
**DEPARTMENT OF SURGERY**
**RULES AND REGULATIONS - SECTION OF ANESTHESIA**

## 1.0 ARTICLE ONE - ORGANIZATION OF THE ANESTHESIA SECTION

**THE SECTION OF ANESTHESIA SHALL:**

1.1 Include all members of the Medical Staff who have full anesthesia privileges in the operating rooms of this Hospital.

1.2 Shall meet as necessary, but meetings are not required.

1.3 Be directed by the Section Chief of Anesthesia or designate.

1.4 Be responsible for the general quality of all anesthesia which is performed in this Hospital including pre-anesthesia evaluation, anesthesia services and post-anesthesia care.

1.5 Be responsible for the general quality of all ancillary services requested of the anesthesiologists and/or certified registered nurse anesthetists in which their specialized anesthesia skills, training and experience are utilized.

1.6 Assist in the formulation and management in those areas of all Hospital policies and procedures, which relate to the services of anesthesiologists and/or certified registered nurse anesthetists.

## 2.0 ARTICLE TWO

**THE SECTION CHIEF OF ANESTHESIA SHALL:**

2.1 Be elected for a two-year term.

2.2 Be a member in good standing of the active Medical Staff.

2.3 Attend Surgery Department meetings, Anesthesia Section meetings and Medical Executive Committee meetings.

2.4 Assist the Department Chairperson in its bi-annual review of granting anesthesia privileges.

2.5 Assist the Department Chairperson in evaluating the credentials and qualifications of new applicants for membership and privileges in the Anesthesia Section.

## 3.0 ARTICLE THREE - ANESTHESIA PRIVILEGES

### 3.1 CLASSES OF CLINICAL PRIVILEGES

Appropriate training and/or experience must be documented for Class I and Class II privileges; such privileges may be granted by the department in which the practitioner practices.

3.1-1 Class I

Granted to those members of or applicants to the Medical Staff or other practitioners who are permitted to perform local infiltration anesthesia, topical application, minor nerve blocks or IV sedation.

3.1-2 Class II

Granted to those members of or applicants to the Medical Staff and other practitioners who are qualified to perform more complex anesthetic procedures. Examples include Epidural Analgesia, IV Regional Blocks, Major Peripheral Nerve Blocks, and Retrobulbar Blocks.

3.1-3 Class III General Privileges in Anesthesia

These privileges are granted to physicians or certified registered nurse anesthetists who are qualified to render patients insensible to pain and emotional stress during surgical, obstetrical, and certain medical procedures using general anesthesia, regional anesthesia and/or parenteral sedation to a level at which a patient's reflexes may be obtunded. The performance of preanesthetic, intra-anesthetic and post anesthetic evaluation and management and appropriate measures to protect life and functions and vital organs is required.

3.1-4 Invasive Anesthesia Privileges - Pain Management

These privileges are granted to physicians who are qualified to perform placement of implantable (long term) epidural and subarachnoid catheters, electrical stimulation devices and neurolytic procedures. Privileges will be based on verification of training through residency or fellowship or an acceptable course including hands-on training.

Privileges for admitting patients for observation will be limited to anesthesiologists who have been granted invasive pain management anesthesia privileges. Anesthesiologists granted admitting privileges will be responsible for completing a history and physical, will see the patients on a daily basis and will discharge the patient.

## 4.0 ARTICLE FOUR - CERTIFICATION

4.1 Physicians recommended for initial appointment to the Medical Staff as of May 11, 1993 must be Board Certified or eligible. Documentation of continuing Board certification and/or Board eligibility is required to maintain membership and privileges on the Medical Staff. Any physician on Staff prior to May 11, 1993, with Class III privileges, who is not Board Certified or Board eligible will be exempt.

4.2 Certified Registered Nurse Anesthetists (CRNAs) must be certified by the American Association of Nurse Anesthetists Council on Certification of Nurse Anesthetists. Documentation of continuing certification is required to maintain membership and privileges on the Medical Staff.

