CMS Hospital CoP
Anesthesia Guidelines 2018
Speaker

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Author of Book on the CMS Anesthesia Standards

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Cracking the Code
Understanding the CMS Hospital CoP Standards on Anesthesia

AHC Media
You Don’t Want to Receive One of These
Introduction
The Conditions of Participation (CoPs)

- Regulations first published in 1986
  - Many revisions since then
  - First regulations are published in the Federal Register then CMS publishes the Interpretive Guidelines and some have survey procedures
  - Hospitals should check this website once a month for changes

How to Keep Up with Changes

- First, periodically check to see you have the most current CoP manual and sign up to get the Federal Register
- Once a month go out and check the survey and certification website
- Once a month check the CMS transmittal page and see if new manual
- Have one or two person in your facility who has this responsibility

2 http://www.cms.gov/SurveyCertificationGenInfo/PMSR/list.asp#TopOfPage
3 http://www.cms.gov/Transmittals
Also Called the State Operation Manual

State Operations Manual
Appendix A - Survey Protocol, Regulations and Interpretive Guidelines for Hospitals

Table of Contents
(Rev. 172, 11-17-17)

Transmittals for Appendix A

Survey Protocol

Introduction

Task 1 - Off-Site Survey Preparation
Task 2 - Entrance Activities
Task 3 - Information Gathering/Investigation
Task 4 - Preliminary Decision Making and Analysis of Findings
Task 5 - Exit Conference
Task 6 - Post-Survey Activities

Psychiatric Hospital Survey Module
Psychiatric Unit Survey Module
Rehabilitation Hospital Survey Module

Email questions
hospitalscg@cms.hhs.gov

Policy & Memos to States and Regions

CMS Survey and Certification memoranda, guidance, clarifications and instructions to State Survey Agencies and CMS Regional Offices.

Select From The Following Options:
- Show all items
- Show only (select one or more options):
  - Show only items whose [ ] is within the past [ ]
  - Show only items whose Fiscal Year is [ ]
  - Show only items containing the following word [ ]

Show Items

There are 455 items in this list.
### Policy & Memos to States and Regions

CMS Survey and Certification memoranda, guidance, clarifications and instructions to State Survey Agencies and CMS Regional Offices.

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<tr>
<th>Title</th>
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<tr>
<td><strong>Implementation Issues, Long-Term Care Regulatory Changes:</strong> Substandard Quality of Care (SQC) and Clarification of Notice before Transfer or Discharge Requirements</td>
<td>17-27-NH</td>
<td>2017-05-12</td>
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<td>2017-05-12</td>
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<td><strong>Notice of Proposed Regulation Changes to Requirements Related to Survey Team Composition and Investigation of Complaints</strong></td>
<td>17-26-NH</td>
<td>2017-04-28</td>
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<td><strong>Electronic Staffing Submission - Payroll-Based Journal Update</strong></td>
<td>17-25-NH</td>
<td>2017-04-21</td>
<td>2017</td>
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<td><strong>Notice of Proposed Regulation Changes for Accrediting Organizations (AOs) Transparency and Termination Notices</strong></td>
<td>17-24-ALL</td>
<td>2017-04-14</td>
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Email questions to CMS at hospitalscg@cms.hhs.gov

Each Appendix is a separate file that can be accessed directly from the SOM Appendices Table of Contents, as applicable.

The appendices are in PDF format, which is the format generally used in the IOM to display files. Click on the red button in the "Download" column to see any available file in PDF.

To return to this page after opening a PDF file on your desktop, use the browser "back" button. This is because closing the file usually will also close most browsers.

CMS Hospital CoP Manuals address
CMS Transmittals

www.cms.gov/Transmittals/01_overview.asp
CMS Infection Control
Worksheet
Safe Injection Practices
CMS Hospital Worksheets History

- First, October 14, 2011 CMS issues 3 worksheets
- Infection Control Worksheet has a section on safe injection practices
- Addresses discharge planning, infection control, and QAPI (performance improvement)
  - Had three revisions
  - Final ones issued November 26, 2014
- Draft 2017 infection control worksheet for 40 hospitals in pilot program and will amend discharge planning and IC when proposed changes are final
DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

Center for Clinical Standards and Quality/Survey & Certification Group

DATE: November 26, 2014
TO: State Survey Agency Directors
FROM: Director Survey and Certification Group
SUBJECT: Public Release of Three Hospital Surveyor Worksheets

Memorandum Summary

- **Three Hospital Surveyor Worksheets Finalized:** The Centers for Medicare & Medicaid Services (CMS) has finalized surveyor worksheets for assessing compliance with three Medicare hospital Conditions of Participation (CoPs): Quality Assessment and Performance Improvement (QAPI), Infection Control, and Discharge Planning. The worksheets are used by State and Federal surveyors on all survey activity in hospitals when assessing compliance with any of these three CoPs.

- **Final Worksheets Made Public:** Via this memorandum we are making the worksheets publicly available. The hospital industry is encouraged, but not required, to use the worksheets as part of their self-assessment tools to promote quality and patient safety.

www.cms.gov/SurveyCertificationGenInfo/PMSR/list.asp#TopOfPage
Date: November 18, 2016

To: State Survey Agency Directors

From: Director
Survey and Certification Group

Subject: Infection Control Pilot: 2017 Update

Memorandum Summary

- Project Overview: The Centers for Medicare & Medicaid Services (CMS) is in the second year of a three year pilot project to improve assessment of infection control and prevention regulations in Long Term Care (LTC) facilities, hospitals, and during transitions of care. All surveys during the pilot will be educational surveys (no citations will be issued) and will be conducted by a national contractor.

- Second Year Activities: Using draft surveyor Infection Control Worksheets (ICWS) based on the new Long Term Care regulation as well as a revised hospital surveyor ICWS, 40 hospital surveys will be paired with surveys of LTC facilities, in order to provide an opportunity to assess infection prevention during transitions of care. In addition, CMS will pilot technical assistance opportunities for facilities in efforts to improve infection prevention and control.
CMS Infection Control Pilot

- The survey memo is 64 pages long
- All surveys during the pilot will be educational
- No citations will be issued
- These are being conducted by a national contractor and not CMS surveyors
- As mentioned, 40 hospital surveys will be paired with surveys of LTC
- This is being done to assess infection prevention during the transition of care
CMS Hospital Worksheets

- Also has a section on surgery and MDRO
- And of course completing the forms helps the hospital to comply with those three CoPs
- Citation instructions are provided on each of the worksheets
- The surveyors will follow standard procedures when non-compliance is identified in hospitals
- Not used in CAH but good tool for CAH to use
- Questions to: hospitalscg@cms.hhs.gov
CMS Hospital Worksheets

- However, some of the questions asked might not be apparent from a reading of the CoPs
  - A worksheet is a good communication device
  - Has a section on **safe injection practices** which is very important and all staff should be aware
  - Anesthesia can **not** give **single dose medications** to more than one person unless prepared in pharmacy
  - Cannot take multidose vials into the OR unless P&P and treat as single dose and dispose of at end of case
  - Hospitals should consider attaching the documentation and P&P to the worksheet
# Section 2. B Injection Practices and Sharps Safety (Medications, Saline, Other Infusates)

<table>
<thead>
<tr>
<th>Elements to be assessed</th>
<th>Manner of Assessment Code (check all that apply) &amp; Surveyor Notes</th>
<th>Manner of Assessment Code (check all that apply) &amp; Surveyor Notes</th>
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</thead>
<tbody>
<tr>
<td>Injections are given and sharps safety is managed in a manner consistent with hospital infection control policies and procedures to maximize the prevention of infection and communicable disease including the following:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. B.1 Injections are prepared using aseptic technique in an area that has been cleaned and free of visible blood, body fluids, or contaminated equipment.</td>
<td>□ Yes 1 □ No 2 □ N/A 3 □ N/A 4 □ N/A 5</td>
<td>□ Yes 1 □ No 2 □ N/A 3 □ N/A 4 □ N/A 5</td>
</tr>
<tr>
<td>2. B.2 Needles are used for only one patient.</td>
<td>□ Yes 1 □ No 2 □ N/A 3 □ N/A 4 □ N/A 5</td>
<td>□ Yes 1 □ No 2 □ N/A 3 □ N/A 4 □ N/A 5</td>
</tr>
<tr>
<td>2. B.3 Syringes are used for only one patient (this includes manufactured prefilled syringes and insulin pens).</td>
<td>□ Yes 1 □ No 2 □ N/A 3 □ N/A 4 □ N/A 5</td>
<td>□ Yes 1 □ No 2 □ N/A 3 □ N/A 4 □ N/A 5</td>
</tr>
</tbody>
</table>

Interview = 1  Observation = 2  Infection Control Document Review = 3  Medical Record Review = 4  Other Document Review = 5
Injections prepared using aseptic technique in area cleaned and free of blood and bodily fluids

Is rubber septum disinfected with alcohol before piercing?

Are single dose vials, IV bags, IV tubing and connectors used on only one patient?

Are multidose vials dated when opened and discarded in 28 days unless shorter time by manufacturer?

Make sure expiration date is clear as per P&P

If multidose vial found in patient care area must be used on only one patient
Safe Injection Practices Patient Safety Brief

By: Sue Dill Calloway RN MSN JD CPHRM
    Ruth Carrico PhD RN FSHEA CIC

July 2012

The Centers for Disease Control and Prevention (CDC) says there are 1.7 million healthcare-associated infections in the US every year. Of these, it is estimated that about 99,000 deaths occur as a result. Infection prevention...
Safe Injection Practices in the Emergency Department

Written by Sue Dill Calloway RN MSN JD

Safe injection practices should be on the radar screen of all urgent care and emergency department physicians, midlevels and nursing staff. There is an increased focus on safe injection practices by regulators such as the Center for Medicare and Medicaid Services (CMS) in the hospital Conditions of Participations (CoPs) and accreditation organizations like the Joint Commission, DNV Healthcare, the Healthcare Facilities Accreditation Program (HFAP), and the Center for Improvement in Healthcare Quality (CIHQ). The recommendations have come from documents that are discussed in this brief and cited at the bottom of the article. It is recommended that this EPIX Patient Safety Brief be shared...
Injection Practices & Sharps Safety

- Are all sharps disposed of in resistant sharps container?
- Are sharp containers replaced when fill line is reached?
  - Are sharps disposed of in accordance with state medical waste rules
  - Hospitals should have a system in place where someone has the responsibility to check these and ensure they are replaced when they are full
Unsafe Injection Practices and Disease Transmission

Reuse of syringes combined with the use of single-dose vials for multiple patients undergoing anesthesia can transmit infectious diseases. The syringe does not have to be used on multiple patients for this to occur.

1. A clean syringe and needle are used to draw the sedative from a new vial.
2. It is then administered to a patient who has been previously infected with hepatitis C virus (HCV). Backflow into the syringe contaminates the syringe with HCV.
3. The needle is replaced, but the syringe is reused to draw additional sedative from the same vial for the same patient, contaminating the vial with HCV.
4. A clean needle and syringe are used for a second patient, but the contaminated vial is reused. Subsequent patients are now at risk for infection.

Source: www.southernnevadahealthdistrict.org
Not All Vials Are Created Equal

SINGLE-DOSE OR MULTI-DOSE?

NOT ALL VIALS ARE CREATED EQUAL.
Dozens of recent outbreaks have been associated with reuse of single-dose vials and misuse of multiple-dose vials. As a result of these incidents, patients have suffered significant harms, including death. CDC and the One & Only Campaign urge healthcare providers to recognize the differences between single-dose and multiple-dose vials and to understand appropriate use of each container type.

This information can literally save a life.

ONE NEEDLE, ONE SRINGE, ONLY ONE TIME.
Safe Injection Practices Coalition, www.ONEandONLYcampaign.org

ONEANDONLYCAMPAIGN.ORG
DO YOU PROVIDE TREATMENT FOR PATIENTS WITH CANCER?

PROTECT YOUR PATIENTS, YOURSELF, AND YOUR BUSINESS

Since 2002, at least nine serious infectious disease outbreaks have occurred in cancer clinics. These outbreaks involved unsafe injection practices, including the reuse of syringes. As a result, hundreds of patients became infected and thousands more required notification and testing for bloodborne pathogens.

REMEMBER! WHEN PREPARING MEDICATIONS AND INJECTIONS...

NEVER reuse these items:

- Needles or syringes that have been used for any purpose
- Vials with “single-dose vial” printed on the label
- Saline bags
- Intravenous tubing

ALWAYS follow aseptic technique* when:

- Preparing any medication
- Disinfecting a vial's septum
- Accessing a central line
- Injecting any medications

*Aseptic technique is used by healthcare workers to prevent the contamination of clean areas, equipment, and sterile medications. This will help prevent the spread of infection. Please refer to CDC’s Basic Infection Control and Prevention Plan for Outpatient Oncology Settings for more information.

LEARN MORE ABOUT WAYS YOU CAN KEEP YOUR PATIENTS
CMS Survey Memos on Safe Injection Practices
CMS publishes 4 page memo on infection control breaches and when they warrant referral to the public health authorities

This includes a finding by the state agency (SA), like the Department of Health, or an accreditation organization

- TJC, DNV Healthcare, CIHQ, or AOA HFAP

CMS has a list and any breaches should be referred

Referral is to the state authority such as the state epidemiologist or State HAI Prevention Coordinator
Infection Control Breaches

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland  21244-1850

Center for Clinical Standards and Quality/Survey & Certification Group

DATE:      May 30, 2014
TO:        State Survey Agency Directors
FROM:      Director
           Survey and Certification Group
SUBJECT:   Infection Control Breaches Which Warrant Referral to Public Health Authorities

Memorandum Summary

- **Infection Control Breaches Warranting Referral to Public Health Authorities**: If State Survey Agencies (SAs) or Accrediting Organizations (AOs) identify any of the breaches of generally accepted infection control standards listed in this memorandum, they should refer them to appropriate State authorities for public health assessment and management.

- **Identification of Public Health Contact**: SAs should consult with their State’s Healthcare Associated Infections (HAI) Prevention Coordinator or State Epidemiologist on the preferred referral process. Since AOs operate in multiple States, they do not have to confer with State public health officials to set up referral processes, but are expected to refer identified breaches to the appropriate State public health contact identified at: [http://www.cdc.gov/HAI/state-based/index.html](http://www.cdc.gov/HAI/state-based/index.html)
CMS Memo Infection Control Breaches

- Using the same (pre-filled/manufactured/insulin or any other) syringe, pen or injection device for more than one individual

- Re-using a needle or syringe which has already been used to administer medication to an individual to subsequently enter a medication container (e.g., vial, bag), and then using contents from that medication container for another individual

- Using the same lancing/fingerstick device for more than one individual, even if the lancet is changed

- Using the same needle for more than one individual;
CMS Memo on Safe Injection Practices

- CMS issues a 7 page memo on safe injection practices
- Discusses the safe use of single dose medication to prevent healthcare associated infections (HAI)
- Notes new exception which is important especially in medications shortages
- General rule is that single dose vial (SDV) can only be used on one patient unless pharmacy prepares
  - Will allow SDV to be used on multiple patients if prepared by pharmacist under laminar hood following USP 797 guidelines
Single Dose Safe Injection Practices

Office of Clinical Standards and Quality/Survey & Certification Group

DATE: June 15, 2012
TO: State Survey Agency Directors
FROM: Director Survey and Certification Group
SUBJECT: Safe Use of Single Dose/Single Use Medications to Prevent Healthcare-associated Infections

Memorandum Summary

- Under certain conditions, it is permissible to repack single-dose vials or single use vials (collectively referred to in this memorandum as “SDV’s”) into smaller doses, each intended for a single patient. The United States Pharmacopeia (USP) has established standards for compounding which, to the extent such practices are also subject to regulation by the Food and Drug Administration (FDA), may also be recognized and enforced under §§501 and 502 of the Federal Food, Drug and Cosmetics Act (FDCA). These USP compounding standards include USP General Chapter 797, Pharmaceutical Compounding - Sterile Preparations (“USP 797-”). Under USP 797- , healthcare facilities may repack SDV’s into smaller doses, each intended for use with one patient. Among other things, these standards currently require that:
  - The facility doing the repackaging must use qualified, trained personnel to do so, under International Organization for Standardization (ISO) Class 5 air quality conditions within an ISO Class 7 buffer area. All entries into a SDV for purposes of repackaging under these conditions must be completed within 6 hours of the initial needle puncture.
  - All repackaged doses prepared under these conditions must be assigned and labeled with a beyond use date (BUD), based on an appropriate determination of contamination risk level in accordance with USP 797-, by the licensed healthcare professional supervising the repackaging process.
  - Administering doses from one SDV to multiple patients without adhering to USP 797-
CMS Memo on Safe Injection Practices

- All entries into a SDV for purposes of repackaging must be completed with 6 hours of the initial puncture in pharmacy following USP guidelines

- Only exception is when SDV can be used on multiple patients where pharmacy prepares

- Otherwise using a single dose vial on multiple patients is a violation of CDC standards

- CMS will cite hospital under the hospital CoP infection control standards since must provide sanitary environment
  - Also includes ASCs, hospice, LTC, home health, CAH, dialysis, etc.
CMS Memo on Safe Injection Practices

- Bottom line is you can not use a single dose vial on multiple patients
- CMS requires hospitals to follow nationally recognized standards of care like the CDC guidelines which has 10 practices
- SDV typically lack an antimicrobial preservative
- Once the vial is entered the contents can support the growth of microorganisms
- The vials must have a beyond use date (BUD) and storage conditions on the label
So if make it in a single dose vial then you need to buy it in a single dose vial

- If they only make it in a multi-dose vial then try and use it as a single dose vial
- If not then try and use it only on one patient

Do not take multi-dose vial into patient room or into OR

- Unless in OR you treat it as a single dose vial and discard
- Mark multi-dose vial expires in 28 days unless sooner by manufacturer
- Clean off lid even if new vial for 10-15 seconds and let dry or as per manufacturer instructions (new one is 5 seconds)
ISMP IV Push Guidelines
ISMP IV Push Medications Guidelines

- ISMP has published a 26 page document called “ISMP Safe Practice Guidelines for Adult IV Push Medications at www.ismp.org

- The document is organized into factors that increase the risk of IV push medications in adults,
  - Current practices with IV injectible medications
  - Developing consensus guidelines for adult IV push medication and
  - Safe practice guidelines
  - About 90% of all hospitalized patients have some form of infusion therapy
Remember; CMS says you have to follow standards of care and specifically mentions the ISMP so surveyor can cite you if you do not follow this.
IV Push Medications Guidelines

- Provide IV push medications in a ready to administer form
- Use only commercially available or pharmacy prepared prefilled syringes of IV solutions to flush and lock vascular access devices
- If available in a single dose vial then need to buy in single dose vial
- Aseptic technique should be used when preparing and administering IV medication
  - This includes hand hygiene before and after administration
The diaphragm on the vial should be disinfected even if newly opened

- The top should be cleaned using friction and a sterile 70% isopropyl alcohol, ethyl alcohol, iodophor, or other approved antiseptic swab for at least ten seconds to it dry

- Medication from glass ampules should be used with a filter needle unless the specific drug precludes this

- Medication should only be diluted when recommended by the manufacturer or in accordance with evidence based practice or approved hospital policies
IV Push Medications Guidelines

- If IV push medication needs to be diluted or reconstituted these should be performed in a clean, uncluttered, and separate location.

- Medication should not be withdrawn from a commercially available, cartridge type syringe into another syringe for administration.

- It is also important that medication not be drawn up into the commercially prepared and prefilled 0.9% saline flushes.
  - This are to flush an IV line and are not approved to use to dilute medication.
3.6 Do NOT dilute or reconstitute IV push medications by drawing up the contents into a commercially-available, prefilled flush syringe of 0.9% sodium chloride.

