MedStar Georgetown University Hospital

Department of Anesthesia	
Title: PATIENT CARE PROCEDURES	**Policy Number:** 9056
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POLICY:

All patients must have an anesthetic care plan and an immediate preoperative evaluation by a member of the Anesthesia Care Team. Ultimately the attending anesthesiologist assigned to the case must make a final preoperative assessment.

PROCEDURES:

1. Pre-Anesthesia Evaluation

A) The pre-anesthesia evaluation (as well as postoperative evaluations) must be performed by a person qualified to administer anesthesia. It does not need to be the same practitioner who administered the anesthesia.

B) Must be performed whenever general anesthesia, regional anesthesia, monitored anesthesia care, or deep sedation/analgesia is administered.

C) The evaluation or re-evaluation encounter must be completed and documented within 48 hours of induction. Other elements must be performed within 30 days prior to the surgery/procedure. Under no circumstances may these elements be performed more than 30 days prior.

D) The pre-anesthesia evaluation/re-evaluation includes at a minimum:

- Elements that must be performed within 48 hours of induction:
  - Review of medical history (including anesthesia, drug, allergy history)
  - Interview & examination
- Elements which may be performed during or within 30 days:
  - ASA classification of risk
  - Identification of potential anesthesia problems (airway, infection, IV access)
  - Additional pre-anesthesia data or information (stress tests, consultation)
  - Development of anesthesietic plan and discussion of risks

E) The standing preparation for Anesthesia shall include:

- Nothing per mouth in accordance with policy #9055.
- Preoperative medications may be ordered by the Anesthesiologist. Patients will continue to receive antibiotics, anti-seizure medications, chemotherapy, steroids,

antiarrhythmics, anti-hypertensive medications, anti-anginal or cardiac medications. Asthmatic patients will continue all asthma medications.

- An operative permit must be signed by all competent adult patients or the parents/legal guardians for children under 21 years of age, unless patient is an emancipated minor. (See Hospital Policy # 117 for Consents/Procedures).

2. Pre-Anesthesia Care

Pre-anesthesia care will include:

A) Participation in Surgical "Time Out" for patient safety:
- Check, Ensure and Verify patient id with patient's date of birth, medical chart and/or hospital id band.
- Check surgical procedure laterality.
- Check and ensure correct laterality of patient when using blocks. (See department policy #9121).
- Check for blood readiness (both blood type and blood cross match)
- Confirm medication use and the use of any beta blockers.

B) Immediate pre-anesthesia review with emphasis on the following:
- Period of fasting.
- All necessary lab data returned to the chart.
- Premedication administered, if any, and its effect.
- Appraisal of any change in the patient's condition since last seen.
- Immediate pre-induction vital signs.

C) Pre-induction check of equipment for readiness.

D) Monitoring – the monitoring for a surgical patient undergoing anesthesia shall include:
- Observation of respiratory effort, color
- Blood Pressure
- Electrocardiogram (EKG)
- Precordial or esophageal stethoscope
- Oxygen analyzer
- End tidal capnography
- Pulse oximetry
- Temperature
- Additional monitoring that may be used includes:
  - Direct Arterial Pressure
  - Central Venous Pressure
  - Pulmonary Artery Pressure
  - Urine Output
  - Dopplers
  - Neuromuscular blockade monitors
  - Transesophageal Echocardiogram
  - Agent Analyzer
  - Brain Function Monitoring
  - Other Monitoring as requested by surgeon

3. Intraoperative Anesthesia Record

A) An accurate record of the administration of the anesthesia shall be maintained. There must be an Intraoperative anesthesia record for each patient who receives general anesthesia, regional anesthesia, or monitored anesthesia care.

B) Significant data to be recorded include:

- Name and IDX Provider number of each anesthesia provider, both legibly printed and signed.
- Name of operating practitioner
- Date of surgery
- Times:
  - Tourniquet time
  - Induction and conclusion of the anesthetic
  - Surgery start and finish time
  - Periods of controlled hypotension or cardiac arrest
  - Bypass times
  - Occlusion times, e.g. carotid or aortic
- Fluids Given - colloids, crystaloids, blood and blood products
- Fluids Lost – surgical blood loss, drains and sumps, urine output
- Monitoring
- Percutaneous lines
- Drugs/Anesthetics – including dosage and duration
- Vital signs
- Positioning and Protective measures
- Anesthetic technique and equipment used
- Reversal of neuromuscular blockade
- Special anesthetic techniques used e.g., hypotensive, double lumen, fiberoptic, intubations, other air way techniques
- Airway support given
- Pre – induction vital signs
- Patient weight
- Known drug allergies

C) Intraoperative recording may be done by any member of the anesthesia team. The attending anesthesiologist will be ultimately responsible for the accuracy and completeness of the chart and must sign all charts for cases under his or her supervision.

4. Post – Anesthesia Care

A) At the conclusion of an anesthetic, the attending anesthesiologist, nurse anesthetist, anesthesia resident, or student nurse anesthetist will accompany the patient to the recovery area and will remain in attendance as long as necessary until such time as full care can be entrusted to the recovery area personnel or the Intensive Care Unit staff. Any anesthetic problems will require the presence of the resident or attending anesthesiologist in the recovery area or Intensive Care Unit.

