Anesthesia Services

Definitions

Topical or local anesthesia: The application or injection of a drug or combination of drugs to 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.

Minimal sedation (anxiolysis): A drug-induced state during which a patient responds normally to verbal commands. Cognitive functions and coordination may be impaired, but ventilatory and cardiovascular functions are unaffected. Minimal sedation is not considered to be anesthesia.

Moderate sedation/ analgesia (conscious sedation): A drug-induced depression of consciousness during which a patient responds purposefully to verbal commands, either alone or accompanied by physical stimulation. No interventions are required to maintain a patent airway and spontaneous ventilation is adequate. Cardiovascular function is maintained. Moderate sedation is not considered to be anesthesia.
For more information on Moderate sedation, see policy 9.13.5 Moderate Sedation (Conscious Sedation)

Monitored anesthesia care (MAC): anesthesia care that includes the monitoring of the patient by a practitioner who is qualified to administer anesthesia. 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: A drug-induced depression of consciousness during which a patient cannot be easily aroused but responds purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. The patient may require assistance with maintaining a patent airway and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained. *A non-anesthesiologist must be privileged to administer deep sedation by the Department of Anesthesiology.* See policy 7.71 Administration of Anesthetics by Non Anesthesiologists

Definitions

General anesthesia: A drug-induced loss of consciousness during

continued

which patients are not arousable, even by painful stimulation. The ability to maintain ventilatory support if 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.

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 regional loss of voluntary and involuntary movement is required.

Continual monitoring: repeated regularly and frequently in steady rapid succession.

Continuous monitoring: prolonged without any interruption at any time.

Scope/ Policy

Anesthesia services throughout the hospital (including all departments in all campuses and off-site locations where anesthesia services are provided) are organized into one anesthesia service, which is under the direction of the Chair of the department of Anesthesia.

The Anesthesiology Department maintains a major role in the direction of the Surgical Intensive Care Unit (SICU) and Ambulatory Surgery Services. The department also operates a Pain Management Clinic, provides analgesia for obstetrical patients, and serves as a consultant in airway management. The department advises UTMB on the provision of moderate sedation at various locations throughout its hospitals.

Any time that anesthesia is performed, a physician who is qualified to administer anesthesia will be available in the facility to manage complications and provide cardiopulmonary resuscitation for patients in the PACU.

Areas where anesthesia services are furnished may include (but are not limited to):
Operating room suite(s), both inpatient and outpatient
Obstetrical suite(s)
Radiology department
Clinics
Emergency department

Scope/ Policy

Special procedure areas (e.g. endoscopy suite, cardiac catheterization

continued

lab, radiation oncology, etc.)

Typically, the procedural sedation provided by non anesthesia professionals in the emergency department and/ or non operating suite procedure rooms involves analgesia, rather than anesthesia.

Privileges

Minimal sedation may be ordered/ performed by an LIP operating within the scope of their practice with no additional supervision requirements.

Minimum qualification and supervision requirements for providers of moderate sedation are outlined in the policy 9.13.5 Moderate Sedation (Conscious Sedation).

Deep sedation is performed only by those providers who have been granted privileges through the UTMB credentialing process. See policy 7.71 Administration of Anesthetics by Non Anesthesiologists

Regional and/ or general anesthesia is performed by qualified providers who have been granted privileges through the UTMB credentialing process under the direction of the Chairman of the Department of Anesthesia.

Equipment

Equipment detailed herein shall be available, including but not limited to:

1. Device to measure blood pressure;
2. Pulse oximeter;
3. Continuous ECG shall be used for patients requiring continuous ECG monitoring;
4. Oxygen, including a positive pressure oxygen delivery system;
5. A functional suction apparatus;
6. Emergency medication and equipment, including emergency airway equipment; and
7. Appropriate reversal agents located in the procedure room.

Informed Consent

Each patient, parent, or guardian must receive an explanation regarding the risks and alternatives of anesthesia.

Appropriate informed consent for the procedure and sedation shall be obtained prior to anesthesia. Refer to the following related policies: IHOP Policy 9.3.17 *Patient Consent - Overview and Basic Requirements* and IHOP Policy 9.3.18, *Consent for Medical Care of a Minor*.

Pre anesthesia evaluation

A pre-anesthesia assessment is completed and documented on all patients for whom anesthesia is contemplated. This information is collected by an anesthesia resident, Certified Registered Nurse Anesthetist (CRNA) or PA under the direction of a faculty Anesthesiologist. For cases where deep sedation is contemplated, the preanesthesia evaluation may be conducted by an LIP with deep sedation privileges.

The preanesthesia evaluation must be completed and documented within 48 hours immediately prior to surgery or a procedure requiring anesthesia services. Some of the elements contributing to a preanesthesia evaluation may be performed prior to the 48 hour time frame, but no more than 30 days prior to surgery or a procedure requiring anesthesia services. Review of these elements must be conducted and documented immediately prior to deep sedation or anesthesia.

The pre anesthesia evaluation includes:

1. Patient interview to assess:
    a. Patient and procedure identification
    b. Medical history
    c. Anesthetic history
    d. Medication/ Allergy history
    e. Previous anesthetic experience
2. Appropriate physical examination, including vital signs and documentation of airway assessment.
3. Review of objective diagnostic data (e.g., laboratory, ECG, X-ray) and medical records.
4. Medical consultations when applicable.
5. Assignment of ASA physical status, including emergent status when applicable.