**Discussion:** Commercially available prefilled syringes of saline and heparin are regulated by the US Food and Drug Administration as *devices*, not as medications. These devices have been approved for the flushing of vascular access devices, but have NOT been approved for the reconstitution, dilution, and/or subsequent administration of IV push medications. Such use would be considered “off label” and not how manufacturers intended these products to be used, nor have prefilled flush syringes been tested for product safety when used in this manner.

Warnings intended to limit the use of prefilled syringes for medication preparation and administration appear on some syringe barrels, clearly stating “IV flush only.” Some manufacturers have also limited or removed the gradation markings on the prefilled flush syringes in order to prevent measurement of a secondary medication in the flush syringe. When prefilled syringes are used in an off-label manner, the practitioner and employer bear the legal liability for any adverse events occurring from this practice.¹³¹

The mislabeling that occurs when medications are added to a prefilled syringe and a secondary label is not applied creates significant risk for errors. In many cases, the manufacturer’s label is permanently affixed to the syringe barrel and contains product codes and a barcode as well as specific information about the fluid and its volume. When another medication is added to this syringe, there is no adequate method to amend the manufacturer’s label, without covering the current information.¹³¹ Thus, the syringe frequently remains labeled as 0.9% sodium chloride, when it also contains the diluted or reconstituted medication.

Although this unsafe practice is widespread, and many who use it mistakenly believe the risk of an error is insignificant—a belief clearly reinforced during public comment regarding this guidance statement—summit participants arrived at a consensus that the practice must be eliminated.

3.7 When necessary to prepare more than one medication in a single syringe for IV push administration,
IV Push Medications Guidelines

- Combination of more than one medication is a single syringe is seldom necessary and could result in unwanted changes in the medication.
- Never use IV solution or mini bags as a common source to flush an IV as to dilute for more than one patient.
- Label syringes of IVP medication unless prepared and immediately given with no break.
- Administer IV push medication at rate recommended by manufacturer or supported by evidenced based practices and often given too fast.
TJC Speak Up Poster
Anesthesia & Sedation
TJC Speak Up Poster Anesthesia & Sedation

www.jointcommission.org/assets/1/6/Speak_Up_Anesthesia_infographic_final.pdf
Local produces a loss of feeling to a small, specific area of the body. A shot is given to numb the area.

Tell your doctor or anesthesia professional about:
- General health issues and any recent changes
- Allergies to medicines, foods, latex, rubber or any other things
- Medical problems, such as high blood pressure, heart disease, diabetes, kidney or liver disease, asthma, acid reflux and sleep apnea
- Recent hospital admissions, surgeries or procedures
- Experience with anesthesia, especially any problems
- Any family history of anesthesia problems
- Any hearing or language concerns
- If you are or could be pregnant
- All drugs you are taking, including prescriptions, supplements, herbs and over-the-counter drugs
- Questions or concerns

Before surgery or a procedure:
- Ask a friend or relative to be your advocate. They can help remember questions, write down answers, and remind you about directions.
- Arrange to take off work and other activities.
- Have someone care for your small children.
- An anesthesia professional will talk to you. This could be a physician anesthesiologist, a nurse anesthetist or an anesthesiologist assistant.
- Ask the anesthesia professional about the benefits and risks of anesthesia.
- Follow instructions for eating, drinking and taking medicines, especially instructions for when not to eat or drink.

Don’t:
- Drive a car, operate equipment or drink alcohol for at least 24 hours
- Make any important decisions or sign any legal documents until you recover
- Go back to your regular activities, such as work and exercise, until your doctor says it’s OK

After surgery or a procedure:
You may feel sleepy. The drugs can stay in your body for up to 24 hours. Remember, it is important to follow the instructions provided after the procedure.

Do:
- Speak up if you have any questions
- Ask for written instructions. Know what signs should cause you to call the doctor.
- Ask how to contact someone in an emergency
- Ask what medicines you should or should not take
- Have a friend or family member take you home
- Take liquids first and slowly progress to a light meal
- Take it easy until you feel back to normal
CMS Anesthesia Deficiency Data
Access to Hospital Complaint Data

- CMS issued Survey and Certification memo on March 22, 2013 regarding access to hospital complaint data
- Includes acute care and CAH hospitals
  - Does not include the plan of correction but can request
  - Questions to bettercare@cms.hhs.com
- This is the CMS 2567 deficiency data and lists the tag numbers
- Updating quarterly
  - Available under downloads on the hospital website at www.cms.gov
Hospitals

This page provides basic information about being certified as a Medicare and/or Medicaid hospital provider and includes links to applicable laws, regulations, and compliance information.

A hospital is an institution primarily engaged in providing, by or under the supervision of physicians, inpatient diagnostic and therapeutic services or rehabilitation services. Critical access hospitals are certified under separate standards. Psychiatric hospitals are subject to additional regulations beyond basic hospital conditions of participation. The State Survey Agency evaluates and certifies each participating hospital as a whole for compliance with the Medicare requirements and certifies it as a single provider institution.

Under the Medicare provider-based rules it is possible for ‘one’ hospital to have multiple inpatient campuses and outpatient locations. It is not permissible to certify only part of a participating hospital. Psychiatric hospitals that participate in Medicare as a Distinct Part Psychiatric hospital are not required to participate in their entirety.

However, the following are not considered parts of the hospital and are not to be included in the evaluation of the hospital’s compliance:

- Components appropriately certified as other kinds of providers or suppliers, i.e., a distinct part Skilled Nursing Facility and/or distinct part Nursing Facility, Home Health Agency, Rural Health Clinic, or Hospice; Excluded residential, custodial, and non-service units not meeting certain definitions in the Social Security Act; and,
- Physician offices located in space owned by the hospital but not functioning as hospital outpatient services departments

Accredited Hospitals - A hospital accredited by a CMS-approved accreditation program may substitute accreditation under that program for survey by the State Survey Agency. Surveyors assess the hospital’s compliance with the Medicare Conditions of Participation (CoP) for all services, areas and locations covered by the hospital’s provider agreement under its CMS Certification Number (CCN).

Although the survey generally occurs during daytime working hours (Monday through Friday), surveyors may conduct
# Anesthesia Deficiencies

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<th>Section</th>
<th>Tag Number</th>
<th>Oct 4, 2017</th>
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<td>23</td>
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<tr>
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<td>4</td>
</tr>
<tr>
<td>Delivery Anesthesia Services</td>
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<td>Intra-Operative Record</td>
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<td>12</td>
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<tr>
<td>Post Anesthesia Evaluation</td>
<td>1005</td>
<td>35</td>
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**Total**: 111
CMS Anesthesia Regulations and Interpretive Guidelines
CMS Manual and Anesthesia Changes

- All the manuals are now located at

- There were four anesthesia revisions over a 2 year period of time
  - CAH standards are different and at the end

- Three were published in survey and certification website and one in a transmittal
  - December 11, 2009
  - February 5, 2010
  - May 21, 2010 (transmittal) and
  - February 14, 2011
Location of CMS Hospital CoP Manual

Medicare State Operations Manual
Appendix

- Each Appendix is a separate file that can be accessed directly from the SOM Appendices Table of Contents, as applicable.

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CMS CoP Manuals are now located at www.cms.hhs.gov/manuals/downloads/som107_Appendixtoc.pdf

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</table>
First and Second of Four Anesthesia Changes

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-12-25
Baltimore, Maryland 21244-1850

Center for Medicaid and State Operations/Survey and Certification Group

Date: December 11, 2009
To: State Survey Agency Directors
From: Director
Survey and Certification Group

Subject: Revised Hospital Anesthesia Services Interpretive Guidelines – State Operations Manual (SOM) Appendix A

***Attached guidelines include corrections to figure on page 2 and monitored anesthesia care (MAC) section on page 3***

Memorandum Summary

- **Hospital Anesthesia Services Requirements Clarified** – The Centers for Medicare & Medicaid Services (CMS) is clarifying the interpretive guidelines (IGs) for the Hospital Condition of Participation (CoP) governing Anesthesia Services.
- **Types of Anesthesia Services** - The guidance indicates which types of anesthesia services are subject to the requirements governing administration of anesthesia specified at 42 CFR 482.52.
- **Anesthesia Requirements** - Further details on the pre-, intra- and post-operative anesthesia requirements are also provided.

Ref: S&C-10-09-Hospital
REVISED 2-05-2010

www.cms.hhs.gov/SurveyCertificationGenInfo/PMSR/list.asp
**SUBJECT:** Clarification of the Interpretive Guidelines for the Anesthesia Services Condition of Participation

**I. SUMMARY OF CHANGES:** Revisions to Appendix A, “Survey Protocol, Regulations and Interpretive Guidelines for Hospitals.” This instruction updates and clarifies the guidance for the Anesthesia Services Condition of Participation and related standards.

**NEW/REVISED MATERIAL - EFFECTIVE DATE**: May 21, 2010
**IMPLEMENTATION DATE**: May 21, 2010

*The revision date and transmittal number apply to the red italicized material only. Any other material was previously published and remains unchanged.*

**II. CHANGES IN MANUAL INSTRUCTIONS:** (*N/A if manual not updated.*)
(R = REVISED, N = NEW, D = DELETED) – (*Only One Per Row.*)

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<thead>
<tr>
<th>R/N/D</th>
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<td>R</td>
<td>Appendix A/§482.52(b)(2)/Standard: Intraoperative Anesthesia Record/Tag A-1004</td>
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4th Changes

January 14, 2011

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop 02-02-38
Baltimore, Maryland 21244-1850

Center for Medicaid, CHIP, and Survey & Certification/Survey & Certification Group

Ref: S&C-11-10-Hospitals

DATE: January 14, 2011
TO: State Survey Agency Directors
FROM: Director
Survey and Certification Group

SUBJECT: Revised Hospital Anesthesia Services Interpretive Guidelines—State Operations Manual (SOM) Appendix A

Memorandum Summary

Revisions to Recently Updated Interpretive Guidelines for Anesthesia Services: The Centers for Medicare & Medicaid Services (CMS) has revised the guidelines concerning the anesthesia services Condition of Participation (CoP) at 42 CFR 482.52.

- Hospitals are expected to develop and implement policies and procedures that address the clinical circumstances under which medications that fall along the analgesia-anesthesia continuum are considered anesthesia, and specify the qualifications of practitioners who can administer analgesia.
- Additional clarifications related to pre- and post-anesthesia evaluation requirements are provided.
- Frequently Asked Questions (FAQs) are also attached.

On December 11, 2009 CMS released updated Interpretive Guidelines for the Anesthesia Services Condition of Participation (CoP) for Hospitals as an attachment to S&C memo 10-09. Among other things, this guidance was a response to requests for clarification of the distinction between analgesia and anesthesia, given that the regulation at 42 CFR 482.52(c) limits the administration of anesthesia.
A-1000

(Rev.74, Issued: 12-02-11, Effective: 12-02-11, Implementation: 12-02-11)

§482.52 Condition of Participation: Anesthesia Services

If the hospital furnishes anesthesia services, they must be provided in a well-organized manner under the direction of a qualified doctor of medicine or osteopathy. The service is responsible for all anesthesia administered in the hospital.

Interpretive Guidelines §482.52

The provision of anesthesia services is an optional hospital service. However, if a hospital provides any degree of anesthesia service to its patients, the hospital must comply with all the requirements of this Condition of Participation (CoP).

“Anesthesia” involves the administration of a medication to produce a blunting or loss of:

- pain perception (analgesia);
- voluntary and involuntary movements;
- autonomic function; and
- memory and/or consciousness.

depending on where along the central neuraxial (brain and spinal cord) the medication is delivered.

In contrast, “analgesia” involves the use of a medication to provide relief of pain through the blocking of pain receptors in the peripheral and/or central nervous system. The patient does not
CMS Hospital CoPs

- Interpretative guidelines under state operations manual
  - Appendix A, Tag A-0001 to A-1164 and 525 pages long
  - Anesthesia section starts at tag number 1000 and goes to 1005

- Every hospital should have a copy of the CMS manual consider placing on the intranet and this is where all the manuals are located (new website)

Hospitals are expected to have P&P on when medications that fall along the analgesia-anesthesia continuum are considered anesthesia

- P&P must be based on nationally recognized guidelines

- Must specify the qualifications of practitioners who can administer analgesia

- CMS further clarified pre-anesthesia and post-anesthesia evaluations

- CMS added FAQs which are very helpful
  - Hospitals should review these as many changes and clarifications were made
CMS Anesthesia Standards Changes

- CMS has added additional requirements for the definition and use of analgesia (pain) throughout the hospital
- These are less prescriptive than the prior changes
- CMS requires the hospital to develop policies on specific clinical privileges involving anesthesia and analgesia (pain)
- Must specify the qualifications for each category of practitioners who administer analgesia
- Strong emphasis on rescue capacity of hospitals
FAQs for Revisions to Anesthesia Services Interpretive Guidelines

The revised interpretative guidelines (IG) require each individual hospital to develop its own internal policies and procedures as to what medications, under what circumstances, constitute anesthesia and therefore require administration by an anesthesia professional as delineated at 42 CFR 482.52(a). The IG also requires that hospitals base their policies on nationally recognized guidelines.

The following questions and answers are provided to facilitate understanding of the revised guidance:

Q1: How can the same drug be used at the same facility for general anesthesia in the operating room and for a sedative in the emergency department or a procedure room?

A1: The physiological result in terms of level of sedation for a particular medication may vary based on dosage, route and timing of administration, the metabolism and interaction with other medications, the clinical status and body habitus of the patient, etc. However, there is neither a bright line nor predictability about when a patient will inadvertently convert from moderate to deep sedation, or how much medication will bring about the desired sedation state. In addition, for some medications there is no antidote that can quickly reverse its effects, rescue of an overly-sedated patient requires very specific skills in airway management and ventilation. For this reason the IG continues to require that hospitals ensure that procedures are in place to rescue patients whose level of sedation becomes deeper than originally intended.

Q2: What nationally recognized guidelines are available for hospitals to use to develop their policies concerning what is anesthesia and what is analgesia and which procedures need which? What does “nationally recognized guidelines” mean?

A2: CMS’ expectation is that such guidelines are issued by a national organization that has appropriate expertise and which has used consensus-setting process of professionals with appropriate expertise in developing its guidelines. We recognize that such organizations may not always fully agree with each other. Examples of organizations with guidelines related to anesthesia administration include, but not limited to, the following:
§482.52 Condition of Participation: Anesthesia Services

If the hospital furnishes anesthesia services, they must be provided in a well-organized manner under the direction of a qualified doctor of medicine or osteopathy. The service is responsible for all anesthesia administered in the hospital.

Interpretive Guidelines §482.52

The provision of anesthesia services is an optional hospital service. However, if a hospital provides any degree of anesthesia service to its patients, the hospital must comply with all the requirements of this Condition of Participation (CoP).

“Anesthesia” involves the administration of a medication to produce a blunting or loss of:

- pain perception (analgesia);
- voluntary and involuntary movements;
Introduction

- Divides into two buckets which are the anesthesia and analgesia (pain)

- Analgesia (pain) is bucket one and includes 4 things; Topical, local, moderate and minimal sedation
  - Patient does not lose consciousness (Tag 1000)
  - CRNA or anesthesiologist not required
  - No requirement for preanesthesia or post anesthesia assessment but would want to do an assessment
  - TJC has standards in the PC chapter on pre-sedation and post-sedation evaluation and this is the standard of care (SOC)
Introduction

- Bucket one analgesia or pain (continued)
  - CMS removes language that says administration of epidural or spinal during labor and delivery is not subject to the anesthesia standard
  - Need policy on who can do analgesia such as PA, NP, or RN
    - PA, physician or NP may give local with 1% Lidocaine to suture in the ED
    - RN may give Valium 2.5 mg PO to patient before MRI
    - RN may help with moderate sedation in the ED or GI lab
Introduction

- Anesthesia is bucket two and includes:
  - General, epidural and spinal (regional), MAC, and deep sedation by one qualified to give anesthesia such as
    - CRNA, Anesthesiologist, or Anesthesiology Assistant (AA)
    - Dentist, podiatrist, or oral surgeon allowed within scope of practice
    - Does say physician other than anesthesiologist but must be qualified such as an ED or GI physician
  - Preanesthesia and post anesthesia evaluation required by anesthesia provider and must document elements required
  - CMS also has what must be documented during surgery by anesthesia provider and adds requirements so make sure your form to include these
Anesthesia 1000

- Must be provided in well organized manner under qualified doctor
  - Final revision changed the section on the criteria for the qualification of the anesthesia director
  - Service responsible for all anesthesia administered in the hospital
- Optional service and must be integrated into hospital QAPI
STATEMENT ON THE ANESTHESIA CARE TEAM

Committee of Origin: Anesthesia Care Team

(Approved by the ASA House of Delegates on October 18, 2006, and last amended on October 21, 2009)

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 nonphysician 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 nonphysicians. 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.

Core Members of the Anesthesia Care Team

The Anesthesia Care Team includes both physicians and nonphysicians. 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 nonphysician personnel as resident physicians or practicing physicians. The nomenclature below is appropriate terminology for this purpose.

Physicians:

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.

ANESTHESIOLOGY FELLOW – a medical student who has completed a training program in anesthesiology training program and is in training as a physician assistant.
ASA Guidelines and Standards


Standards, Guidelines, Statements and Other Documents

ASA Standards, Guidelines and Statements provide guidance to improve decision-making and promote beneficial outcomes for the practice of anesthesiology. They are not intended as unique or exclusive indicators of appropriate care. The interpretation and application of Standards, Guidelines and Statements takes place within the context of local institutions, organizations and practice conditions. A departure from one or more recommendations may be appropriate if the facts and circumstances demonstrate that the rendered care met the physician’s duty to the patient.

**Standards** provide rules or minimum requirements for clinical practice. They are regarded as generally accepted principles of patient management. Standards may be modified only under unusual circumstances, e.g., extreme emergencies or unavailability of equipment.

**Guidelines** are systematically developed recommendations that assist the practitioner and patient in making decisions about health care. These recommendations may be adopted, modified, or rejected according to clinical needs and constraints and are not intended to replace local institutional policies. In addition, practice guidelines are not intended as standards or absolute requirements, and their use cannot guarantee any specific outcome. Practice guidelines are subject to revision as warranted by the evolution of medical
Anesthesia A-1000

- **Anesthesia** involves administration of medication to produce a blunting or loss of:
  - Pain perception (analgesia)
  - Voluntary and involuntary movements
  - Autonomic function
  - Memory and or consciousness

- **Analgesia** (pain) is use of medication to provide pain relief thru blocking pain receptor in peripheral and or CNS where patient does not lose consciousness but does not perceive pain.
Anesthesia exists on a continuum

There is not a bright line that distinguishes when the drug’s properties from analgesia to anesthesia

CMS has definitions of what constitutes general anesthesia and, regional, monitored anesthesia care (MAC), and deep sedation

For the most part, definitions follow the ASA practice guidelines

- Anesthesiology 2002; 96:1004-17
• **General anesthesia**: a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory support is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired. For example, a patient undergoing major abdominal surgery involving the removal of a portion or all of an organ would require general anesthesia in order to tolerate such an extensive surgical procedure. General anesthesia is used for those procedures when loss of consciousness is required for the safe and effective delivery of surgical services;

• **Regional anesthesia**: the delivery of anesthetic medication at a specific level of the spinal cord and/or to peripheral nerves, including epidurals and spinals and other central neuraxial nerve blocks, is used when loss of consciousness is not desired but sufficient analgesia and loss of voluntary and involuntary movement is required. Given the potential for the conversion and extension of regional to general anesthesia in certain procedures, it is necessary that the administration of regional and general anesthesia be delivered or supervised by a practitioner as specified in 42 CFR 482.52(a).
Monitored Anesthesia Care (MAC)

- Monitored Anesthesia Care (MAC) that includes monitoring of patient by a person qualified to give anesthesia (like anesthesiologist or CRNA)
- Include potential to convert to a general or regional anesthetic
- Deep sedation/analgesia is included in a MAC
- Deep sedation where drug induced depression of consciousness during which patient can not easily be aroused but responds purposefully following repeated or painful stimulus
  - Removed: An example of deep sedation is when Propofol is used for a screening colonoscopy
Monitored anesthesia care (MAC): anesthesia care that includes the monitoring of the patient by a practitioner who is qualified to administer anesthesia as defined by the regulations at §482.52(a). Indications for MAC depend on the nature of the procedure, the patient’s clinical condition, and/or the potential need to convert to a general or regional anesthetic. Deep sedation/analgesia is included in MAC.