B) The PACUs in SDS and GOR are under the supervision of the Department of Anesthesia and the department has final responsibility for discharging patients from the PACUs. Discharge criteria will be used to determine discharge from the Recovery Room, unless orders specify otherwise.

C) The anesthesiologist assigned to a case or another designated Anesthesia Care Team member will provide post-operative care as indicated, including a follow up visit. The purpose of this visit is to improve patient care and to determine the presence or absence of anesthetic related complications. Where complications have been identified, the patient will be followed by the Anesthesia Care Team until the problems are resolved. Follow up of anesthetic related complications requires personal involvement of anesthesiologist. A follow up visit will be recorded on post anesthesia follow up note or the progress note. Anesthesia care team is responsible for reporting anesthetic related complication to the departmental QA/QI team, If complication involve risk management implications, report to hospital risk management team as well.

D) The Post Anesthesia Evaluation –

- Must be completed and documented by an individual qualified to administer anesthesia no later than 48 hours after surgery/procedure (the 48 hour time period begins with arrival to the recovery area) ; however, it needs not to be the same practitioner who administered the anesthetic.

- Must be completed in accordance with state law and with hospital P&Ps approved by the medical staff, and reflect current standards of anesthesia care.

- Should not begin until the patient is sufficiently recovered so as to participate in the evaluation (e.g. answer questions appropriately, perform simple tasks, etc.) It can be completed after the patient is discharged from the hospital, so long as it is completed with 48 hours.

- The elements of an adequate post-anesthesia evaluation include:

    - Respiratory function
    - Cardiovascular function
    - Mental Status
    - Temperature
    - Pain
    - Nausea and vomiting
    - Hydration

- Those patients unable to participate in the post anesthesia evaluation (e.g. sedation, mechanical ventilation) should have a notation made within 48 hours that the patient was unable to participate. The reason for inability to participate should be documented as well as expectations for recovery time.

- Those patients receiving a long-acting regional anesthetic must still have a post anesthesia evaluation completed and documented within 48 hours. The notation should state that the patient is otherwise able to participate, but full recovery from regional anesthesia has not occurred.

5. Obstetrical Anesthesia

All patients should be visited within 24 hours of delivery to determine the presence or absence of post-anesthetic complications.

6. Anesthetizing Locations Outside of the Operating Suite

Special circumstances may require the administration of an anesthetic outside of the conventional operating rooms. In order to conduct an anesthetic in these locations, certain minimal support is necessary:

1. Properly functioning anesthetic machine apparatus or ambu bag capable of delivering positive pressure ventilation with 100% oxygen.
2. All necessary drugs and equipment for establishing an airway.
3. Suction apparatus.
4. Oxygen source.
5. Resuscitation Equipment.

7. Outpatient Anesthesia

Anesthesia services are provided to selected outpatients through the Same Day Surgery Unit of the Operating Rooms. The anesthesia staff is expected to be familiar with the Guidelines governing outpatient anesthetics and adhere to them.

8. Infection Control

All staff under the direction of the Chief of Service will have the responsibility for reducing the incidence of nosocomially-acquired infection. To this end, the department has established procedures for the cleaning and sterilizing of equipment and periodic culture surveillance. In addition, all staff should be familiar with the departmental Guidelines for Reducing Infections and Guidelines for handling Infections or Contaminated Cases.

9. Quality Monitoring and Review

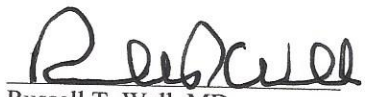
The Department of Anesthesia Quality Monitoring and Review program consists of the following activities:

1. Mortality Review – Automatic review of all intra-operative deaths and post-operative deaths within two days of surgery initially by individual staff members involved in the case. These reports are then reviewed by the Chief of Service and the departmental Director of Quality Improvement for identification of areas for discussion at Staff Meetings. These reports are then further presented at the Georgetown University Hospital Clinical Case Review Committee.

2. QA/QI Conference – One Thursday of every month the department gathers to discuss critical incidence. The review includes presentation of the best method for handling the cases, and discussion of the errors or possible errors that could occur in the care of these patients. Attendance at this meeting is mandatory and includes Attending Staff, Resident Staff, Nurse Anesthetist Staff and Student Nurse Anesthetists.

3. Critical Incident Review – Critical Incident reports are submitted by anesthesia staff and gathered from other sources. These are reviewed by the coordinators for QA/QI and recorded in a computerized database. Unusual cases are brought to the attention of the Chief of Service. Tabular and narrative summaries are generated each month. Copies are sent to the Chief of Service and Associate Medical Directors. Selected cases are chosen for discussion at the M&M conferences.

4. Structure Peer Review – A quality small group consisting of the coordinator of QA/QI, and a junior faculty member. Review of critical incidences to identify those that are preventable. Incidences are then reviewed by the department practice committee to identify remedy and then sent to the Chief of Service for review. Data is recorded to reflect which anesthesia providers were major and minor contributors to human error.



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