4.3 Practitioners who complete an accredited residency but are unable to establish eligibility to take the exam for Board Certification, may be eligible to be appointed to the medical staff for a period of time not to exceed six months if:

- the Medical Staff Department is able to confirm with the program director that the applicant has met all of the requirements of the program to be able to apply for board status, or
- if the practitioner is able to confirm that he/she is eligible to sit for the board certification exam and can produce documentation from the respective board.

It is the responsibility of the practitioner to provide evidence of board status to the Medical Staff Services Department. If the appropriate board status is not achieved within six months, the practitioner will have been deemed to have voluntarily resigned from the staff.

## 5.0 ARTICLE FIVE - MEMBERSHIP IN THE ANESTHESIA SECTION

5.1 The Section Chief of Anesthesia may be consulted prior to the granting of temporary anesthesia privileges and may recommend to the Chief of Surgery that temporary privileges be accorded upon a completed application.

5.2 Observed cases may be required at Banner Del E. Webb Medical Center if necessary in the opinion of the Department Chairman to (1) establish the necessary extent of privileges to be granted, or (2) if deemed necessary on reapplication when records indicate low level of clinical activity on the part of a particular anesthesiologist or certified registered nurse anesthetist, or (3) whenever the Department Chairman concludes, in his or her discretion, there is a concern about the anesthesiologist's or certified registered nurse anesthetist's ability to perform a procedure, or (4) when concerns about quality of care have been raised in the application or reapplication process. Such observation is in the interest of patient safety, is neither punitive nor disciplinary, does not restrict practice and, therefore, is not reviewable and not reportable to the anesthesiologist's or certified registered nurse anesthetist's respective licensing Board.

5.3 Should observation be imposed by the Department Chairman, no more than two (2) observations may be provided by the same observer.

5.4 The Section Chief of Anesthesia, or their designee, shall insure timely ongoing assessment of the quality of anesthesia care through: routine quality review activities; investigation of referrals from the Chief of Surgery or members of the Medical Staff or Administration or from the Director of Surgical Services. Routine quality review activities will include, but not be limited to, the following:

a. JCAHO-required continuous review activities (invasive procedures review, medication usage evaluation, blood usage review, and medical records timeliness and clinical pertinence review,);

b. other routine reviews of:
   1. anesthesia-related complications;
   2. anesthesia-related mortality;
   3. discrepancy between autopsy results and diagnosis;
   4. infection control,
   5. risk management, including sentinel events;
   6. comparative outcome data;
   7 regulatory and accreditation results

8. ethics considerations
9. patient satisfaction feedback

5.5 Each anesthesiologist and certified registered nurse anesthetist shall be subject to reappointment to the Anesthesia Section, as provided in Article 3 of the Medical Staff Rules and Regulations Policy Manual.

5.6 All anesthesiologists and certified registered nurse anesthetists on the Staff of Banner Del E. Webb Medical Center shall provide emergency coverage in a manner deemed necessary and/or appropriate by the Section Chief of Anesthesia. Where a life-threatening emergency exists and the surgeon has failed in his/her attempt to secure his/her regular anesthesiologist or certified registered nurse anesthetist, the Section Chief of Anesthesia or his/her designee shall provide emergency coverage.

## 6.0 ARTICLE SIX - RESPONSIBILITIES OF ANESTHESIA OBSERVERS

6.1 An anesthesia observer shall be with the observed anesthesiologist or certified registered nurse anesthetist during each anesthesia procedure.

Observers will complete an observation report for each procedure observed. The Chief of Surgery and Section Chief will review the observation reports and use for assessment. If an observer believes that an observed anesthesiologist or certified registered nurse anesthetist is performing in a manner that will result in imminent harm to the patient, the observer will immediately relieve the observed anesthesiologist or certified registered nurse anesthetist and assume the responsibility for care of the patient. The Section Chief, the Chief of Surgery and the CEO will be immediately notified of this matter.

## 7.0 ARTICLE SEVEN - STANDARDS FOR ANESTHESIA CARE

The Anesthesia Section is responsible for the establishment of One Level of anesthesia care and shall participate in definitive statements describing comprehensive anesthesia care; preoperative assessment, administration, intraoperative/intraprocedural monitoring, documentation, postoperative evaluation, recovery and discharge by practitioners with any/all levels of anesthesia privileges.