Deep sedation/analgesia: a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained. Because of the potential for the inadvertent progression to general anesthesia in certain procedures, it is necessary that the administration of deep sedation/analgesia be delivered or supervised by a practitioner as specified in 42 CFR 482.52(a).
Anesthesia Services 1000

- Services **not** subject to anesthesia administration and supervision requirements
  - Topical or local anesthesia; application or injection of drug to stop a painful sensation
  - Minimal sedation; drug induced state in which patient can respond to verbal commands such as oral medication to decrease anxiety for MRI
  - Moderate or conscious sedation; in which patients respond purposely to verbal commands, either alone or by light tactile stimulation
Definitions of Analgesia (Pain)

- **Moderate sedation/analgesia**: ("Conscious Sedation"): a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained. CMS, consistent with ASA guidelines, does not define moderate or conscious sedation as anesthesia (71FR 68690-1).

- **Minimal sedation**: a drug-induced state during which patients respond normally to verbal commands. Although cognitive function and coordination may be impaired, ventilator and cardiovascular functions are unaffected. This is also not anesthesia.

- **Topical or local anesthesia**: the application or injection of a drug or combination of drugs to stop or prevent a painful sensation to a circumscribed area of the body where a painful procedure is to be performed. There are generally no systemic effects of these medications, which also are not anesthesia, despite the name.
Rescue capacity

- Sedation is a continuum
- It is not always possible to predict how any individual patient will respond
- So may need to rescue by one with expertise in airway management and advanced life support
- Must have procedures in place to rescue patients whose sedation becomes deeper than initially intended
TJC has standards also on how to safely perform moderate or procedural sedation and anesthesia in the PC chapter.

Still need to do a pre-sedation assessment and post-sedation assessment but since not anesthesia not a pre or post-anesthesia assessment.

Also references the need to follow nationally standards of practice such as ASA (American Society of Anesthesiologists), ACEP (American College of Emergency Physicians) and ASGE (American Society for GI Endoscopy), AGA, ENA, ADA, etc.

Listed at the end as additional resources.
One Anesthesia Service  1000

- Anesthesia services must be under one anesthesia services under direction of qualified physician no matter where performed through out the hospital

- Including if done in any of the following:
  - Operating room for both inpatients and outpatients
  - OB
  - Radiology (interventional radiology), clinics (pain clinic),
  - ED
  - Psychiatry (ECT)
  - Endoscopy, pain management clinics etc.
Anesthesia Services under Qualified Director

- Anesthesia services must be under the direction of one individual who is a qualified doctor (1000)
- Need to have medical staff rules and regulations establishing the criteria for the qualifications for the director of anesthesia services
- MS establishes this criteria for director’s qualifications
- The board approves after consideration of the medical staff’s recommendation
- Must be consistent with state law and acceptable standards of practice
The regulation states, “…under the direction of a qualified doctor of medicine or osteopathy.” This means the anesthesia service can be directed by any type of MD or DO who is qualified.

You are correct that in most hospitals with an anesthesia service, an anesthesiologist would “generally” be the director. However, some hospitals do not have an anesthesiologist on staff. If a hospital provides any type of anesthesia service, the hospital would have to find an MD or DO that has the qualifications to be the Director of Anesthesia Services in the hospital.

The hospital would establish criteria for determining that a particular MD or DO was qualified to be the director (such as knowledge of anesthesia procedures, anesthesia/sedation/analgesia medications, State scope of practice rules, National Standards of practice, administrative skills, management, and other criteria). Hospitals already must establish criteria for determining whether a physician is qualified to provide care and which types of care. Therefore, a hospital should be able to ensure that whichever MD or DO they select as the Director of Anesthesia Services is qualified for that position.
The anesthesia services must be under the direction of one individual who is a qualified doctor of medicine (MD) or doctor of osteopathy (DO). Consistent with the requirement at § 482.12(a)(4) for it to approve medical staff bylaws, rules and regulations, the hospital’s governing body approves, after considering the medical staff’s recommendations, medical staff rules and regulations establishing criteria for the qualifications for the director of the anesthesia services. Such criteria must be consistent with State laws and acceptable standards of practice.
Hospital needs to have policies and procedures that are based on nationally recognized guidelines as to whether it is anesthesia or analgesia

- Be sure to cite standard such as ASA, ASGE, ACEP etc.

Hospitals need to determine if sedation done in the ED or procedures rooms is anesthesia or analgesia

Must take into consideration for P&P characteristics of patients served, skill set of staff and what medications are being used

This standard also sets forth the supervision requirements for staff who administer anesthesia
Supervision and Privileges

- P&Ps need to establish minimum qualifications and supervision requirements including moderate sedation
  - MS credentialing standards and the nursing standards exist to make sure staff are qualified and competent
  - Want to make sure that staff administering drugs are qualified
  - Drugs must be given with accepted standards of practice
  - MS bylaws address criteria for determining privileges and to apply the criteria to those who request privileges
Supervision and Privileges

- If nursing staff give IV medication then must be competent in specified areas
  - Amended June 6, 2014 so follow P&P
  - This is one of the education requirements of CMS
  - Also training on restraint and seclusion, infection control and hand hygiene, abuse and neglect, advance directives, organ donation, IV and blood and blood products and ED staff with ED common emergencies, timing of medication, medication error, safe opioid use, ADE and drug incompatibilities

- Must have P&P to look at adverse events, medication errors and other safety and quality indicators
  - Must periodically re-evaluate these and include in PI
Blood Transfusions and IVs 409

- Standard: Blood transfusions and IV medications must be administered with state law and MS bylaws.
- Use to require special training for this and there was a long list of things that nurses had to be trained on.
- CMS eliminated the regulations mandating training for non-physicians who administer IV medication and blood and blood products.
  - CMS says because this training is already standard practice but must still be competent in those areas.
  - Must follow your P&P and state scope of practice.
Blood and IV Medication Training

- Must still follow **state law requirements**
  - In some states an LPN can not hang blood
  - Or the LPN can not push certain IV medications in some states
  - Must show they are competent

- Must still have approved **Medical Staff Policies** and Procedures in place

- Staff must follow these which have most of the things that were previously required
Hospital Medical Staff determine the qualifications for the Director of Anesthesia

Must be in accordance with the state law and acceptable standards of practice

Anesthesia service is responsible for developing policies and procedures governing all categories of anesthesia service

This includes the minimum qualification for each category of practitioner who is permitted to provide anesthesia services
Anesthesia Survey Procedure 1000

- Surveyor is supposed to ask for a copy of the organizational chart for anesthesia

- Make sure MD or DO has authority and responsibility for directing anesthesia services throughout the hospital

- Anesthesia must be integrated into the QAPI program
  - Every department has a role in PI including anesthesia
  - See Anesthesia Quality Institute (AQI) which is home to national anesthesia clinical outcomes registry (NACOR) and has list of things to measure
**Process indicators**: on time starting, prophylactic antibiotic administration, adherence to central line bundle, normothermia in the PACU, number of patient complaints

Are anesthesia staff educated on the CMS grievance and TJC Complaint standard?
Yes  No

**Clinical outcome indicators**: patient satisfaction, number of cases completed without any event, number of each critical event occurring by location (high spinal, epidural hematoma, infection after regional, perioperative MI, death, unplanned difficult airway, local anesthesia toxicity, medication error, incorrect patient, OR fire, transfusion reaction, new stroke, visual loss, Intraoperative awareness, peripheral neurologic deficit, etc)

CMS 2011 outpatient surgical measure is antibiotic timing and is described by CMS as “Percentage of outpatients having surgery who were given the right kind of antibiotic at the right time (within one hour before surgery) to help prevent infection of surgical wounds.” This measure is already in place for inpatient data and will be used in conjunction to obtain a more comprehensive view of the quality of care being provided in hospitals.

**Case information**: no untoward event, significant delay, case cancelled, equipment problem, extended PACU stay, unanticipated ICU admission, unanticipated hospital admission, death, cardiac arrest, anaphylaxis, malignant hyperthermia, transfusion reaction, visual loss, stroke, PONV, PACU pain control in adequate, hypotension or hypothermia in the PACU, vascular access complication, infection after regional anesthesia, high spinal, postdural puncture headache,
### Reason for Review

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<td>An-3 AMI post anesthesia</td>
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<td>An-4 Cardiac Arrest post anesthesia</td>
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<td>An-5 Respiratory Arrest post anesthesia</td>
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<td>An-6 Death w/in 48 hours of anesthesia</td>
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<td>An-7 Unplanned adm w/in 24 hours d/t anesthesia</td>
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<td>An-8 Unplanned adm to ICU w/in 24 hours of anes</td>
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<td>An-9 Pulmonary Edema w/in 24 hrs of anesthesia</td>
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<td>An-10 Aspiration pneumonitis w/in 48 hours</td>
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<td>An-13 Anesthesia Awareness</td>
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<td>M-1 Death w/i 48 hours of surgical/invasive proc</td>
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<td>M-4 Death w/i 48 hours of IV sedation</td>
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What Do You Measure?

| S-1 Unscheduled admission following outpt proc |
| S-2 Unplanned return to surgery |
| S-3 Foreign object/material found/left in wound |
| S-4 Burn or non-surgical trauma |
| S-5 Wrong procedure or wrong pt |
| S-9 Nerve damage noted post-operatively |
| S-12 Any untoward patient reaction in OR/PACU/ENDO |
| S-16 Post Operative Complication |
| S-17 Path/operative dx mismatch |
| S-20 Accidental puncture or laceration during proc |
| S-23 Mismatch pre and post op diagnosis |
| ModSed-1 Reversal Agent Administered |
| ModSed -2 Hemodynamic Instability |
| ModSed -3 Extended recovery time |
| ModSed -4 Unplanned Admission |
| ModSed -5 Unplanned Surgery |
| ModSed-7 Decreased O2 Sat |
QUALITY MEASUREMENT TOOLS

NACOR Data Element Conceptual Definitions
NACOR Minimum Data Set Conceptual Definitions
NACOR Administrative Data Conceptual Set Definitions
NACOR Outcomes Data Set Conceptual Definitions

Reporting Outcomes/Adverse Events (excluding CMS measure data)

- If a practice is reporting outcomes to NACOR, a blank outcome field is represented in the database as "no adverse event." Ideally, the most accurate capture is to record 'yes' or 'no' to an adverse event for every case. We recognize that many practices are capturing outcomes on paper or some other manual system where clicking a box 'yes' or 'no' for every case may be resource intense and interrupt workflow.

- Outcomes definitions are standardized and available for all vendors and groups who should report based on the definitions provided.

- Outcomes reported separately from NACOR's minimum dataset cannot be loaded until the coinciding case is in NACOR. Files are joined by the unique anesthesia case ID provided in both files.

Templates for Capturing Outcomes Data

Anesthesia Quality Indicators Capture Sheet (Intraoperative)
Assists with the capture of intraoperative events. Please update to suit your local conditions.

Anesthesia Quality Indicators Capture Sheet (PACU Discharge)
Assists with the capture of PACU discharge events. Please update to suit your local conditions.

Anesthesia Quality Indicators Capture Sheet (Patient Follow-up After PACU Discharge)
Assists with the capture of patient follow-up. Please update to suit your local conditions.
### Anesthesia Quality Improvement PACU Discharge

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<td>Hypotensive Episode</td>
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<td>Airway Trauma</td>
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<td>Anaphylaxis</td>
<td>Aspiration</td>
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<tr>
<td>Adverse Drug Reaction</td>
<td>Delayed emergence</td>
</tr>
<tr>
<td></td>
<td>Inadequate reversal of neuromuscular block</td>
</tr>
<tr>
<td></td>
<td>Transfusion Reaction</td>
</tr>
</tbody>
</table>


Intraoperative Events.

- **Death**: (Excludes ASA 6 patients presenting for organ harvest)
- **Cardiac**
  - Cardiac arrest
  - New PVCs, bradycardia, atrial fibrillation, or other dysrhythmias requiring unanticipated therapy
  - Myocardial ischemia, indicated by ST segment changes or echocardiography
  - Hypotension requiring unanticipated therapy with a continuous infusion of pressor agents
  - Pulmonary edema
- **Respiratory**
  - Unanticipated difficult airway
  - Inability to secure an airway
  - Unplanned reintubation
  - Unplanned respiratory arrest
  - Aspiration
  - Laryngospasm
  - Bronchospasm requiring unanticipated treatment
- **Medication**
  - Anaphylaxis
  - Other unanticipated adverse reaction to a medication
  - Malignant hyperthermia
  - Transfusion reaction
  - Medication error
  - Use of sedation/narcotic reversal agents (e.g. flumazenil, naloxone)
  - Inability to reverse neuromuscular blockade
  - Delayed emergence
- **Procedural**
  - Vascular access complication: vessel injury
  - Vascular access complication: pneumothorax
  - High spinal
  - Local anesthesia systemic toxicity
  - Failed regional anesthetic
  - Unintended dural puncture
Anesthesia Survey Procedure 1000

- Surveyor to look in directors file
- Will review job or position description of MD/DO director and look for appointment
- Will make sure privileges and qualifications are consistent with the criteria adopted by the board
- Will confirm directors responsibilities include:
  - Planning, directing, and supervision of all activities
  - Removed section on establishing staffing schedules
  - Evaluate the quality and appropriateness of anesthesia services provided to patients as part of PI process
Anesthesia Survey Procedure 1000

- Surveyor is suppose to request and review all of the anesthesia policies and procedures
- Will make sure the anesthesia apply to every where in the hospital where anesthesia services are provided
- Will make sure the P&P indicate the necessary qualifications that each clinical practitioner must possess in order to administer anesthesia as well as moderate sedation or other forms of analgesia
Anesthesia Survey Procedure 1000

- Surveyor is to make sure that the clinical applications are considered involving analgesia such as moderate sedation as opposed to anesthesia.
- Document what national guidelines are being followed.
- See the FAQ on this which will be discussed later.
- The surveyor will make sure the hospital has an adverse event system related to both anesthesia and analgesia.
  - Are they tracked and acted upon (incident report, RCA, etc.)
  - Reiterated in Hospital Improvement Act proposed 6-2016.
Anesthesia (general, regional, MAC including deep sedation) can only be administered by:

- Qualified anesthesiologist or CRNA
- Anesthesiology assistant (AA) under the supervision of anesthesiologist who is immediately available if needed
- Dentist, oral surgeon, or podiatrist who is qualified to administer anesthesia under state law
- A MD or DO other than anesthesiologist (must be qualified)
  - Lots of discussion on this
  - Hospital needs to follow standards of anesthesia care when establishing P&P governing anesthesia administration by these types of practitioners as well as MDs or DOs who are not anesthesiologists
Who Is Qualified to Give Anesthesia

Note: Chart Removed from 4th Revision

Hospital Anesthesia Services

Anesthesia
- General
- Regional
- MAC
- Deep Sedation

Analgesia/Sedation
- Topical
- Local
- Minimal
- Moderate

Opt-Out State?

Yes
No

No MD supervision required for CRNA
MD supervision required for CRNA

Rescue Capacity

To be administered by anesthesiologist, qualified physician, CRNA or anesthesia assistant as specified at §482.52(a)

To be administered by appropriately trained medical practitioner within scope of practice

Note: analgesia via epidurals/spinals for Labor & Delivery is permitted to be administered by CRNAs without MD supervision.
Who Can Administer Anesthesia

Administration by an MD/DO/dentist/oral surgeon/podiatrist

The hospital’s anesthesia services policies must address the circumstances under which an MD or DO who is not an anesthesiologist, a dentist, oral surgeon or podiatrist is permitted to administer anesthesia. In the case of a dentist, oral surgeon or podiatrist, administration of anesthesia must be permissible under State law and comply with all State requirements concerning qualifications. Hospitals should conform to generally accepted standards of anesthesia care when establishing policies governing anesthesia administration by these types of practitioners as well as MDs or DOs who are not anesthesiologists.
CRNA can be supervised by the operating surgeon or the anesthesiologist.

CRNA may not require supervision if state got an exemption from supervision.

Governor sends a letter to CMS requesting this after attesting that the State Medical Board and Nursing Board were consulted and in best interests of the state.

List of 17 state exemptions at www.cms.hhs.gov/CFCsAndCoPs/02_Spotlight.asp

- Iowa, Nebraska, Kentucky, Idaho, Minnesota, New Hampshire, New Mexico, Kansas, North Dakota, Washington, Alaska, Oregon, South Dakota, Wisconsin, Montana, Colorado, and California
Administering

- Need P&P concerning who may administer analgesia
  - Topical, local, minimal sedation and moderate sedation
  - Consistent with scope of practice set by state law
- General, regional, MAC and deep sedation can only be administered by the 5 categories mentioned
- Hospital must follow generally accepted standards of anesthesia care if anyone other than anesthesiologist, CRNA, or AA does
- Need policy on supervision also
CRNA can administer anesthesia if under the operating surgeon or by an anesthesiologist.

If supervised by an anesthesiologist must be immediately available.

What does immediately available mean?

Anesthesiologist must be physically located in the same area as the CRNA.

Example: In the same operative suite, same procedure room, same L&D unit and nothing prevents from immediate hands on intervention.
CRNA Supervision

- No supervision if in one of the 17 states that has opted out and so no longer requires it
- Otherwise must be supervised by
  - Operating practitioner who is performing the procedure or
  - Anesthesiologist who is immediately available
- Immediately available means anesthesiologist must be located within the same area of the CRNA and not occupied to prevent him/her from immediately conducting hands on intervention if needed
  - If CRNA in OR then anesthesiologist must be somewhere in the OR suite
Administration by a CRNA

Unless the hospital is located in a State that has chosen to opt out of the CRNA supervision requirements, a CRNA administering general, regional and monitored anesthesia must be supervised either by the operating practitioner who is performing the procedure, or by an anesthesiologist who is immediately available.

Hospitals should conform to generally accepted standards of anesthesia care when establishing policies for supervision by the operating practitioner. An anesthesiologist is considered “immediately available” when needed by a CRNA under the anesthesiologist’s supervision only if he/she is physically located within the same area as the CRNA, e.g., in the same operative suite, or in the same labor and delivery unit, or in the same procedure room, and not otherwise occupied in a way that prevents him/her from immediately conducting hands-on intervention, if needed.
Improper Supervision of Anesthesia Services

- A federal qui tam whistle blower lawsuit was filed by former anesthesiologist and professor Dr. Dennis O’Connor
- Investigated by the US Dept of Justice
- Hospital in California pays $1.2 million to resolve claims of improper supervision of anesthesia services
- Said no supervisory anesthesiologist was present or immediately available in violation of federal law
- Anesthesia records pre-filled out to make it look like anesthesiologist were there
UC-Irvine to Pay $1.2M to Settle Claims of Improper Supervision for Anesthesia

Written by Molly Gamble | March 27, 2013

The Regents of the University of California, the university’s governing body, has agreed to pay $1.2 million to resolve allegations that anesthesia was routinely administered at University of California-Irvine by healthcare providers when a supervisory anesthesiologist was not present, according to a news release from the law offices of Louis J. Cohen, PC, which represented the whistleblower in this case.

The settlement stems from a 2008 lawsuit filed by a former UC-Irvine anesthesiologist. His complaint triggered a “multi-year” investigation by the Department of Justice, according to the release.

The complaint alleged that certified registered nurse anesthetists or residents at UC-Irvine administered anesthesia in many instances when the supervisory anesthesiologist was in another facility, which violates federal regulations.