    The American Society of Anesthesiologists (ASA) Physical Status Classifications as follows:

    - Class I a normal healthy patient
    - Class II a patient with mild systemic disease
    - Class III a patient with severe systemic disease
      Class IV a patient with severe systemic disease which is a constant threat to life
    - Class V a moribund patient who is not expected to survive with or without the operation.

    Formulation of the anesthetic plan and discussion of the risks and benefits of the plan (including discharge issues when indicated) with the patient or the patient's legal representative and/or escort.

Pre anesthesia evaluation

6. Documentation of appropriate informed consent(s).

Appropriate premedication and prophylactic antibiotic administrations

(continued)	(if indicated).
Intraoperative/ intra procedural anesthesia	Immediate Reassessment: Patients are reevaluated immediately before the induction of anesthesia by a provider qualified to administer anesthesia. This information must also be documented. Qualified anesthesia personnel shall be present in the room throughout the conduct of all general anesthetics, regional anesthetics, and monitored anesthesia care. During all anesthetics, the patient's oxygenation, ventilation, circulation and temperature shall be continually evaluated. Every patient receiving anesthesia shall have temperature monitored when clinically significant changes in body temperature are intended, anticipated or suspected. Documentation during the procedure includes: 1. Monitoring of the patient** (e.g., recording of vital signs and use of any non-routine monitors). 2. Doses of drugs and agents used, times and routes of administration and any adverse reactions. 3. The type and amounts of intravenous fluids used, including blood and blood products, and times of administration. 4. The technique(s) used and patient position(s). 5. Intravenous/intravascular lines and airway devices that are inserted including technique for insertion, and location. 6. Unusual events during the administration of anesthesia. 7. The status of the patient at the conclusion of anesthesia.
Post anesthesia evaluation	The postoperative status of the patient is assessed by the anesthesia provider on admission to the Post Anesthesia Care Unit (PACU), during the patient's PACU stay if indicated, and upon the patient's discharge from the PACU. A post-anesthesia evaluation must be performed and documented by a provider qualified to administer anesthesia, and should not begin until the patient is sufficiently recovered from the acute administration of anesthesia so as to participate in the evaluation. Although the evaluation should begin in the designated recovery area, it may be completed after the patient has moved to another location. This post-anesthesia evaluation must be completed within 48 hours. The 48 hour time frame begins when the patient is moved into the designated recovery area. For those patients who are unable to participate in the post anesthesia evaluation, an evaluation should be completed and documented within
Post anesthesia evaluation	48 hours with a notation that the patient was unable to participate along with the reasons why. For those patients whose regional anesthetic

(continued)

effects are expected to continue beyond the 48 hour time frame, a post anesthesia evaluation must be completed within 48 hours, with notation that full recovery has not occurred and is not expected within the stipulated timeframe but that the patient was otherwise able to participate in the evaluation.
For deep sedation cases, the post-anesthesia note may be documented by an LIP with deep sedation privileges. A post-anesthesia note is not required for moderate sedation cases.
Documentation of the post anesthesia evaluation includes:

1. Respiratory function, including respiratory rate, airway patency and oxygen saturation
2. Cardiovascular function, including pulse rate and blood pressure
3. Mental status
4. Temperature
5. Pain
6. Nausea and vomiting and
7. Postoperative hydration

A physician is responsible for the discharge of the patient from the PACU. In the absence of the physician, the patient may be discharged when criteria are met.

Policy review

Periodic reevaluation of this policy will include analysis of adverse events, medication errors and other quality indicators for the use of analgesia as reported through the institutional quality structure.

Related Policies

Pharmacy Policy 7.71 Administration of Anesthetic Agents by Non-Anesthesiologists.
Pharmacy Policy 07.49 Preparation and Administration of Medications via Continuous Intravenous Infusion (Adult)
IHOP Policy 9.13.5 Moderate Sedation (Conscious Sedation)

References

The Joint Commission Comprehensive Accreditation Manual for Hospitals (July 2012).

Practice Guidelines for Preoperative Fasting and the Use of Pharmalogical Agents to Reduce the Risk of Pulmonary Aspiration: Application to Healthy Patients Undergoing Elective Procedures. *Anesthesiology,* V 90, No 3, Mar 1999.

Section 9 Clinical Policies Subject General Procedures **Policy** **Anesthesia Services**	09/10/2012 -Originated -Reviewed w changes -Reviewed w/o changes XXXXX - Effective Hospital Administration -Author

References, continued

American Society of Anesthesiologists: Standards, Guidelines, Statements and Other Documents
(www.asahq.org)

1. Guidelines for Ambulatory Anesthesia and Surgery, (2008)
2. Statement on Non-Operating Room Anesthetizing Locations (last amended Oct 22, 2008)
3. Basic Standards for Pre Anesthesia Care (last amended Oct. 20, 2010)
4. Statement on Standard Practice for Infection Prevention and Control Instruments for Tracheal Intubation (2010)
5. Standards for Basic Anesthetic Monitoring (effective date July 1, 2011)
6. Standards for Post Anesthesia Care (last amended Oct. 21, 2009)
7. Documentation of Anesthesia Care (Last amended Oct. 22, 2008)

Combined Statement from the American Society for Gastrointestinal Endoscopy (ASGE), the American College of Gastroenterology (ACG) and the American Gastroenterology Association (AGA) titled "Universal adoption of capnography for moderate sedation in adults undergoing upper endoscopy and colonoscopy has not been shown to improve patient safety or clinical outcomes and significantly increases costs for moderate sedation" published Feb 2012 and accessed 9-5-2012 at http://www.gastro.org/practice/medical-position-statements