of 16.10.9.10 NMAC and certification of required continuing education.

C. The Board assumes no responsibility for renewal applications not received by the licensee for any 16.10.19 NMAC 2 reason. It is the licensee's responsibility to make timely request for the renewal application if one has not been received.

D. Renewal applications postmarked or hand-delivered after July 1 will be subject to late penalties as defined in Subsection D of 16.10.9.10 NMAC.

E. Unless a complete renewal application is received by the Board office, or post-marked, by October 1, the license shall be suspended.

[16.10.19.13 NMAC - N, 8/11/01]

**16.10.19.14 INACTIVE STATUS AND REINSTATEMENT:**

**A.** Upon request an anesthesiologist assistant may place the license on inactive status. Licensing or renewal fees already paid to the Board will not be refunded, regardless of the date of the status change. A license placed in inactive status does not require payment of renewal fees.

**B.** An anesthesiologist assistant with a license in inactive status may not practice as an anesthesiologist assistant.

**C.** Re-instatement within two years. An inactive or suspended license may be placed on active status upon completion of a renewal application in which the applicant has supplied all required fees and proof of current competence.

**D.** Re-instatement after two years. An inactive or suspended license may be placed on active status upon completion of a re-instatement application for which the applicant has supplied all required fees, information and correspondence requested by the Board on forms and in a manner acceptable to the Board. Applicants may be required to personally appear before the Board or the Board's designee for an interview.

[16.10.19.14 NMAC - N, 8/11/01]

**16.10.19.15 CONTINUING EDUCATION:**

**A.** Proof of forty hours of continuing education are required for each bi-annual renewal.

**B.** Current certification in Advanced Cardiac Life Support is also required for license renewal and the hours spent in refresher courses count as part of the required education hours.

**C.** Required continuing education will be prorated during the initial licensing period. Individuals licensed less than one year will require no continuing education for the initial renewal. Individuals licensed more than one year, but less than two years must submit proof of twenty hours of continuing education, including ACLS certification.

[16.10.19.15 NMAC - N, 8/11/01]

**16.10.19.16 SEVERABILITY:** If any provision of this rule is determined to be void or illegal by a court of law or other authority, the remainder of