The complaint also alleged that postoperative evaluations would routinely be provided by unsupervised or unlicensed residents, which is also a violation of federal regulations.

A comment from UC-Irvine was not provided in the release.
Some states have a practice act for AAs or anesthesiology assistants

An AA may administer anesthesia only when under the direct supervision of an anesthesiologist only

Anesthesiologist must also be immediately available if needed

This means physically in the same department and not occupied in a way to prevent immediate hands on intervention if needed
Administration by an anesthesiologist’s assistant

An anesthesiologist’s assistant may administer anesthesia when under the direct supervision of an anesthesiologist. The anesthesiologist must be immediately available if needed. An anesthesiologist is considered “immediately available” to assist the anesthesiologist’s assistant under the anesthesiologist’s supervision only if he/she is physically located within the same area as the anesthesiologist’s assistant, e.g., in the same operative suite, or in the same labor and delivery unit, or in the same procedure room, and not otherwise occupied in a way that prevents him/her from immediately conducting hands-on intervention, if needed.

An anesthesiologist’s assistant is defined in §410.69(b) as a “…person who – (1) works under the direction of an anesthesiologist; (2) is in compliance with all applicable requirements of State law, including any licensure requirements the State imposes on nonphysician anesthetists; and (3) is a graduate of a medical school-based anesthesiologist’s assistant education program that – (A) is accredited by the Committee on Allied Health Education and Accreditation; and (B) includes approximately two years of specialized basic science and clinical education in anesthesia at a level that builds on a premedical undergraduate science background.”
Welcome to the Ultimate Anesthesiologist Assistant Resource website!

Who are Anesthesiologist Assistants?
The answer to this question will soon be common knowledge as medical schools race to open Anesthesiologist Assistant programs and Hospitals throughout the United States begin recruiting anesthesiologist assistants to meet the growing shortage of Anesthesia professionals.

Anesthesiologist Assistants are highly skilled, knowledgeable, Master degree earning members of the anesthesia care team who with their impeccable safety records work side by side with Certified Registered Nurse Anesthetist's (CRNA's). The Anesthesiologist

http://anesthesiaassistant.com/
Anesthesia Services Policies  1001

- MS bylaws or R/R must include criteria for determining anesthesia privileges
- Board must approve the specific anesthesia service privilege for each practitioner who does anesthesia services
- Must address the type of supervision required, if any, and must specify who can supervise CRNA (unless exempted)
- Privileges must be granted in accordance with state law and hospital policy
Supervision by Operating Practitioner 1002

- If hospital allows supervision by operating practitioner of CRNAs
  - Such as surgeons, podiatrist, or gastroenterologist

- Medical staff bylaws or R/R must specify for each category of operating practitioners

- The type and complexity of the procedures that the category of practitioner may supervise

- See resources at the end that discuss standards of practice on credentialing and privileging
Survey Procedure 1001

- Surveyor is to review the qualifications of individuals allowed to give anesthesia to make sure they are qualified
- Make sure licenses and certifications are current
- Determine if state has opted out for CRNA supervision
- Review the hospital P&P to make sure supervision of CRNA and AA meets requirements
- Review qualifications of other anesthesia services to make sure they are consistent with the hospital anesthesia policies
Anesthesia Services and Policies 1002

- Anesthesia must be consistent with needs of patients and resources
- P&P must include delineation of pre-anesthesia and post-anesthesia responsibilities
- Must be consistent with the standards of care

- Policies include;
  - Consent
  - Infection Control measures
  - Safety practices in all areas
  - How hospital anesthesia service needs are met
Policies required (continued);

- Protocols for life support function such as cardiac or respiratory emergencies
- Reporting requirements
- Documentation requirements
- Equipment requirements
- Monitoring, inspecting, testing and maintenance of anesthesia equipment
- Pre and post anesthesia responsibilities
Pre-Anesthesia Assessment 1003

- Pre-anesthesia evaluation must be performed with 48 hours prior to the surgery
  - Including inpatient and outpatient procedures
- For regional, general, and MAC
- Not required for moderate sedation but still need to do pre sedation assessment
- Preanesthesia assessment must be done by some one qualified person to administer anesthetic (non-delegable)
Pre-Anesthesia Evaluation 1003

- Must have policies to make sure the pre-anesthesia guidelines are met
- Pre-anesthesia evaluation must be completed, documented and done by one qualified to administer anesthesia within 48 hours
  - Can not delegate the pre-anesthesia assessment to someone who is not qualified which is 5 categories mentioned
  - Must be done within 48 hours of surgery or procedure
5 Qualified to do Pre-Anesthesia Assessment

- Anesthesiologist
- CRNA under the supervision of operating surgeon or anesthesiologist unless state is exempt
- AA under supervision of anesthesiologist
- MD or DO other than an anesthesiologist
- A dentist, oral surgeon, or podiatrist who is qualified to administer anesthesia under State law
Pre-Anesthesia Evaluation 1003

- Delivery of first dose of medication for inducing anesthesia marks end of 48 hour time frame

- Pre-anesthesia assessment must be done for generals, regional, or MAC which includes deep sedation

- If moderate sedation current practice dictates a pre-procedure assessment but not a pre-anesthesia assessment

- See TJC standards at the end of presentation on pre-sedation assessment for patients having moderate sedation
Pre-Anesthesia Evaluation 1003

- CMS says pre-anesthesia must be done within 48 hours of procedure or surgery
- However, some of the elements in the evaluation can be collected prior to the 48 hours time frame but it can never be more than 30 days (new)
  - If you saw a patient on Friday for Monday surgery would need to show that on Monday there were no changes
  - CMS also specifies the four of the six required elements that can be performed within 30 days
Pre-Anesthetic Assessment

- Must include;
  - Review of medical history, including anesthesia, drug, and allergy history (within 48 hours)
  - Interview and exam the patient
    - Within 48 hours and rest are updated in 48 hours but can be collected within 30 days
  - Notation of anesthesia risk (such as ASA level)
  - Potential anesthesia problems identification (including what could be complication or contraindication like difficult airway, ongoing infection, or limited intravascular access)
Pre-Anesthetic Assessment 1003

- Pre-anesthetic Assessment to include (continued);
  - Additional data or information in accordance with SOC or SOP
    - Including information such as stress test or additional consults
  - Develop plan of care including type of medication for induction, maintenance, and post-operative care
  - Of the risks and benefits of the anesthesia
**PREANESTHESIA EVALUATION**

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**AIRWAY / TEETH / HEAD & NECK**

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<td>☐ Significant Other</td>
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<th>Communication / Language Problems:</th>
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<th>Poor Historian:</th>
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ASA Physical Status Classification System

- ASA PS I – normal healthy patient
- ASA PS II – patient with mild systemic disease
- ASA PS III – patient with severe systemic disease
- ASA PS IV – patient with severe systemic disease that is a constant threat to life
- ASA PS V – moribund patient who is not expected to survive without the operation
- ASA PS VI – declared brain-dead patient whose organs are being removed for donor purposes
Survey Procedure Pre-anesthesia Evaluation

- Surveyor to review sample of inpatient and outpatient records who had anesthesia
- Make sure pre-anesthesia evaluation done and by one qualified to deliver anesthesia
- Determine the pre-anesthesia evaluation had all the required elements
- Make sure done within 48 hours before first does of medication given for purposes of inducing anesthesia for the surgery or procedure
- ASA and AANA has pre-anesthesia standards that hospitals should be familiar with
ASA Guideline Pre-Anesthesia

- Preanesthesia Evaluation
  - Patient interview to assess Medical history, Anesthetic history, Medication history
- Appropriate physical examination
- Review of objective diagnostic data (e.g., laboratory, ECG, X-ray)
- Assignment of ASA physical status
- Formulation of the anesthetic plan and discussion of the risks and benefits of the plan with the patient or the patient’s legal representative

1 www.asahq.org/publicationsAndServices/standards/03.pdf American Society of Anesthesiologist
STANDARDS FOR BASIC ANESTHETIC MONITORING

Committee of Origin: Standards and Practice Parameters

(Approved by the ASA House of Delegates on October 21, 1986, and last amended on October 20, 2010 with an effective date of July 1, 2011)

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 anesthetic 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. These standards are not intended for application to the care of the obstetrical patient in labor or in the conduct of pain management.

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.

1.1 Objective –
3.2.4 During regional anesthesia (with no sedation) or local anesthesia (with no sedation), the adequacy of ventilation shall be evaluated by continual observation of qualitative clinical signs. During moderate or deep sedation the adequacy of ventilation shall be evaluated by continual observation of qualitative clinical signs and monitoring for the presence of exhaled carbon dioxide unless precluded or invalidated by the nature of the patient, procedure, or equipment.

SPECIAL ARTICLE

Anesthesiology 2002; 96:485-96
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Practice Advisory for Preamesthesia Evaluation

A Report by the American Society of Anesthesiologists Task Force on Preamesthesia Evaluation

PRACTICE advisories are systematically developed reports that are intended to assist decision-making in areas of patient care where scientific evidence is insufficient to develop an evidence-based model. Practice advisories provide a synthesis of opinion from experts, open forums, and other public sources. Practice advisories report the current state of scientific literature, but are not supported by literature to the same degree as standards or guidelines due to the lack of sufficient numbers of adequately controlled studies.

Advisories are not intended as guidelines, standards, or absolute requirements. The use of practice advisories cannot guarantee any specific outcome. They may be adopted, modified, or rejected according to clinical needs and constraints. Practice advisories are subject to periodic revision as warranted by the evolution of medical knowledge, technology, and practice.

Definition of Preamesthesia Evaluation

the patient’s medical records, interview, physical examination, and findings from medical tests and evaluations. As part of the preanesthesia evaluation process, the anesthesiologist may choose to consult with other healthcare professionals to obtain information or services that are relevant to perioperative anesthetic care. Preoperative tests, as a component of the preanesthesia evaluation, may be indicated for various purposes, including but not limited to (1) discovery or identification of a disease or disorder that may affect perioperative anesthetic care, (2) verification or assessment of an already known disease, disorder, medical or alternative therapy that may affect perioperative anesthetic care, and (3) formulation of specific plans and alternatives for perioperative anesthetic care. For this Advisory, perioperative refers to the care surrounding operations and procedures.

The assessments made in the process of a preanesthesia evaluation may be used to educate the patient, organize resources for perioperative care, and formulate
ASA Standard on Pre-anesthesia Care

BASIC STANDARDS FOR PREANESTHESIA CARE

Committee of Origin: Standards and Practice Parameters

(Approved by the ASA House of Delegates on October 14, 1987, and last affirmed on October 20, 2010)

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

An anesthesiologist shall be responsible for determining the medical status of the patient and developing a plan of anesthesia care.

The anesthesiologist, before the delivery of anesthesia care, is responsible for:

1. Reviewing the available medical record.
2. Interviewing and performing a focused examination of the patient to:
   2.1 Discuss the medical history, including previous anesthetic experiences and medical therapy.
   2.2 Assess those aspects of the patient’s physical condition that might affect decisions regarding perioperative risk and management.
3. Ordering and reviewing pertinent available tests and consultations as necessary for the delivery of anesthesia care.
4. Ordering appropriate preoperative medications.
5. Ensuring that consent has been obtained for the anesthesia care.
6. Documenting in the chart that the above has been performed.

Standards for Nurse Anesthesia Practice

- American Association of Nurse Anesthetists (AANA) has standards for nurse anesthesia practice
- Has a section on standard for pre-anesthesia assessment and post-anesthesia assessment
- AANA website has many excellent resources
  - Includes practice documents,
  - Standards, guidelines, joint position statements,
  - Advisory opinions, forms, resources, practice considerations, position statements, quality of care in anesthesia, and more
AANA Standards for Nurse Anesthesia

Standard I
Perform and document a thorough preanesthesia assessment and evaluation.

Standard II
Obtain and document informed consent for the planned anesthetic intervention from the patient or legal guardian, or verify that informed consent has been obtained and documented by a qualified professional.

Standard III
Formulate a patient-specific plan for anesthesia care.

Standard IV
Implement and adjust the anesthesia care plan based on the patient’s physiologic status. Continuously assess the patient’s response to the anesthetic, surgical intervention, or procedure. Intervene as required to maintain the patient in optimal physiologic condition.

Standard V
Monitor, evaluate, and document the patient’s physiologic condition as appropriate for the type of anesthesia and specific patient needs. When any physiological monitoring device is used, variable pitch and threshold alarms shall be turned on and audible. The CRNA should attend to the patient continuously until the responsibility of care has been accepted by another anesthesia professional.

a. Oxygenation
Continuously monitor oxygenation by clinical observation and pulse oximetry. If indicated, continually monitor oxygenation by arterial blood gas analysis.

b. Ventilation
Continuously monitor ventilation. Verify intubation of the trachea or placement of other artificial airway devices by auscultation, chest excursion, and confirmation of expired carbon dioxide. Use ventilatory pressure monitors as indicated. Continuously monitor end-tidal carbon dioxide during controlled or assisted ventilation and any anesthesia or sedation technique requiring artificial airway support. During moderate or deep sedation, continuously monitor for the presence of expired carbon dioxide.

c. Cardiovascular
Continuously monitor cardiovascular status via electrocardiogram. Perform auscultation of heart sounds as
Intra-operative Anesthesia Record 1004

- Need policies related to the intra-operative anesthesia record
- Need intra-operative anesthesia record for patients who have general, regional, deep sedation or MAC
- Still need monitoring of moderate sedation before, during, and after but the monitoring required by this section does not apply to that
- See the TJC standards on this
MEDIUM SEDATION POLICY FOR NON-ANESTHESIA STAFF

Purpose
The purpose of this policy is to set forth procedures for the management of all patients receiving moderate sedation while undergoing therapeutic, diagnostic or surgical procedures at Methodist Lebonheur Healthcare System Hospitals. These guidelines apply to all locations where moderate sedation is administered. These include, but are not limited to:

Endoscopy Suites
Critical Care areas
Emergency Department
Diagnostic Imaging
Operating Room
Cardiac Cath Lab
Starlight Room

Focus
This policy is not intended to apply to the following settings:

General anesthesia
Administration of medication intended solely to counteract anxiety
Administration of medication intended for deep sedation as defined by department(s) of anesthesia.
Management of pain before, after, or unrelated to a therapeutic or diagnostic procedure
The use of parental or oral medications in the setting of alcohol withdrawal management
# Guide To Moderate Sedation / Analgesia By Non-Anesthesiologists

<table>
<thead>
<tr>
<th>Drug</th>
<th>Onset of action (Dose-dependent)</th>
<th>Duration of effect (Dose-dependent)</th>
<th>Initial Dose ADULTS</th>
<th>Initial Dose CHILDREN</th>
<th>Titration</th>
<th>Special instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chloral Hydrate</td>
<td>PO: 30 - 60 minutes PR: 30 - 60 minutes</td>
<td>PO: 4 - 8 hours</td>
<td>PO: 500 - 1000 mg PR: 500 - 1000 mg</td>
<td>PO: 25-100 mg/kg (max: 1.5 gm/dose)</td>
<td>25 - 50% of the initial dose every 30 - 45 minutes prn.</td>
<td>Give 30-60 minutes prior to procedure. Can cause nausea, vomiting. Can premedicate with promethazine (12.5-25 mg). (Max. 2 gm/day)</td>
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<tr>
<td>(Nocet)</td>
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<tr>
<td>Diphenhydramine</td>
<td>PO: 10 - 30 minutes IV: 1 - 10 minutes</td>
<td>PO: 4 - 6 hours IV: 2 - 6 hours</td>
<td>PO: 25 - 50 mg IV: 10 - 50 mg</td>
<td>PO: 1 mg/kg IV: 0.5 - 1 mg/kg (max: 50 mg/dose)</td>
<td>25 - 50% of the initial dose every 15 - 30 minutes prn.</td>
<td>Only use as adjunct. Evidence as only agent for conscious sedation are limited. Can cause excitement in young children.</td>
</tr>
<tr>
<td>(Benadryl)</td>
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<tr>
<td>Droperidol</td>
<td>IV: 5 - 10 minutes IV: 2 - 4 hours</td>
<td>IV: 2.5 - 10 mg</td>
<td>IV: 0.05 - 0.1 mg/kg Not a first-line agent</td>
<td>25 - 50% of the initial dose every 5 - 15 minutes prn.</td>
<td>All patients should undergo a 12-lead EKG to assess QT interval prior to procedure. Avoid if risks of arrhythmias. Antiemetic properties. Can cause extrapyramidal symptoms.</td>
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<tr>
<td>(Inapsine)</td>
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<tr>
<td>Ketamine</td>
<td>PO: 15 - 30 minutes IV: 5 - 15 minutes</td>
<td>PO: 5 - 10 mg/kg IV: 1 - 3 mg/kg</td>
<td>PO: 5 - 10 mg IV: 0.5 - 1 mg/kg</td>
<td>25 - 50% of the initial dose every 5 - 15 minutes prn.</td>
<td>Sedation / analgesia. Can cause emergence reactions, cardiovascular side effects, hypersalivation. Infuse over 1-2 min. Can be given IM.</td>
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<tr>
<td>(Ketalar)</td>
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<tr>
<td>Pentobarbital</td>
<td>PO,PR: 30 minutes IV: 30 - 60 seconds</td>
<td>PO,PR: 1 - 4 hours IV: 15 - 30 minutes</td>
<td>PO,PR: 60 - 200 mg IV: 50 - 100 mg</td>
<td>PR,PO: 3 - 6 mg/kg IV: 1 - 3 mg/kg (max: 100 mg/dose)</td>
<td>25 - 50% of the initial dose every 5 - 15 minutes prn.</td>
<td>Sedation-hypnotic effects, no analgesia. Administered IV over 2-5 minutes. Accumulation with repeated doses. Can be given IM.</td>
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<tr>
<td>(Nembutal)</td>
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</table>

<table>
<thead>
<tr>
<th>Reversal Agents</th>
<th>Duration</th>
<th>IV/Dose</th>
<th>May repeat after</th>
<th>IV prn</th>
<th>Effectiveness</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flumazenil</td>
<td>30-60 seconds</td>
<td>0.1 - 0.2 mg</td>
<td>(≤20kg): 0.01 mg/kg (&gt;20 kg): 0.2 mg/dose</td>
<td>May repeat after 1 minute IV prn</td>
<td>Effective in reversing excessive sedation – not for respiratory depression. May wear off before benzo. Infuse over 15 - 30 seconds.</td>
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<tr>
<td>(Romazicon)</td>
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<tr>
<td>Naloxone</td>
<td>IV: 1-2 minutes</td>
<td>IV: 0.2 - 0.4 mg</td>
<td>IV: 0.005 - 0.01 mg/kg</td>
<td>May repeat after 2-3 minutes IV prn</td>
<td>May wear off before effects of opioids. Infuse total dose over 15 - 30 seconds. Only for use to reverse opioids Can be given IM, SC.</td>
<td></td>
</tr>
<tr>
<td>(Narcan)</td>
<td>IV: 45 minutes</td>
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</tbody>
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### Miscellaneous Agents

- **Droperidol**: Should be used with extreme caution in patients with risk factors for prolonged QT syndrome (ie, CHF; bradycardia; cardiac hypertrophy; significant cardiac disease; diuretic use; hypokalemia; hypomagnesemia; concomitant use of antiarrhythmics, MAO inhibitor, erythromycin, haloperidol; age > 65 years; alcohol abuse.
- Continuous EKG should be done prior to treatment and 2-3 hours after treatment to monitor arrhythmias.
- **Ketamine**: Emergence reactions (hallucination, delirium) and cardiovascular side effects can be attenuated by administering midazolam or any other benzodiazepines prior to ketamine use.
- Hypersalivation can be attenuated by administering atropine (0.01 mg/kg) or glycopyrrolate (0.005 mg/kg) prior to ketamine use.
- Risk of respiratory depression if infused too rapidly. Infuse over 1-2 minutes.
- Use with caution in patients with poorly controlled hypertension, congestive heart failure, angina or any other coronary artery diseases.
- **Pentobarbital**: When given orally or rectally, pentobarbital should be given at least 30 minutes prior to performing a procedure.
- In obese patients, the dose should be calculated based on adjusted body weight.

*See FDA Warning*

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### Reversal Agents

- Complete monitoring is necessary for at least 90 minutes following the use of any reversal agents.
- Reversal agents should be used to reverse excessive sedation. (Note that flumazenil may not reverse hypotension or respiratory depression)
- Use flumazenil cautiously in patients on long term benzodiazepine therapy, history of seizures. May need to redose after 30 – 45 minutes.
- Careful monitoring should be continued after reversal is initiated.
- In obese patients, the dose should be calculated based on adjusted body weight.
Moderate Sedation Toolkit

Moderate Sedation Toolkit for Non-Anesthesiologists

To assist VA facilities in assuring that the practice of moderate sedation is reliable and safe, the VA National Center for Patient Safety (NCPS) has developed a Moderate Sedation Toolkit for Non-Anesthesiologists, based upon work done at the Durham VAMC Patient Safety Center of Inquiry.

The toolkit is composed of nine components:

1. Facilitator’s Guide This introductory guide describes the moderate sedation toolkit components and provides guidelines for the sedation training facilitator including answers to frequently asked questions.
2. Learner Objectives These 18 objectives describe the knowledge, skills and behaviors that should be demonstrated by individuals who administer moderate sedation.
3. Curriculum Guide This document provides detailed information about moderate sedation practice. Topics include:
   - Introduction - general principles of moderate sedation
   - Pharmacology of commonly used medications
   - Relevant anatomy and physiology
   - Principles of pre-procedural patient assessment and education
   - Monitoring guidelines and techniques
   - Intra-Procedure Guideline - required safety equipment and common complication recognition and treatment
   - Special situations and high-risk patients
4. Pre-Procedure Evaluation Template This template identifies key features of patient evaluation that should be performed prior to beginning a procedure that requires moderate sedation. Facilities may use this as a guide for creating CPRS templates.
5. Moderate Sedation Study Aid This colorful graphic summary includes key elements of moderate sedation practice, including many of the topics from the curriculum guide. This 8.5- by 11-inch front and back reference guide may be posted for practitioners in all sites where moderate sedation is administered.
6. Moderate Sedation Cognitive Aid Modeled after the NCPS Cognitive Aid for Anesthesiology, this colorful 8.5- by 11-inch front and back reference guide provides bulleted guidelines for managing common complications of moderate sedation (hypotension, hypertension, bradycardia, tachycardia, hypoxemia and agitation/difficult to sedate). Each complication is addressed in three parts: initial response; follow-up response; and things to consider. It is intended to be available to practitioners in all sites where moderate sedation is administered.
7. Call for Help Card This template identifies key resources for assistance. Facilities must customize this card for local use. The local version should be posted and CLEARLY VISIBLE in all sites where moderate sedation is administered.
8. High-Fidelity Simulation Cases Four cases are available for use in facilities that have the capability to conduct simulation training using a high-fidelity medical simulator. The cases demonstrate the common and important problems encountered during sedation practice.
   - Case 1: Orientation to Simulator and Training Sessions

http://www.patientsafety.gov/pubs.html#sedate
Intra-operative Anesthesia Record 1004

- Intra-operative Record must contain the following:
  - Include name and hospital id number
  - Name of practitioner who administer anesthesia
  - Techniques used and patient position, including insertion of any intravascular or airway devices
  - Name, dosage, route and time of drugs
  - Name and amount of IV fluids
Intra-operative Anesthesia Record

- Intra-operative Record must contain the following (continued):
  - Blood/blood products
  - Oxygenation and ventilation parameters
  - Time based documentation of continuous vital signs
  - Complications, adverse reactions, problems during anesthesia with symptom, VS, treatment rendered and response to treatment
## ANESTHESIA RECORD

<table>
<thead>
<tr>
<th>Pre-Procedures</th>
<th>Monitors and Equipment</th>
<th>Anesthetic Technique</th>
<th>Airway Management</th>
<th>Recovery</th>
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<tbody>
<tr>
<td><strong>Identified:</strong></td>
<td><strong>Monitors:</strong></td>
<td><strong>General:</strong></td>
<td><strong>Intubation:</strong></td>
<td><strong>Location:</strong></td>
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<td>ID: □ □</td>
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<th><strong>Pre-Anesthetic State:</strong></th>
<th><strong>General:</strong></th>
<th><strong>Intubation:</strong></th>
<th><strong>Location:</strong></th>
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<th><strong>Anesthetic Technique:</strong></th>
<th><strong>Airway Management:</strong></th>
<th><strong>Recovery:</strong></th>
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<tbody>
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<td><strong>Regional:</strong></td>
<td><strong>Type:</strong></td>
<td><strong>Time:</strong></td>
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**TIME:**
- Oxygen (L/min): □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ ^...
**Anesthesia Record**

<table>
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<tr>
<th>Date</th>
<th>OR #</th>
<th>INTGUAGE</th>
<th>SITE</th>
<th>R</th>
<th>L</th>
<th>Anesthesia Technique</th>
<th>Gen</th>
<th>Reg</th>
<th>IV</th>
<th>Sed</th>
<th>LMAC</th>
<th>ASA Prior to Induction</th>
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<td>1 2 3 4 5 6 E</td>
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**Anesthesia Time**

<table>
<thead>
<tr>
<th>Start</th>
<th>Stop</th>
<th>Initial</th>
<th>Pre-Medication &amp; Time</th>
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**“Time Out” Performed** (Correct Patient, Correct Procedure, Correct Side/Site, Correct Position, Special Anesthesia Equipment)

<table>
<thead>
<tr>
<th>Co L</th>
<th>M</th>
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<th>Totals</th>
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<tbody>
<tr>
<td>NaO</td>
<td>Air</td>
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<td>Changed</td>
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<td>O2</td>
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<td>Desflurane</td>
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**IV Fluids**

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**Time**

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**Symbols**

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**Remarks**

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**Recovery**

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<td>Time in:</td>
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<td>Awake - Responsive - Not Responsive</td>
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**Other**

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**Provider Signature**

<table>
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<tr>
<th>Provider Signature</th>
<th>Witness Signature</th>
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STATEMENT ON DOCUMENTATION OF ANESTHESIA CARE

Committee of Origin: Quality Management and Departmental Administration
(Approved by the ASA House of Delegates on October 15, 2003, and amended on October 22, 2008)

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, intraoperative/procedural anesthesia and postanesthesia components. Anesthesia care should be documented to reflect these components and to facilitate review.

The record should include documentation of:

I. Preanesthesia Evaluation
A. Patient interview to assess:
   1. Patient and procedure identification.
   2. Verification of admission status (inpatient, outpatient, “short stay”, etc.)
   3. Medical history
   4. Anesthetic history
   5. Medication/Allergy history
   6. NPO status
B. Appropriate physical examination, including vital signs and documentation of airway assessment.
C. Review of objective diagnostic data (e.g., laboratory, ECG, X-ray) and medical records.
D. Medical consultations when applicable.
E. Assignment of ASA physical status, including emergent status when applicable.
F. Formulation of the anesthetic plan and discussion of the risks and benefits of the plan.

Post-Anesthesia Evaluation 1005

- Must have policies in place to ensure compliance with the post-anesthesia evaluation requirements

- Post-anesthesia evaluation must be done by someone who is qualified to give anesthesia
  - 5 who are qualified to give as previously mentioned
  - Can not delegate it to a RN, PA, or NP

- Must be done no later than 48 hours after the surgery or procedure requiring anesthesia services
Post-Anesthesia Evaluation 1005

- Must be completed as required by hospital policies and procedures
- Must be completed as required by any state specific laws
  - State law can be more stringent but not less stringent so if state wants to require it to be done in 24 instead of 48 hours you must comply
- P&Ps must be approved by the MS
- P&Ps must reflect current standards of care
Post Anesthesia Evaluation 1005

- Document in chart within **48 hours** for patients receiving anesthesia services (general, regional, deep sedation, MAC)

- For inpatients and outpatients now
  - So may have to call some outpatients if not seen before they left the hospital
  - Note different for CAH hospitals under their manual under tag 322 (perform before patient leaves the hospital)

- Does not have to be done by the same person who administered the anesthesia
Post Anesthesia Evaluation

- Has to be done only by anesthesia person (CRNA, AA, anesthesiologist) or qualified doctor, dentist, podiatrist, or oral surgeon

- 48 hours starts at time patient moved into PACU or designated recovery area (SICU etc.)

- 48 hour is an outside parameter

- Individual risk factors may dictate that the evaluation be completed and documented sooner than 48 hours
  - This should be addressed by hospital P&P
Evaluation can not generally be done at point of movement to the recovery area since patient not recovered from anesthesia.

Patient must be sufficiently recovered so as to participate in the evaluation e.g. answer questions, perform simple tasks etc.
Post Anesthesia Evaluation

- For same day surgeries may be done after discharge if allowed by P&P and state law
- If the patient is still intubated and in the ICU still need to do within the 48 hours
  - Would just document that the patient is unable to participate
  - If patient requires long acting anesthesia that would last beyond the 48 hours would just document this and note that full recovery from regional anesthesia has not occurred
Post-Anesthesia Assessment to Include 1005

- Respiratory function with respiratory rate, airway patency and oxygen saturation
- CV function including pulse rate and BP
- Mental status, temperature
- Pain
- Nausea and vomiting
- Post-operative hydration
  - Consider having a form to capture these requirements
Post-Anesthesia Survey Procedure

- Surveyor is review medical records for patients having anesthesia and make sure post-anesthesia evaluation is in the chart
- Surveyor to make sure done by practitioner who is qualified to give anesthesia
- Surveyor to make sure all postanesthesia evaluations are done within 48 hours
- Surveyor to make sure all the required elements are documented for the postanesthesia evaluation
Post Anesthesia ASA Guidelines

- Patient evaluation on admission and discharge from the postanesthesia care unit
- A time-based record of vital signs and level of consciousness
- A time-based record of drugs administered, their dosage and route of administration
- Type and amounts of intravenous fluids administered, including blood and blood products
- Any unusual events including postanesthesia or post procedural complications
- Post-anesthesia visits
STANDARDS FOR POSTANESTHESIA CARE

Committee of Origin: Standards and Practice Parameters

(Approved by the ASA House of Delegates on October 27, 2004, and last amended on October 21, 2009)

These standards apply to postanesthesia care in all locations. These standards may be exceeded based on the judgment of the responsible anesthesiologist. They are intended to encourage quality patient care, but cannot guarantee any specific patient outcome. They are subject to revision from time to time as warranted by the evolution of technology and practice.

STANDARD I

ALL PATIENTS WHO HAVE RECEIVED GENERAL ANESTHESIA, REGIONAL ANESTHESIA OR MONITORED ANESTHESIA CARE SHALL RECEIVE APPROPRIATE POSTANESTHESIA MANAGEMENT.¹

1. A Postanesthesia Care Unit (PACU) or an area which provides equivalent postanesthesia care (for example, a Surgical Intensive Care Unit) shall be available to receive patients after anesthesia care. All patients who receive anesthesia care shall be admitted to the PACU or its equivalent except by specific order of the anesthesiologist responsible for the patient’s care.

2. The medical aspects of care in the PACU (or equivalent area) shall be governed by policies and procedures which have been reviewed and approved by the Department of Anesthesiology.

3. The design, equipment and staffing of the PACU shall meet requirements of the facility’s accrediting and licensing bodies.

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.

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
STANDARDS FOR POSTANESTHESIA CARE

Committee of Origin: Standards and Practice Parameters

(Approved by the ASA House of Delegates on October 27, 2004, and last amended on October 21, 2009)

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STANDARD II

A PATIENT TRANSPORTED TO THE PACU SHALL BE ACCOMPANIED BY A MEMBER OF THE ANESTHESIA CARE TEAM WHO IS KNOWLEDGEABLE ABOUT THE
ASA Practice Guideline Postanesthesia Care

http://asahq.org/For-Members/Practice-Management/Practice-Parameters.aspx

Practice Guidelines for Postanesthetic Care

A Report by the American Society of Anesthesiologists Task Force on Postanesthetic Care

PRACTICE guidelines are systematically developed recommendations that assist the practitioner and patient in making decisions about health care. These recommendations may be adopted, modified, or rejected according to clinical needs and constraints.

Practice guidelines are not intended as standards or absolute requirements. The use of practice guidelines cannot guarantee any specific outcome. Practice guidelines are subject to periodic revision as warranted by the evolution of medical knowledge, technology, and practice. The Guidelines provide basic recommendations that are supported by analysis of the current literature and by a synthesis of expert opinion, open forum commentary, and clinical feasibility data (Appendix).

A. Definition of Postanesthetic Care

The literature does not provide a standard definition for postanesthetic care. For these Practice Guidelines, postanesthetic care refers to those activities undertaken to manage the patient following completion of a surgical procedure and the concomitant primary anesthetic.

anesthesia or sedation and analgesia care. This is accomplished by evaluating available evidence and providing recommendations for patient assessment, monitoring, and management with the goal of optimizing patient safety. It is expected that each recommendation will be individualized according to the needs of each patient.

C. Focus

These Guidelines focus on the perioperative management of patients with the goal of improving postanesthetic quality of life, reducing postoperative adverse events, providing a uniform assessment of recovery, and streamlining postoperative care and discharge criteria.

These Guidelines apply to patients of all ages who have just received general anesthesia, regional anesthesia, or moderate or deep sedation. The Guidelines may need to be modified to meet the needs of certain patient populations, such as children or the elderly. The Guidelines do not apply to patients receiving infiltration local anesthesia without sedation, patients receiving minimal sedation (anxiolysis) \(^1\) or patients receiving intensive care.
AANA Post-anesthesia Care Standards

Postanesthesia Care Standards for the Certified Registered Nurse Anesthetist

www.aana.com/resources2/professionalpractice/Pages/Postanesthesia-Care-Standards.aspx

Standard VII of AANA Scope and Standards for Nurse Anesthesia Practice:

Evaluate the patient’s status and determine when it is safe to transfer the responsibility of care. Accurately report the patient’s condition, including all essential information, and transfer the responsibility of care to another qualified healthcare provider in a manner that assures continuity of care and patient safety.

Standard VII is not specific to postanesthesia care, but includes all transfers of the responsibility of care for the patient from the CRNA to another qualified healthcare provider. For example, transfers of the responsibility of care may occur when the CRNA transfers care to another anesthesia professional during the provision of anesthesia care or when the CRNA transfers care to another qualified healthcare provider for postanesthesia recovery. During all transfers of care, the CRNA is responsible for first determining that it is safe to transfer the responsibility of care of the patient to another qualified healthcare provider and to accurately report all essential information to the qualified healthcare provider who accepts responsibility for the patient’s care.

That said, the AANA believes that the postanesthesia period is an extension of the anesthesia process and warrants additional consideration. The anesthesia professional’s responsibility to the patient extends through this period. Regardless of the practice setting, this responsibility includes a thorough knowledge of the patient’s needs, the communication of those needs to qualified providers, and the assurance that the postanesthesia care will be consistent with the patient’s needs.

Anesthesia services are being performed in increasingly diverse settings as medical care services expand and change. These standards shall apply to all settings where postanesthesia care is rendered.

The anesthesia professional, with specialized knowledge and skills, has a primary role in overseeing postanesthesia
Six FAQs

- How can the same drugs be used in the OR for anesthesia but in the ED for a sedative?
- What nationally recognized guidelines are available for hospitals to use to develop their P&Ps?
- What is the appropriate training for a sedation nurse?
- Why is there a particular mention in the interpretive guidelines on ED sedation policies?
- Can hospital adopt a P&P that all anesthesia agents in lower doses can be used for sedation (NO!)
FAQ 1   Drugs Used

The following questions and answers are provided to facilitate understanding of the revised guidance:

Q1: How can the same drug be used at the same facility for general anesthesia in the operating room and for a sedative in the emergency department or a procedure room?

A1: The physiological result in terms of level of sedation for a particular medication may vary based on dosage, route and timing of administration, the metabolism and interaction with other medications, the clinical status and body habitus of the patient, etc. However, there is neither a bright line nor predictability about when a patient will inadvertently convert from moderate to deep sedation, or how much medication will bring about the desired sedation state. In addition, for some medications there is no antidote that can quickly reverse its effects; rescue of an overly-sedated patient requires very specific skills in airway management and ventilation. For this reason the IG continues to require that hospitals ensure that procedures are in place to rescue patients whose level of sedation becomes deeper than originally intended.
Q2: What nationally recognized guidelines are available for hospitals to use to develop their policies concerning what is anesthesia and what is analgesia and which procedures need which? What does “nationally recognized guidelines” mean?

A2: CMS’ expectation is that such guidelines are issued by a national organization that has appropriate expertise and which has used consensus-setting process of professionals with appropriate expertise in developing its guidelines. We recognize that such organizations may not always fully agree with each other. Examples of organizations with guidelines related to anesthesia administration include, but not limited to, the following:

- The American Society of Anesthesiologists (ASA)

- The American College of Emergency Physicians (ACEP)
  - Clinical Policies Subcommittee, which included members of ACEP and the Emergency Nurses Association (ENA) published their “Clinical policy on
Questions 3 and 3 ED and Sedation Nurse

Q3: What is the appropriate training for a “sedation” nurse?

A3: Currently there is no Medicare definition of a “sedation nurse,” nor does there appear to be any uniformly accepted training for a sedation nurse. Some states specifically address RN-administered sedation in their professional licensure laws and regulations. It is possible that national organizations producing anesthesia guidelines may develop guidelines/recommendations in this area in the future.

Q4: Why is there a particular mention in the IG on the emergency department’s (ED’s) sedation policies?

A4: The ED is a unique environment where patients present on an unscheduled basis with often very complex problems that may require several emergent or urgent interventions to proceed simultaneously to prevent further morbidity or mortality. In addition, emergency medicine-trained physicians have very specific skill sets to manage airways and ventilation that is
Q5: The regulations and IG state that hospital anesthesia services be under the direction of one individual. How can hospitals ensure that the policies and procedures that define the various uses of analgesia and anesthesia are not too narrow (or broad) or based on the opinions of one individual?

A5: In the IG, hospitals are encouraged to develop the anesthesia services policies in collaboration with other hospital disciplines, such as surgery, pharmacy, nursing, safety experts, etc. A hospital may choose to require medical staff review and approval of the anesthesia policies. These collaborative approaches are not, however, a regulatory requirement. A hospital may therefore allow the director to develop the policies alone. However, as in all cases, the hospital’s governing body is ultimately responsible to assure that the policies adopted meet the regulatory requirements.

Q6: Is it acceptable if a hospital adopts a policy stating that all anesthetic agents in lower doses can be used for sedation and therefore no medications qualify as anesthesia, and thus there is no need for them to be administered by anesthesia professionals? Is this acceptable?

A6: We are not aware of any such nationally recognized guidelines at this time, nor do we think it likely that an organization would adopt a broad guideline stating that there are no medications that ever qualify as anesthesia.
Anesthesia Standard CAH

§485.639(b) Standard: Anesthetic Risk and Evaluation

(1) A qualified practitioner, as specified in paragraph (a) of this section, must examine the patient immediately before surgery to evaluate the risk of the procedure to be performed.

(2) A qualified practitioner, as specified in paragraph (c) of this section, must examine each patient before surgery to evaluate the risk of anesthesia.

(3) Before discharge from the CAH, each patient must be evaluated for proper anesthesia recovery by a qualified practitioner, as specified in paragraph (c) of this section.

Interpretive Guidelines §485.639(b)

The pre-anesthesia evaluation must be performed prior to inpatient or outpatient surgery. The pre-anesthesia evaluation must be performed by an individual qualified to administer anesthesia. The pre-operative anesthetic evaluation should include:

• Notation of anesthesia risk
CAH Hospitals

- Current CAH manual
- Anesthesia standard starts at tag C-0322 and see 323
  - Most of the sections are the same but no standard for having a medical director and post-anesthesia is different as must be done before patient leaves the hospital
- Much shorter section
  - Does not mention CRNA going to OB unit to put in epidural but most likely is treated the same
CAH Pre-anesthesia Assessment  C-322

- Must be done by qualified practitioner
  - Example would include CRNA and anesthesiologist

- Includes what must be in the preanesthesia assessment
  - Notation of anesthesia risk
  - Anesthesia, drug and allergy history
  - Any potential anesthesia problems identified
  - Patient's condition prior to induction of anesthesia
Post Anesthesia Assessment CAH 322

- Cardiopulmonary status
- Level of consciousness
- Any follow-up care and/or observations and
- Any complications occurring during post-anesthesia recovery
- States that the postanesthesia follow up report must be written prior to discharge from anesthesia services
The End

Questions?

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CPHRM, CCMSCP
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Dublin, Ohio 43017
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sdill1@columbus.rr.com

TJC standards follow
ASGE, ACEP (ED), ENA
AQI Quality Metrics for Procedural Sedation

AQI consensus recommendations for the Director of Anesthesia Services charged with initiating a quality management program in procedural sedation. Data must be gathered each month from each unit where patients receive sedation. Data gathering should be modified as necessary to fit the information technology available and the patient population served.

Core Elements

**Volume Metrics**
- Type and number of procedures performed
- Number of patients receiving light or moderate sedation
  - Number receiving sedation via Computer-Assisted Personalized Sedation (CAPS)
- Number of patients receiving deep sedation
- Number of patients cared for by an anesthesia team

**Outcomes**
- Cases completed as planned, without complication, versus:
- Cases cancelled due to patient discomfort or anxiety
- Cases with unplanned escalation in the continuum of sedation
- Patients receiving rescue medication: flumazenil or naloxone
- Unplanned respiratory support required in light or moderate sedation cases
  - Placement of nasal trumpet or oral airway
  - Placement of supraglottic airway (e.g. LMA) or endotracheal tube
  - Assisted ventilation with bag-valve-mask
  - Oxygen saturation < 85% for greater than 3 minutes
- Patients experiencing a serious adverse event (e.g. perforation, anaphylaxis, cardiac arrest)
Epidural or Spinal for Pain Relief

- Bucket one analgesia or pain
  - CMS removes language that says administration of epidural or spinal during labor and delivery is not subject to the anesthesia standard
- Need policy on who can do analgesia such as PA, NP, or RN
  - PA, physician or NP may give local with Lidocaine to suture in the ED
  - RN may give Valium 2.5 mg to patient before MRI
  - RN may help with moderate sedation in the ED or GI lab
CDC Requirements

- Any CRNA or anesthesiologist who puts in an epidural or spinal should remember the CDC standard
- The CDC requires that a mask be worn
- There were five women who had an epidural for pain relief and the anesthesiologist did not wear a mask
- All became septic and one dies from strept salivarius
- CDC issues a notice in MMWR
Safe Injection Practices Patient Safety Brief
Emergency Medicine Patient Safety Foundation

By Sue Dill Calloway RN MSN JD
Ruth Carrico PhD RN FSHEA CIC

July 2012

The Centers for Disease Control and Prevention (CDC) says there are 1.7 million healthcare-associated infections in the US every year. Of these, it is estimated that about 99,000 deaths occur as a result. Infection prevention and control is an important issue in today’s healthcare environment. It is important to accreditation organizations like the Joint Commission (TJC). The Joint Commission has eight pages of standards in the chapter on
Morbidity and Mortality Weekly Report (MMWR)

www.cdc.gov/mmwr/preview/mmwrhtml/mm5903a1.htm

Bacterial Meningitis After Intrapartum Spinal Anesthesia --- New York and Ohio, 2008--2009

Weekly

January 29, 2010 / 59(03);65-69

In June 2007, the Healthcare Infection Control Practices Advisory Committee (HICPAC) recommended for the first time that surgical masks be worn by spinal procedure operators to prevent infections associated with these procedures (1). HICPAC made the recommendation in response to several reports of meningitis following myelography procedures. In September 2008, three bacterial meningitis cases in postpartum women were reported to the New York State Department of Health (NYSDOH); in May 2009, two similar cases were reported to the Ohio Department of Health. All five women had received intrapartum spinal anesthesia. Four were confirmed to have Streptococcus salivarius meningitis, and one woman subsequently died. This report summarizes the investigations of these five cases, which determined that the New York cases were associated with one anesthesiologist and the Ohio cases were associated with a second anesthesiologist. In Ohio, the anesthesiologist did not wear a mask; wearing a mask might have prevented the infections. The findings underscore the need to follow established infection-control recommendations during spinal procedures, including the use of a mask and adherence to aseptic technique.

Case Reports

New York. In September 2008, a healthy woman aged 24 years (patient A) was admitted in active labor to a New York City hospital. She received combined spinal-epidural anesthesia from anesthesiologist A, and delivered a healthy baby. Approximately 22 hours after receiving anesthesia, patient A experienced headache, back pain, rigors, nausea, vomiting, and disorientation.

Within 1 hour of patient A's admission, a second healthy woman aged 31 years (patient B) was admitted to the same hospital in active labor. Patient B also received combined spinal-epidural anesthesia from anesthesiologist A and delivered a healthy baby.
Injection Safety

Injected medicines are commonly used in healthcare settings for the prevention, diagnosis, and treatment of various illnesses. Unsafe injection practices put patients and healthcare providers at risk of infectious and non-infectious adverse events and have been associated with a wide variety of procedures and settings. This harm is preventable. Safe injection practices are part of Standard Precautions and are aimed at maintaining basic levels of patient safety and provider protections. As defined by the World Health Organization, a safe injection does not harm the recipient, does not expose the provider to any avoidable risks and does not result in waste that is dangerous for the community.
Unsafe Injection Practices and Disease Transmission

Reuse of syringes combined with the use of single-dose vials for multiple patients undergoing anesthesia can transmit infectious diseases. The syringe does not have to be used on multiple patients for this to occur.

1. A clean syringe and needle are used to draw the sedative from a new vial.
2. It is then administered to a patient who has been previously infected with hepatitis C virus (HCV). Backflow into the syringe contaminates the syringe with HCV.
3. The needle is replaced, but the syringe is reused to draw additional sedative from the same vial for the same patient, contaminating the vial with HCV.
4. A clean needle and syringe are used for a second patient, but the contaminated vial is reused. Subsequent patients are now at risk for infection.

Source: www.southernnevadahealthdistrict.org
## Injection Practices (injectable medications, saline, other infusates)

**Additional Instructions:**

Observations are to be made of staff who prepare and administer medications and perform injections (e.g., anesthesiologists, certified registered nurse anesthetists, nurses).

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<th>Was practice performed?</th>
<th>Manner of confirmation</th>
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<tbody>
<tr>
<td>A. Needles are used for only one patient</td>
<td>1 Yes 2 No 3 N/A</td>
<td>4Observation 5Interview 6Both</td>
</tr>
<tr>
<td>B. Syringes are used for only one patient</td>
<td>1 Yes 2 No 3 N/A</td>
<td>4Observation 5Interview 6Both</td>
</tr>
<tr>
<td>C. Medication vials are always entered with a new needle</td>
<td>1 Yes 2 No 3 N/A</td>
<td>4Observation 5Interview 6Both</td>
</tr>
<tr>
<td>D. Medication vials are always entered with a new syringe</td>
<td>1 Yes 2 No 3 N/A</td>
<td>4Observation 5Interview 6Both</td>
</tr>
<tr>
<td>E. Medications that are pre-drawn are labeled with the time of draw, initials of the person drawing, medication name, strength, and expiration date or time</td>
<td>1 Yes 2 No 3 N/A</td>
<td>4Observation 5Interview 6Both</td>
</tr>
</tbody>
</table>

*Note: A “No” answer should result in citation as a deficient practice in relation to 42 CFR 416.48(a), Administration of Drugs*
The Centers for Disease Control and Prevention (CDC) says there are 1.7 million healthcare-associated infections in the US every year. Of these, it is estimated that about 99,000 deaths occur as a result. Infection prevention and control is an important issue in today’s healthcare environment. It is important to accreditation organizations like the Joint Commission (TJC). The Joint Commission has eight pages of standards in the chapter on Infection Prevention and Control (IC).

Infection prevention and control is also important to the Centers for
Advancing ASC Quality

To support the ASC industry’s focus on high quality care, the ASC Quality Collaboration is assembling ASC Tools for Infection Prevention, or ASC TIPS. Our goal is to make infection prevention resources readily accessible to ASCs by bringing them together in one location.

The following ASC TIPS are now available:

- Hand Hygiene Toolkit
- Safe Injection Practices Toolkit
- Point of Care Devices Toolkit
- Environmental Infection Prevention Toolkit
- Single-Use Device Reprocessing Toolkit
- Endoscope Reprocessing Toolkit
- Sterilization and High-Level Disinfection Toolkit

http://ascquality.org/advancing_asc_quality.cfm
Safe Injection Practices Toolkit

The resources in this toolkit may only be used for internal improvement and education efforts. They may not be used for commercial purposes.

Safe injection practices are crucial to basic levels of patient safety and provider protection. Hepatitis C virus, hepatitis B virus, and HIV can be spread from patient to patient when safe injection practices are not used.

The ASC Quality Collaboration has assembled a variety of resources and information that may be used to supplement your current processes to enhance existing injection practices.

The BASIC Safe Injection Practices Toolkit includes three essential resources:

- Safe Injection Practices: What CMS Surveyors Are Looking For
- One Needle, One Syringe, One Time Poster
- Injection Practices Policy and Procedure Template

The EXPANDED Safe Injection Practices contains both essential resources and a broader array of materials, including:

- Assessment Tools
- Implementation Aids
- Training Materials
- Monitoring Tools
- Workplace Reminders
- Guidelines from Leading Authorities
Standards of Practice

- Standards of care and practice follow including:
  - ASA
  - ACEP
  - ENA
  - AANA
  - ASGE
  - ACS
[ST-46] Statement on patient safety principles for office-based surgery utilizing moderate sedation/analgesia, deep sedation/analgesia, or general anesthesia

[by the American College of Surgeons]

The following statement was approved by the ACS Board of Regents at its October 2003 meeting.

Over the past few years, there has been a noticeable increase in the number of invasive procedures being performed in the office setting. Recognizing that many states still haven’t issued patient safety guidelines in this area, the American College of Surgeons (ACS) sponsored a resolution, which was passed at the American Medical Association’s (AMA’s) December 2002 Interim Meeting of its House of Delegates. In brief, the resolution called on the AMA to work with the ACS in "convening a work group of interested specialty societies and state medical associations to identify specific requirements for optimal office-based procedures and utilize those requirements to develop guidelines and model state legislation for use by state regulatory authorities to assure quality of office-based procedures."

On February 5, 2003, the ACS convened a meeting of interested surgical specialty societies to discuss the surgical community’s perspective on this issue. In addition, the College invited representatives from the American Society of Anesthesiologists (ASA) to provide information and guidance regarding ASA’s anesthesia guidelines. As a result of this meeting, a majority of the surgical community reached consensus on a set of 10 core principles that states should examine when moving to regulate office-based procedures.

http://facs.org/fellows_info/statements/st-46.html
FDA Upholds ASA Stance on Safe Use of Propofol

Thursday, August 19, 2010

In 2005, ASA submitted comments to and testified before the FDA opposing a Citizen Petition (Docket FDA-2005-P-0059) by the American College of Gastroenterology (ACG) asking that FDA remove the following language:

“For general anesthesia or monitored anesthesia care (MAC) sedation, DIPRIVAN Injectable Emulsion should be administered only by persons trained in the administration of general anesthesia and not involved in the conduct of the surgical/diagnostic procedure.”

In a letter dated August 11, 2010, and made available on August 16, FDA denied the ACG petition in its entirety.

FDA summarized its reasoning as follows (page 2): “After considering your [petitioners’] claims and the literature you provided for our review, we conclude that you have not shown that the warning is no longer warranted or appropriate. In fact, we conclude that the warning is warranted and appropriate in light of the significant risks associated with propofol, and we further conclude that the warning should help ensure that propofol is used safely. Accordingly, we will not seek to have the warning removed, reduced, or otherwise amended.”

The letter also references ASA, saying that the warning is consistent with recommendations of ASA, among others (see p. 7, p. 11, footnote 20). FDA also dispatched ACG’s cost contention, saying that added costs associated with having an anesthesiologist administer the drug was warranted in light of the risks.

Finally, FDA concluded that the warning did not unduly restrict the practice of gastroenterology, mentioning that hospitals typically set their own procedures, but that in any event the warning was “appropriate and warranted in light of the significant risks associated with propofol.”

- FDA Denial Letter to ACG Petition on Propofol – August 11, 2010
- ASA Comment Letter to FDA – October 19, 2005
AUG 11 2010

Richard M. Cooper, Esq.
Williams & Connolly LLP
725 Twelfth Street, N.W.
Washington, D.C. 20005

Re: Docket No. FDA-2005-P-0059

Dear Mr. Cooper:

This responds to your citizen petition dated June 27, 2005 (Petition), submitted on behalf of the American College of Gastroenterology.¹ You ask the Food and Drug Administration (FDA or Agency) to remove the following warning from the labeling for Diprivan (propofol) (Petition at 1-2):²

For general anesthesia or monitored anesthesia care (MAC) sedation, DIPRIVAN Injectable Emulsion should be administered only by persons trained in the administration of general anesthesia and not involved in the conduct of the surgical/diagnostic procedure.

After carefully considering your request, we deny it for the reasons given below. This decision is based on a review of the Petition including the scientific and medical literature accompanying the Petition, the comments submitted on the petition,³ and the experience and judgment of the Agency.
II. DISCUSSION

You request that FDA remove the warning from the propofol labeling stating that propofol should be administered only by persons trained in the administration of general anesthesia and not involved in the conduct of the surgical/diagnostic procedure.\(^7\) You state that propofol has several advantages over alternative sedation agents for endoscopic procedures but has a similar “risk profile” (Petition at 2). You claim the warning is no longer warranted because studies have established that propofol can be administered safely and effectively by medical professionals other than anesthesiologists and nurse anesthetists (Petition at 3-8). You believe that the requested labeling change will promote efficiency and reduce costs to payors by eliminating the need for an anesthesiologist or nurse anesthetist to be present to administer propofol during an endoscopic procedure (Petition at 1). You also suggest that the current warning places an unwarranted restriction on the ability of gastroenterologists to practice medicine (Petition at 1).

After considering your claims and the literature you provided for our review, we conclude that you have not shown that the warning is no longer warranted or appropriate. In fact, we conclude that the warning is warranted and appropriate in light of the significant risks associated with propofol, and we further conclude that the warning should help ensure that propofol is used safely. Accordingly, we will not seek to have the warning removed, reduced, or otherwise amended.
ASA Standards, Guidelines and Statements provide guidance to improve decision-making and promote beneficial outcomes for the practice of anesthesia. They are not intended as unique or exclusive indicators of appropriate care. The interpretation and application of Standards, Guidelines and Statements takes place within the context of local institutions, organizations and practice conditions. A departure from one or more recommendations may be appropriate if the facts and circumstances demonstrate that the rendered care met the physician's duty to the patient.

**Standards** provide rules or minimum requirements for clinical practice. They are regarded as generally accepted principles of patient management. Standards may be modified only under unusual circumstances, e.g., extreme emergencies or unavailability of equipment.

**Guidelines** are systematically developed recommendations that assist the practitioner and patient in making decisions about healthcare. These recommendations may be adopted, modified, or rejected according to clinical needs and constraints and are not intended to replace local institutional policies. In addition, practice guidelines are not intended as standards or absolute requirements, and their use cannot guarantee any specific outcome. Practice guidelines are subject to revision as warranted by the evolution of medical knowledge, technology, and practice. They provide basic recommendations that are supported by a synthesis and analysis of the current literature, expert opinion, open forum commentary, and clinical feasibility data.

**Statements** represent the opinions, beliefs, and best medical judgments of the House of Delegates. As such, they are not necessarily subjected to the same level of formal scientific review as ASA Standards or Guidelines. Each ASA member, institution or practice should decide individually whether to implement some, none, or all of the principles in ASA statements based on the sound medical judgment of anesthesiologists participating in that institution or practice.

Also see Practice Parameters

These files require Adobe Acrobat Reader®

www.asahq.org/publicationsAndServices/sgstoc.htm
STATEMENT ON SAFE USE OF PROPPOFOL

Committee of Origin: Ambulatory Surgical Care

(Approved by the ASA House of Delegates on October 27, 2004, and amended on October 21, 2009)

Because sedation is a continuum, it is not always possible to predict how an individual patient will respond. Due to the potential for rapid, profound changes in sedative/anesthetic depth and the lack of antagonist medications, agents such as propofol require special attention. Even if moderate sedation is intended, patients receiving propofol should receive care consistent with that required for deep sedation.

The Society believes that the involvement of an anesthesiologist in the care of every patient undergoing anesthesia is optimal. However, when this is not possible, non-anesthesia personnel who administer propofol should be qualified to rescue* patients whose level of sedation becomes deeper than initially intended and who enter, if briefly, a state of general anesthesia.**

- The physician responsible for the use of sedation/anesthesia should have the education and training to manage the potential medical complications of sedation/anesthesia. The physician should be proficient in airway management, have advanced life support skills appropriate for the patient population, and understand the pharmacology of the drugs used.

The physician should be physically present throughout the sedation and remain immediately available until the patient is medically discharged from the post procedure recovery area.

- The practitioner administering propofol for sedation/anesthesia should, at a minimum, have the education and training to identify and manage the airway and cardiovascular changes which occur in a patient who enters a state of general anesthesia, as well as the ability to assist in the management of complications.

The practitioner monitoring the patient should be present throughout the procedure and be completely dedicated to that task.

- During the administration of propofol, patients should be monitored without interruption to
STATEMENT ON GRANTING PRIVILEGES FOR ADMINISTRATION OF MODERATE SEDATION TO PRACTITIONERS WHO ARE NOT ANESTHESIA PROFESSIONALS

Committee of Origin: Ad Hoc Committee on Credentialing

(Approved by the ASA House of Delegates on October 25, 2005, and amended on October 18, 2006)

The American Society of Anesthesiologists is vitally interested in the safe administration of anesthesia. As such, it has concern for any system or set of practices, used either by its members or the members of other disciplines that would adversely affect the safety of anesthesia administration. It has genuine concern that individuals, however well intentioned, who are not anesthesia professionals may not recognize that sedation and general anesthesia are on a continuum and thus deliver levels of sedation that are, in fact, general anesthesia without having the training and experience to recognize this state and respond appropriately.

The intent of this statement is to suggest a framework for granting privileges that will help ensure competence of individuals who administer or supervise the administration of moderate sedation. Only physicians, dentists or podiatrists who are qualified by education, training and licensure to administer moderate sedation should supervise the administration of moderate sedation. This statement can be used by any facility—hospital, ambulatory care or physician’s, dentist’s or podiatrist’s office—in which an internal or external credentialing process is required for administration of sedative and analgesic drugs to establish a level of moderate sedation.
STATEMENT ON GRANTING PRIVILEGES FOR DEEP SEDATION TO NON-ANESTHESIOLOGIST SEDATION PRACTITIONERS

Committee of Origin: Ad Hoc on Non-Anesthesiologist Privileging
(Approved by the ASA House of Delegates on October 20, 2010)

1. INTRODUCTION

The American Society of Anesthesiologists is vitally interested in the safe administration of all anesthesia services including moderate and deep sedation. As such, it has concern for any system or set of practices, used either by its members or the members of other disciplines that would adversely affect the safety of anesthesia or sedation administration. It has genuine concern that individuals, however well intentioned, who are not anesthesia professionals may not recognize that sedation and general anesthesia are on a continuum, and thus deliver levels of sedation that may, in fact, be general anesthesia without having the training and experience to respond appropriately.

ASA believes that anesthesiologist participation in all deep sedation is the best means to achieve the safest care. ASA acknowledges, however, that Medicare regulations permit some non-anesthesiologists to administer or supervise the administration of deep sedation. This advisory should not be considered as an endorsement, or absolute condemnation, of this practice by ASA but rather to serve as a potential guide to its members who may be called upon by administrators or others to provide input in this process. This document provides a framework to identify those physicians, dentists, oral surgeons or podiatrists who may potentially qualify to administer or supervise the administration of deep sedation.
ASA Guidelines for Privileges

GUIDELINES FOR DELINEATION OF CLINICAL PRIVILEGES IN ANESTHESIOLOGY

Committee of Origin: Quality Management and Departmental Administration

(Approved by the ASA House of Delegates on October 15, 2003, and last amended on October 22, 2008)

The following guidelines are designed to assist anesthesiologists and organizations in developing a program for the delineation of clinical privileges in anesthesiology. The guidelines are meant to apply to physicians practicing anesthesiology within an organization that has a formal process for delineating privileges and a program of peer review that evaluates the clinical performance and patient care results of physicians who are granted 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 should be awarded on a time-limited basis in accordance with medical staff bylaws and institutional/facility and governmental rules and regulations, as applicable.

To be awarded medical staff privileges in anesthesiology, a physician must fully meet certain required criteria. It is possible to make all the following criteria mandatory or to have a mixture of
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:

1. **Management of personnel** – Anesthesiologists should assure the assignment of appropriately skilled physician and/or nonphysician personnel for each patient and procedure.

2. **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 nonphysicians may contribute to the preoperative collection and documentation of patient data, the anesthesiologist is responsible for the overall evaluation of each patient.

3. **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.
Supervision of Nurse Anesthetists by Surgeons

Note: In this paragraph “surgeon(s)” may refer to any appropriately trained, licensed and credentialed nonanesthesiologist who may supervise nurse anesthetists.

General, regional and monitored anesthesia care all expose patients to risks. Nonanesthesiologist physicians may not possess the expertise that uniquely qualifies and enables anesthesiologists to manage the most clinically challenging medical situations that arise during the perioperative period. While a few surgical training programs provide some anesthesiology specific education (e.g., some oral and maxillofacial residencies), no surgical, dental, podiatric or any other nonanesthesiology training programs provide enough training specific to anesthesiology to enable their graduates to provide the level of medical supervision and clinical expertise that anesthesiologists provide. However, surgeons can still significantly add to patient safety and quality of care by assuming medical responsibility for all perioperative care when an anesthesiologist is not present. Anesthetic and surgical complications often arise unexpectedly.
and require immediate medical diagnosis and treatment. Even if state law or regulation says a surgeon is not “required” to supervise nonphysician anesthesia providers, the surgeon may be the only medical doctor on site. Whether the need is preoperative medical clearance or intraoperative resuscitation from an unexpected complication, the surgeon, both ethically and according to training and ability, should be expected to provide medical oversight or supervision of all perioperative health care provided, including nonphysician nurse anesthesia care. To optimize patient safety, careful consideration is required when surgeons can be expected to be the only medical doctor available to provide oversight of all perioperative care. This is especially true in freestanding surgery centers and surgeons’ offices where, in the event of unexpected emergencies, consultation with other medical specialists frequently is not available. In the event of unexpected emergencies, lack of immediately available and appropriately trained physician support can reduce the likelihood of successful resuscitation. This should always be a consideration when deciding which procedures should be performed in these settings, and on which patients, particularly if the individual supervising the nurse anesthetist is not a medical doctor with training appropriate for providing critical perioperative medical management.
STATEMENT ON GRANTING PRIVILEGES FOR DEEP SEDATION TO NON-
ANESTHESIOLOGIST SEDATION PRACTITIONERS

2. ADVISORY

This advisory is designed to assist health care facilities in developing a program for the
delineation of clinical privileges for practitioners who are not anesthesia professionals to
administer sedative and analgesic drugs to establish a level of deep sedation. They are written to
apply to every setting in which an internal or external privileging process is required for granting
privileges to administer sedative and analgesic drugs to establish a level of deep sedation (e.g.,
hospital, freestanding procedure center, ambulatory surgery center, physician’s or dentist’s office,
etc.). These recommendations do not lead to the granting of privileges to administer general
anesthesia.

The granting, reappraisal and revision of clinical privileges will be awarded on a time-limited
basis in accordance with rules and regulations of the health care facility, its medical staff,
organizations accrediting the health care facility, and relevant local, state and federal
governmental agencies.

NON-ANESTHESIOLOGIST SEDATION PRACTITIONERS

Note: The Hospital Anesthesia Services Condition of Participation 42 CFR 482.52(a) limits
the administration of deep sedation to “qualified anesthesia professionals” within their scope
of practice. CMS defines these personnel specifically as an anesthesiologist; non-
4. **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 nonanesthesiologist 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 **Addendum B**).

5. **Postanesthesia care** – Routine postanesthesia care is delegated to postanesthesia nurses. The evaluation and treatment of postanesthetic complications are the responsibility of the anesthesiologist.

6. **Anesthesia consultation** – Like other forms of medical consultation, this is the practice of medicine and should not be delegated to nonphysicians.
ACEP Policies

http://www.acep.org/content.aspx?id=30060
Clinical Policy: Procedural Sedation and Analgesia in the Emergency Department

From the American College of Emergency Physicians Clinical Policies Subcommittee (Writing Committee) on Procedural Sedation and Analgesia:

Steven A. Godwin, MD, Chair
David A. Caro, MD
Stephen J. Wolf, MD
Andy S. Jagoda, MD
Ronald Charles, MD
Benjamin E. Marett, RN, MSN, CEN, CNA, COHN-S (ENA Representative 2002-2003)
Jessie Moore, RN, MSN, CEN (ENA Representative 2001-2002)

Members of the American College of Emergency Physicians Clinical Policies Committee (Oversight Committee) included:

ACEP board-approved policy statements highlight the scope of issues being addressed in emergency medicine. New policies are initially distributed to ACEP members via Annals of Emergency Medicine and posted here. In addition, the ACEP Board of Directors has directed that all policy statements undergo automatic review when they are seven years old. Unless a policy still contains relevant information, it will then sunset. Due to the extensive time required to review seven-year-old or older policies, some are still under review.
Sedation in the Emergency Department

ACEP Policy Statement
Approved by the ACEP Board January 13, 2011

Revised and approved by the ACEP Board of Directors January 2011 by replacing two rescinded policy statements, “Procedural Sedation in the Emergency Department” approved October 2004 and “The Use of Pediatric Sedation and Analgesia” originally approved March 1992; revised January 1997 and April 2008; and reaffirmed October 2001

Sedation in the Emergency Department

Procedural sedation involves the use of sedative and analgesic agents to reduce the anxiety and pain suffered by patients during procedures. Procedural sedation decreases the length of time necessary to perform a procedure, increases the likelihood of success, and reduces the potential risk of injury to the patient or healthcare worker due to uncontrolled movements.

Procedural sedation encompasses a continuum of altered levels of consciousness including minimal, moderate, deep, and dissociative sedation levels.

Procedural sedation is a critically important component of comprehensive emergency care and a required core competency of emergency medicine residency training. This training includes rescue airway interventions for support of patient
The American College of Emergency Physicians is the authoritative body for the establishment of guidelines for **sedation** of patients in the emergency setting. To promote the safe and effective use of **sedation** in emergency department patients, the American College of Emergency Physicians recommends the following:

- Emergency physicians who have received the appropriate training and skills necessary to safely provide procedural **sedation** should be eligible for credentialing in all levels of procedural **sedation**.
- The decision to provide **sedation** and the selection of the specific pharmacologic agents should be individualized for each patient by the emergency physician and should not be otherwise restricted.
- Emergency physicians and staff are expected to be familiar with the pharmaceutical agents they use and be prepared to manage their potential complications.
- To minimize complications, the appropriate drugs and dosages must be chosen and administered in an appropriately monitored setting, and a patient evaluation should be performed before, during, and after their use.
- Institutional and departmental guidelines related to the **sedation** of patients should include credentialing and verification of competency of providers, selection and preparation of patients, informed consent, equipment and monitoring requirements, staff training and competency verification, criteria for discharge, and continuous quality improvement.
Delivery of Agents for Procedural Sedation and Analgesia by Emergency Nurses

Approved by the ACEP Board of Directors April 2005 and the Emergency Nurses Association (ENA) Board March 2005

Published simultaneously, October 2005, in Journal of Emergency Nursing and Annals of Emergency Medicine

The Emergency Nurses Association (ENA) and the American College of Emergency Physicians (ACEP) support the delivery of medications used for procedural sedation and analgesia by credentialed emergency nurses working under the direct supervision of an emergency physician. These agents include but are not limited to etomidate, propofol, ketamine, fentanyl, and midazolam.
Rapid-Sequence Intubation

Reaffirmed by the ACEP Board of Directors October 2006
Reaffirmed by the ACEP Board of Directors October 2000
Originally approved by the ACEP Board of Directors September 1996

Rapid-sequence intubation (RSI) is an important technique for airway management of patients in the emergency department and is in the domain of emergency medicine practice. RSI is defined as a technique where a potent sedative or induction agent is administered virtually simultaneously with a paralyzing dose of a neuromuscular blocking agent to facilitate rapid tracheal intubation. The technique includes specific protection against aspiration of gastric contents, provides excellent access to the airway for intubation, and permits pharmacologic control of adverse responses to illness, injury, and the intubation itself. The American College of Emergency Physicians recognizes the role of RSI in modern emergency care and supports the following principles.

- Physicians performing RSI should possess training, knowledge, and experience in the techniques and pharmacologic agents used to perform RSI.
- Neuromuscular blocking agents and appropriate sedative and induction agents should be immediately available in the ED and accessible to all physicians who perform RSI in the ED.
- Quality review and patient monitoring should be addressed when policies about RSI are developed in the ED.
Level B recommendations. Propofol can be safely administered for procedural sedation and analgesia in the ED.

VII. Can ketamine, midazolam, fentanyl, propofol, and etomidate be safely administered for procedural sedation and analgesia in the ED?

Agents such as ketamine result in a dissociative state in which a patient may not speak or respond purposefully to verbal commands. Use of ketamine in the doses recommended for procedural sedation and analgesia does not result in a loss of protective reflexes. The medical literature documents the safety of its use for procedural sedation and analgesia in pediatric populations. In a well-designed randomized controlled trial in 260 children aged 5 to 15 years, Kennedy et al found that a ketamine and midazolam combination was safer and more efficacious than a fentanyl and midazolam combination for sedation in orthopedic procedures. Hypoxia occurred in 6% of patients receiving ketamine and midazolam versus 20% of patients in the fentanyl and midazolam group. Efficacy as determined by objective measures of physician and parental satisfaction were thought to be superior in the ketamine and midazolam study arm. In a consecutive case series of 1,022 children, Green et al report that ketamine at doses of 4 to 5 mg/kg intramuscularly produced adequate sedation in 98% of children. They reported airway complications in 1.4% of patients that included laryngospasm, apnea, and respiratory depression, all of which were quickly identified and treated without intubation or sequelae. Emetis occurred in 6.7% without evidence of aspiration.

Propofol-induced procedural sedation was reported to have the lowest rate of respiratory depression when compared with methohexital, fentanyl/midazolam, and etomidate. There were no significant complications. A prospective randomized trial with 103 patients receiving propofol or methohexital within the ED compared the depth of sedation with Bispectral Index scores and rates of respiratory depression assessed by ETCO₂. Of note, approximately one half of the patients in both groups met predefined criteria for respiratory depression. The study did not detect a difference in either the level of sedation by Bispectral Index or the level of subclinical respiratory depression between the 2 agents. The authors found no significant adverse events with either sedative.

In another prospective study of 43 children comparing midazolam and propofol, the authors reported successful sedation but also significant hypoxemia and oversedation; however, no significant complications were reported. In another pediatric study involving 40 patients, Skokan et al reported a significant incidence of oxygen desaturation; however, again, there were no clinical sequelae.

The literature regarding safety and efficacy of etomidate in the ED is also mounting. A prospective, double-blinded, randomized trial of 46 adult patients undergoing anterior shoulder dislocation reduction in the ED compared midazolam with etomidate. Burton et al found approximately a 90% procedural success rate for both groups. Patients experienced no episodes of hypotension or arrhythmia. Adverse respiratory events included 13 episodes in the midazolam group, 12 episodes in the etomidate group.
Clinical Policy: Critical Issues in the Sedation of Pediatric Patients in the Emergency Department

From the EMSC Panel (Writing Committee) on Critical Issues in the Sedation of Pediatric Patients in the Emergency Department:
Sharon E. Mace, MD, Chair, American College of Emergency Physicians (ACEP)
Lance A. Brown, MD, MPH (ACEP)
Lisa Francis, BSN, RN (Society of Pediatric Nurses)
Steven A. Godwin, MD (ACEP)
Sigrid A. Hahn, MD (ACEP)
Patricia Kunz Howard, PhD, RN, CEN (Emergency Nurses Association)
Robert M. Kennedy, MD (American Academy of Pediatrics)
David P. Mooney, MD (American Pediatric Surgical Association)
Alfred D. Sacchetti, MD (ACEP)
Robert L. Wears, MD, MS, Methodologist (ACEP)
Randall M. Clark, MD (American Society of Anesthesiologists)

Other members of the EMSC Panel included:
Ramon W. Johnson, MD (ACEP Board Liaison)
Rhonda R. Whitson, RHIA (Clinical Policies Manager, ACEP)
Tuei Doong (Vice President, The Nakamoto Group, Inc)
Jenni Nakamoto-Yingling (President, The Nakamoto Group)

Approved by the ACEP Board of Directors, October 5, 2007
Supported by the Emergency Nurses Association, October 5, 2007
Endorsed by the Society of Pediatric Nurses, November 3, 2007
Endorsed by the American Pediatric Surgical Association, December 20, 2007
January 10, 2011

Dear ACEP Member:

One of the core competencies of an emergency physician is procedural sedation. Our clinical policies have outlined the evidence that we are skilled in the area of analgesia, sedation, and emergency airway management. The Centers for Medicare & Medicaid Services (CMS) has revised its interpretive guidelines for anesthesia services. Hospitals are to use these guidelines in developing their individual credentialing policies. These guidelines and their FAQs note that “...emergency medicine-trained physicians have very specific skill sets to manage airways and ventilation that is necessary to provide patient rescue. Therefore, these practitioners are uniquely qualified to provide all levels of analgesia/sedation and anesthesia (moderate to deep to general).” This change in CMS’ guidelines is the result of vigorous efforts by ACEP leadership and staff working with others to achieve this result.

The CMS document also suggests that hospitals should use specialty-specific guidelines in creating their credentialing policies and specifically cites ACEP’s clinical policy on sedation, and quotes the Emergency Nurses Association (ENA) and ACEP to “support the delivery of medications used for procedural sedation and analgesia by credentialed emergency nurses working under the direct supervision of an emergency physician. These agents include but are not limited to etomidate, propofol, ketamine, fentanyl, and midazolam.”

Recently, the American Society of Anesthesiologists (ASA) issued their “Statement on Granting Privileges for Deep Sedation to Non-Anesthesiologist Sedation Practitioners.” After ACEP leaders met with the ASA, they wrote the attached letter of clarification. Of note, their statement and this letter preceded the CMS revision noted above.

We believe, based on the CMS interpretive guidelines and the ASA’s letter of clarification, that physicians who are residency trained and/or board certified by ABEM/AOBEM in emergency medicine...
Guidelines for conscious sedation and monitoring during gastrointestinal endoscopy

This is one of a series of statements discussing the utilization of GI endoscopy in common clinical situations. The Standards of Practice Committee of the American Society for Gastrointestinal Endoscopy prepared this text. In preparing this guideline, a MEDLINE literature search was performed, and additional references were obtained from the bibliographies of the identified articles and from recommendations of expert consultants. When little or no data exist from well-designed prospective trials, emphasis is given to results from large series and reports from recognized experts.

Guidelines for appropriate utilization of endoscopy are based on a critical review of the available data and expert consensus. Further controlled clinical studies are needed to clarify aspects of this statement, and revision may be necessary as new data appear. Clinical consideration may justify a course of action at variance to these recommendations.

INTRODUCTION

Providing adequate sedation and analgesia is an integral part of the practice of GI endoscopy. Selected patients may not require any sedation for certain endoscopic procedures. However, most endo-

GI endoscopy is a safe procedure. Significant complications can occur as a result of instrumentation, such as bleeding, perforation, and infection, with a frequency that approximates 0.1% for upper endoscopy and 0.2% for colonoscopy. Cardiopulmonary complications may account for over 50% of all reported complications, with the majority because of aspiration, oversedation, hypoventilation, vasovagal episodes, and airway obstruction. In a prospective survey of 14,149 upper endoscopies, the rate of immediate cardiopulmonary incidents was 2 per 1000 cases. The 30-day mortality rate, which included cases of aspiration pneumonia, pulmonary embolism, and myocardial infarction, was 1 per 2000 cases. A retrospective review of 21,011 procedures found the rate of cardiovascular complications was 5.4 per 1000 procedures. Here, complications ranged from mild transient hypoxemia to severe cardiorespiratory compromise and death.

The risk of cardiovascular complications is related to both the patient’s underlying condition and the endoscopic procedure being performed. Patients who are elderly or who have concomitant medical problems, including cardiovascular, pulmonary, renal, hepatic, metabolic, and neurologic disorders, and

Guidelines for the use of deep sedation and anesthesia for GI endoscopy

This is one of a series of statements discussing the utilization of gastrointestinal endoscopy in common clinical situations. The Standards of Practice Committee of the American Society for Gastrointestinal Endoscopy prepared this text. In preparing this guideline, a MEDLINE literature search was performed, and additional references were obtained from the bibliographies of the identified articles and from recommendations of expert consultants. When little or no data exist from well-designed prospective trials, emphasis is given to results from large series and reports from recognized experts.

Guidelines for appropriate utilization of endoscopy are based on a critical review of the available data and expert consensus. Further controlled clinical studies are needed to clarify aspects of this statement, and revision may be necessary as new data appear. Clinical consideration may justify a course of action at variance to these recommendations.

BACKGROUND

“Sedation and analgesia” represent a continuum from minimal sedation or anxiolysis through general anesthesia. Practice guidelines have been put
Position statement: nonanesthesiologist administration of propofol for GI endoscopy

This statement on the use of nonanesthesiologist-administered propofol (NAAP) for GI endoscopy is issued jointly by The American Association for the Study of Liver Diseases, American College of Gastroenterology, American Gastroenterological Association, and American Society for Gastrointestinal Endoscopy. A 4-member committee, composed of a representative from each society, prepared the first draft of this document, which was then reviewed and approved by the governing board of each organization. This document is designed to provide an evidence-based assessment of propofol-mediated sedation by properly trained gastroenterologists and other nonanesthesiologists. The safety, efficacy, cost-effectiveness, and training issues involved with nonanesthesiologist administration of propofol for GI endoscopy are reviewed, and a series of concluding statements and recommendations are provided. Whenever possible, these summary conclusions are graded based upon the strength of the supporting evidence (Table 1).

Both methods involve the administration of small, titrated bolus doses of propofol. Whereas NAPS uses propofol as a single agent and is titrated to deep sedation, BPS combines propofol with a small induction dose of a narcotic, a benzodiazepine, or both, and is targeted to moderate sedation. Both techniques emphasize the importance of appropriate patient selection, education and training of nursing personnel, use of an established protocol for drug administration, and careful assessment of a patient’s physiologic and clinical parameters throughout the procedure; however, several important differences between these techniques do exist.

For the purposes of this document, the following definitions apply:

- Monitored anesthesia care (MAC) is the service provided by an anesthesia specialist to a patient undergoing a diagnostic or therapeutic procedure. In many instances, although not all, MAC results in deep sedation, and the normal airway protective reflexes may be lost. MAC may include general anesthesia with a balanced combination or balanced propofol sedation (BPS).
Sedation and anesthesia in GI endoscopy

BACKGROUND

Sedation may be defined as a drug-induced depression in the level of consciousness. The purpose of sedation and analgesia is to relieve patient anxiety and discomfort, improve the outcome of the examination, and diminish the patient’s memory of the event. Practice guidelines have been put forth by the American Society of Anesthesiologists (ASA) Committee for Sedation and Analgesia by Non-Anesthesiologists, and approved by the ASGE.¹,²

Four stages of sedation have been described, ranging from minimal to moderate, deep, and general anesthesia (Table 2). In general, most endoscopic procedures are performed with the patient under moderate sedation, a practice that was formerly referred to as “conscious sedation.”

At the level of moderate sedation, the patient, while maintaining ventilatory and cardiovascular function, is able to make purposeful responses to verbal or tactile stimulation. In contrast, a patient undergoing deep sedation cannot be easily aroused but may still respond purposefully to repeated or painful stimulation. Airway support may be required for deep sedation. At the level of general anesthesia, the patient is unarousable to painful
ASGE guideline: modifications in endoscopic practice for the elderly

This is one of a series of statements discussing the utilization of gastrointestinal endoscopy in common clinical situations. The Standards of Practice Committee of the American Society for Gastrointestinal Endoscopy prepared this text. In preparing this guideline, a MEDLINE literature search was performed, and additional references were obtained from the bibliographies of the identified articles and from recommendations of expert consultants. When little or no data exist from well-designed prospective trials, emphasis is given to results from large series and reports from recognized experts.

Guidelines for appropriate utilization of endoscopy are based on a critical review of the available data and expert consensus. Further controlled clinical studies are needed to clarify aspects of this statement, and revision may be necessary as new data appear. Clinical consideration may justify a course of action at variance to these recommendations.

INTRODUCTION

The use of gastrointestinal endoscopy in geriatric patients is rising as a result of population demographics management or outcome. The indications for gastrointestinal endoscopy among the elderly are largely the same as those for adults, with some variation in the relative frequency based upon the development of age-related diseases such as cancer, gastrointestinal ischemia, and biliary tract disease. The same relative and absolute contraindications also pertain, without respect to age. Increased attention should be paid, however, to the risk engendered by age-related diseases, such as cardiac and pulmonary dysfunction. Significant risk may outweigh the acknowledged benefits of a procedure.

Several studies of indications and outcomes of patients aged ≥80 years have found elective and emergency endoscopic procedures (including EGD, ERCP, and colonoscopy) to be safe and that advanced age is not a contraindication to endoscopy. For example, in a large multicenter trial on ERCP complications, age was not found to be a risk factor for complications after endoscopic sphincterotomy. In a retrospective analysis, endoscopic sphincterotomy for bile duct stones was found to be a safe and effective treatment in patients aged ≥70 years. In comparison to patients aged 70 to 89 years, those aged ≥90 years underwent more emergency procedures and were frequently required to have procedures and
Principles of privileging and credentialing for endoscopy and colonoscopy

Granting privileges for GI endoscopy

Ensuring that high-quality endoscopy is provided to the public has been one of the main principles of the ASGE for many years. Appropriate training in GI endoscopy is critical to providing quality endoscopists. ASGE's training guidelines call for acquisition of endoscopic skills in the context of training programs in gastroenterology or surgery and for an assessment of endoscopic skill after a threshold number of procedures has been performed. There has been considerable variability among professional societies in the numbers of procedures required to assess the competence of trainees. As additional studies have been performed, it is clear that more procedures are needed than were previously recommended to ensure competency.

I am very pleased that with the cooperation and understanding of my fellow Society Presidents, William Traverso of the Society of American Gastrointestinal Endoscopic Surgeons and John MacKeigan of the American Society of Colorectal Surgeons, our three societies were able to agree on a joint guideline on granting privileges for gastrointestinal endoscopy. This guideline clearly states that all three of our societies are aligned on the importance of training before granting privileges for upper endoscopy and colonoscopy. The other important principle highlighted in this guideline is that these principles of training for endoscopy apply to endoscopy performed in any setting. As more endoscopy is done in the unregulated office setting, payers will ultimately determine who performs endoscopy. Having uniform guidelines for endoscopic privileges should be substantiated by documentation provided by the applicant from Residency Program Directors, Chiefs of Service, or other members of the teaching faculty who have directly observed the applicant performing endoscopy. Individuals applying for privileges for EGD and colonoscopy should have demonstrated satisfactory completion of an Accreditation Council for Graduate Medical Education-accredited training program in adult or pediatric gastroenterology, general surgery, colorectal surgery, or pediatric surgery. Attestation to competency in the performance of these techniques should therefore be provided by the Program Director and, if deemed necessary, by the Credentialing or Privileging Committee at the institution at which these privileges are being sought or by other teaching faculty from the applicant's residency program. In the case of applicants who already have privileges to perform these procedures and are applying for similar privileges at another facility or for renewal of privileges at the same facility, attestation of competency should be provided by the applicant's Chief of Service. Maintenance of continued competency is the responsibility of the respective Credentialing or Privileging Committee and should be based on ongoing review of the applicant's performance by their Chief of Service. These credentialing guidelines are intended to apply to any site at which EGD and colonoscopy are practiced. These guidelines should supplement previously published guidelines by ASGE, ASCRS, and SAGES. More comprehensive discussions of issues surrounding the granting of privileges for gastrointestinal endoscopy are available on the societies' websites, in the ASGE position statement, and the Society of
Pre-procedural Assessment

STANDARDS OF PRACTICE

Minimum staffing requirements for the performance of GI endoscopy

This is one of a series of statements discussing the use of GI endoscopy in common clinical situations. The Standards of Practice Committee of the American Society for Gastrointestinal Endoscopy (ASGE) prepared this text. In preparing this guideline, a search of the medical literature was performed by using PubMed. Additional references were obtained from the bibliographies of the identified articles and from recommendations of expert consultants. Guidelines for appropriate use of endoscopy are based on a critical review of the available data and expert consensus at the time the guidelines are drafted. Further controlled clinical studies may be needed to clarify aspects of this guideline. This guideline may be revised as necessary to account for changes in technology, new data, or other aspects of clinical practice.

This guideline is intended to be an educational device to provide information that may assist endoscopists in providing care to patients. This guideline is not a rule and should not be construed as establishing a legal standard of care or as encouraging, advocating, requiring, or discouraging any particular treatment. Clinical decisions in any particular case involve a complex analysis of the patient’s condition and available courses of action. Therefore, clinical endoscopic procedures, the endoscopy suite staff has three major responsibilities that include, but are not limited to, patient monitoring, documentation, and technical assistance. Technical assistance includes such activities as application of abdominal pressure, manipulation of endoscopic accessory devices (e.g., forceps, snare, balloons, bougie, cautery devices), manipulation of endoscopes (e.g., maintaining endoscope position while the endoscopist performs complex tasks), and cleaning and preparation of endoscopes. Accreditation organizations recommend that endoscopy unit staff receive training appropriate to their responsibilities and document maintenance of competency periodically (e.g., annually). Objective evidence pertaining to the relationship between endoscopy unit staffing levels and patient outcomes is lacking. Therefore, recommendations are based primarily on expert opinion and clinical experience.

ENDOSCOPY WITHOUT SEDATION

The majority of GI endoscopic procedures performed in the United States are performed with sedation. However, sigmoidoscopy and transnasal endoscopy are often
ENDOSCOPIST-DIRECTED SEDATION

For those patients receiving moderate sedation for endoscopic procedures, the physician must perform a pre-procedural assessment to determine the suitability of the patient for sedation and then formulate a sedation plan. Under the supervision of the physician, the RN prepares and administers sedatives while monitoring the patient’s vital signs, comfort, and clinical status to detect any intra-procedural complications. Once the patient’s level of sedation and vital signs are stable, the RN may perform minor, interruptible tasks (eg, biopsy or polypectomy). In patients who require more intensive or prolonged endoscopic interventions (eg, difficult polypectomy, EUS/FNA, ERCP), a second assistant, who may be a UAP, LPN, or another RN, should assist in the procedure to allow the RN administering moderate sedation to remain focused on patient monitoring rather than technical assistance.
EUS Procedural Evaluation Form

A. Pre-procedural Assessment
Understands indications/contraindications including allergies, risks, coagulopathies, etc. Obtains H & P. Obtains informed consent.

- 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9
Unsatisfactory Average Outstanding

Understands the indications and contraindications for the procedure pre-procedure antibiotic coverage. Has reviewed and evaluated pertinent radiographic and laboratory data.

- 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9
Unsatisfactory Average Outstanding

B. Procedural Assessment, General

- 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9
Unsatisfactory Average Outstanding

EUS Procedural Evaluation Form
Created by the ASGE Training Committee
Revised August 2008
DEEP SEDATION OR GENERAL ANESTHESIA

Some patients undergoing prolonged therapeutic procedures have benefited from medications, such as propofol to induce deep sedation. This has been demonstrated to be superior to standard benzodiazepine/narcotic sedation for complex procedures such as ERCP. Use of deep sedation in routine upper and lower endoscopic procedures is controversial and provides little benefit over standard moderate sedation.

Deep sedation requires more intensive monitoring by trained individuals. Sedation-related risk factors, the depth of sedation, and the urgency of the endoscopic procedure all play important roles in determining whether or not the assistance of an anesthesiologist is needed. Sedation-related risk factors include: significant medical conditions such as extremes of age, severe pulmonary, cardiac, renal or hepatic disease, pregnancy, the abuse of drugs or alcohol, uncooperative patients or a potentially difficult airway for intubation. The American Society of Anesthesiologists (ASA) Taskforce states that airway management may be difficult in the following situations: (1) patients with previous problems with anesthesia or sedation; (2) patients with a history of stridor, snoring, or sleep apnea; (3) patients with dysmorphic facial features, such as Pierre-Robin syndrome or trisomy-21; (4) patients with oral abnormalities, such as a small opening (<3 cm in an adult), edentulous, protruding incisors, loose or capped teeth, high, arched palate, macroglossia, tonsillar hypertrophy or a nonvisible uvula; (5) patients with neck abnormalities such as obesity involving the administration of moderate sedation.

- Routine monitoring of the patients pulse rate, blood pressure, oxygen saturation are useful in identifying early problems. (B) Monitoring of EKG recordings may be helpful in selected cases. (C) Capnography, measurement of carbon dioxide retention, may be useful in prolonged cases. (A)

- The use of benzodiazepines and/or opiates will result in a satisfactory outcome in nearly all patients. (B) Endoscopists prefer the combination of these drugs, but it adds little benefit from the patient's viewpoint. (A)

- Specific antagonists of opiates (naloxone) and benzodiazepines (flumazenil) are available and should be present in every endoscopy unit to treat over-sedated patients. (C)

Legend: (A), Prospective controlled trials. (B), Observational studies. (C), Expert opinion.

REFERENCES

SedationFacts.org    Coming Soon
Minimal sedation (anxiolysis)-A drug-induced state during which patients respond normally to verbal commands. Although cognitive function and coordination may be impaired, ventilatory and cardiovascular functions are unaffected.

Moderate sedation/analgesia (conscious sedation)-A drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.
Deep sedation/analgesia-A drug-induced depression of consciousness during which patients cannot be easily aroused, but respond purposefully following repeated or painful stimulation.

The ability to independently maintain ventilatory function may be impaired.

Patients may require assistance in maintaining a patent airway and spontaneous ventilation may be inadequate.

Cardiovascular function is usually impaired.
Anesthesia-Consists of general anesthesia and spinal or major regional anesthesia. It does not include local anesthesia.

General anesthesia is a drug-induced consciousness during which patients are not arousable, even by painful stimulation.

The ability to independently maintain ventilatory function is often impaired.

Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.
The hospital plans operative or other high-risk procedures

- This includes moderate or deep sedation or anesthesia
- Equipment identified in the EPs is available to the OR suites
- Standards apply in any setting for epidural, spinal, MAC, general, moderate or deep sedation
Operative & High Risk Procedures

- EP1 Those administering moderate or deep sedation and anesthesia are qualified
  - Must have credentials to manage and rescue patients at whatever level of anesthesia or sedation

- EP2 Must have sufficient number of qualified staff to evaluate the patient, provide the sedation and/or anesthesia, help with the procedure, and monitor and recover the patient

- EP5 RN supervises perioperative nursing care
  - Such as a RN Director of the OR
Operative & High Risk Procedures

- EP6 Need equipment to monitor the patient’s physiological status during moderate or deep sedation during surgery or high risk procedures
  - Example could include cardiac monitor, blood pressure machine, pulse oximetry, end tidal CO2 etc.

- EP7 Must have equipment to administer IV fluids, medications, blood and blood components during moderate and deep sedation for surgery or high risk procedures
  - Ivs, IV tubings, IV pumps, blood tubing, etc.
Operative & High Risk Procedures

- EP8 Must have resuscitation equipment available for surgery or high risk procedures when using moderate or deep sedation and anesthesia
  - Endotracheal tubes, ambu bags, oxygen, defib, cardioverter, etc.

- EP10 Anesthesia is administered by qualified person (DS)
  - CRNA, anesthesiologist, or AA
  - Qualified physician other than an anesthesiologist
  - CRNA in 35 states must be supervised by anesthesiologist or operating surgeon
Care Before Surgery or High Risk Procedure

- PC.03.01.03 states that the hospital provides the patient with care before surgery or the procedure. The following includes patient having moderate or deep sedation or anesthesia for surgery or a high risk procedure.

- EP1 Conduct a pre-sedation or pre-anesthesia assessment.
  - RC.02.01.01 requires this be documented.
  - CMS includes a requirement that the pre-anesthesia assessment be done and what should be in it.
  - ASA and AANA has standards of practice on this.
Care Before Surgery or High Risk Procedure

- EP2 Assesses the patient’s anticipated needs in order to plan for the post procedure care
- EP3 Do a preprocedural treatment according the patient’s plan for care
- EP4 Provide the patient with preprocedural education, according to their plan of care
- EP7 LIP must review the plan and concur with the plan for sedation or anesthesia
- EP8 Reevaluate the patient immediately before administering deep sedation or anesthesia
Care Before Surgery or High Risk Procedure

- EP18 A preanesthesia evaluation is completed and documented by an individual qualified to administer anesthesia within 48 hours prior
  - CMS measures the 48 hour time frame from when the first drug is given to introduce anesthesia
  - CMS has specific criteria that must be included in the pre and postanesthesia evaluation
  - ASA and AANA has standards of care related to the postanesthesia evaluation
Monitoring During Surgery or Procedure

- PC.03.01.05 states that the hospital monitors the patient during surgery or other high-risk procedures
  - Patient must also be monitored during the administration of moderate or deep sedation or anesthesia
- EP1 The patient’s oxygenation, ventilation, and circulation are monitored continuously during any of the above
  - RC.02.01.03 EP8 requires that this be documented in the medical record including medications, vital signs, level of consciousness, IV fluids or blood given, complications or any unanticipated events
Monitoring During Surgery or Procedure

- CMS also requires monitoring during surgery or anesthesia administration
- CMS has new elements in the hospital CoPs about what must be documented by anesthesia during surgery
- Best to use a form to capture all of the required elements
- Be aware of the ASA and AANA standards of care and practice
## ANESTHESIA RECORD

<table>
<thead>
<tr>
<th>Date</th>
<th>OR No.</th>
<th>Page of</th>
<th>Surgeon(s)</th>
</tr>
</thead>
</table>

### PRE-PROCEDURE
- Identified: □ ID Band □ Questioning
- Chart Reviewed □ Permit Signed
- NPO Since: ____________
- Pre-Anesthetic State: □ Calm □ Awake □ Agitated □ Confused □ Apprehensive □ Uncooperative

### MONITORS AND EQUIPMENT
- □ SpO2 □ BVP (Blood Pressure) □ EKG (Electrocardiogram) □ Blood Pressure Monitor
- □ Pulse Oximeter □ Oxygen Sensor
- □ Continuous EKG □ V Lead EKG
- □ End Tidal CO2 □ Gas Analyzer
- □ Temperature □ Nerve Stimulator
- □ Warming Blanket □ EEG □ Doppler
- □ Airway Humidifier □ Fluid Warmer
- □ Anesthesia Machine □ Nebulizer
- □ Art. Line □ Foley Catheter
- □ CVP □ PA Line □ IV(s)
- □ Ointment □ Saline
- □ Taped □ Pads □ Goggles
- □ MAC □ Other

### ANESTHETIC TECHNIQUE
- General: □ Pre-Oxygenation □ LTA
- Intravenous □ Intramuscular □ Rectal
- Rapid Sequence □ Cricoid Pressure
- Intravenous □ Inhalation
- Intramuscular □ Rectal

### AIRWAY MANAGEMENT
- Intubation: □ Oral □ Tube size: ____________ □ Stylet Used □ Nasal □ Regular
- Magill’s □ Direct □ RAE
- □ Fiber Optic □ Blind □ Armored
- □ Blunt □ Laser
- □ Blade: ____________ □ Epi-dural
- □ Axillary □ Bier Block □ Ankle Block
- □ Position: ____________ □ ET CO2 Present
- □ Pre-op: ____________ □ Local: ____________
- □ Breath Sounds: ____________ □ Uncuffed, Leaks at: ____________ cm H2O
- □ Cuffed □ Min. Occ. Pres. □ Air □ NS
- □ Somaolent □ Intubated □ T-piece Oxygen
- □ Unievable □ Ventilator □ Oral/Nasal Airway

### PATIENT SAFETY
- Anesthesia Machine #: ____________ Checked
- Safety Belt On □ Auxiliary Roll □ Ambulance Restraints □ Arms Tied
- Pressure Points Checked and Pad: ____________
- Eye Care: □ Ointment □ Saline
- □ MAC □ Other

### TIME:
- Oxygen (L/min): ____________
- N2O: ____________ Air (L/min): ____________

### FLUIDS/AGENTS
- Intravenous (ml): ____________
- Urine (ml): ____________

### START/STOP
- Procedure: ____________
- Location: ____________
- Time: ____________
- B/P: ____________ O2 Sat: ____________

### RECOVERY
- □ Awake □ Stable □ Nasal Oxygen
- □ Drowsy □ Unstable □ Mask Oxygen
- □ Somaolent □ Intubated □ T-piece Oxygen
- □ Unievable □ Ventilator □ Oral/Nasal Airway

### FLUID TOTALS
- □ Crystalloid: ____________
- □ Blood: ____________
- □ Urine: ____________

### REMARKS
- ____________
Postanesthesia or Post Procedure Care

- PC.03.01.07 states that care must be provided to the patient after anesthesia, moderate, or deep sedation.
- EP1 Need to assess their physiological status immediately after the above.
- EP2 Must monitors the patient’s physiological status, mental status, and pain level.
- EP4 A qualified LIP discharges the patient from the PACU or from the hospital or uses approved discharge criteria.
  - Many PACUs use Aldrete score.
Postanesthesia or Post Procedure Care

- EP6 Outpatients who have had sedation or anesthesia are discharged in the company of an individual who accepts responsibility for the patient
  - Should take patient out in a wheelchair and make sure they get into the car safely

- EP7 Qualified person does postanesthesia evaluation no later 48 hours after surgery or a procedure requiring anesthesia services
  - CMS has a CoP on the postanesthesia evaluation
  - The 48 hour time frame is measured from the time the patient hits the PACU or recovery area
Postanesthesia or Post Procedure Care

- EP8 Postanesthesia evaluation for anesthesia recovery is completed as required by law and the hospital’s P&P
  - CMS is very specific as to what must be included in the postanesthesia evaluation
  - Consider having a form to capture all of the required elements
  - ASA (American Society of Anesthesiologist) and American Association of Nurse Attorneys (AANA) have standards of care on postanesthesia evaluations