7.1 Protocol will be developed with input and collaboration of the Anesthesia Section and approval for use by any practitioner with Anesthesia privileges.

7.2 The scope of privileges and one level of care will be monitored for compliance to credentialing and protocol criteria through the Medical Staff quality review activities.

7.2-1 Departments/Services will be responsible for ongoing process; Section of Anesthesia may be consulted or referred to for trends, exceptions, etc.

7.2-2 Section of Anesthesia will be responsible to include all departmental practitioners within its quality review process.

7.3 I.V. sedation anesthesia may be administered outside the Operating Room. For this procedure, an IV must be in place and a pulse oximeter, an ECG monitor and a blood pressure monitoring device must be used. Resuscitative equipment including a defibrillator and emergency drugs are available.

## 8.0 ARTICLE EIGHT - RECORD KEEPING

8.1 All patients (both inpatients and outpatients) scheduled for surgery shall be examined pre-operatively by the anesthesiologist or certified registered nurse anesthetist no more than 48 hours prior to the scheduled surgery. The anesthesiologist or certified registered nurse anesthetist shall insert appropriate notes on the Anesthesia Study Record.

8.2 The anesthetic record shall indicate the state of consciousness of the patient on arrival in the operating room.

8.3 The anesthetic record shall contain a record, in duplicate, of all events occurring during the administration of the anesthetic. The original shall remain in the patient's medical record. The copy may be kept by the anesthesiologist or certified registered nurse anesthetist.

8.4 The anesthesiologist or certified registered nurse anesthetist shall be responsible for the discharge of the patient from the PACU. Unusual post-anesthetic complications occurring in the PACU shall be recorded.

8.5 The anesthesiologist or certified registered nurse anesthetist shall record his/her post-anesthetic follow-up on the Anesthesia Study Record, or extend, when necessary, into the Progress Notes.

8.6 Within forty-eight hours after surgery, the Anesthetic Study Record shall contain a note of a post-anesthetic visit after the patient has recovered from anesthesia, describing the presence or absence of anesthesia-related complications. Exceptions may be warranted on outpatients discharged prior to this evaluation.

## 9.0 ARTICLE NINE

9.1 Whenever anesthesia services and post anesthesia care is provided outside the operating room, the level of care must be comparable to the care provided in the operating room suite.

9.2 Any patient who has received anesthesia, other than local anesthesia, is examined before discharge and is accompanied home by a designated person. The examination is performed by an anesthesiologist or certified registered nurse anesthetist. The anesthesiologist or certified registered nurse anesthetist will insure that the patient is given adequate post anesthesia recovery instruction.

9.3 Anesthesia will be administered to patients one year and under if the patient cannot be transferred to another facility without danger to life or limb.

9.4 The responsibility for extubation remains with the anesthesiologist or certified registered nurse anesthetist. Nurses may extubate at the request of the anesthesiologist or certified registered nurse anesthetist, but he or she must be in the immediate vicinity. (Immediate vicinity defined as in the Hospital or Operating Room/Post Operative Care Unit Department.)

9.5 Consistent with Hospital policy and the Bylaws, Rules and Regulations of the Medical and Affiliate Staff of the Hospital, anesthesia will not be started unless the surgeon is in the Hospital. Surgeons must be in the Operating Room and ready to commence operating at the time scheduled.

## 10.0 ARTICLE TEN - INFECTION CONTROL

10.1 The members of the Section of Anesthesia shall follow the guidelines for infection control as approved by the Infection Control Committee.

APPROVED: Medical Staff Organizing Committee - 12/87
Board of Directors - 12/87
REVISED: Medical Executive Committee – 5/00 (suspended initiation of mandatory call)
Operating Board – 5/00
REVISED: Department of Surgery – 1/01
Medical Executive Committee – 1/01
Operating Board – 2/01
REVIEWED: Anesthesia Section – 5/03
Surgery Committee – 5/03
Department of Surgery – 6/03
Medical Executive Committee – 7/03
Operating Board – 9/03
REVISED: Medical Executive Committee – 7/05
Operating Board – 7/05
REVISED: Surgery Committee – 11/05
Department of Surgery – 12/05
Medical Executive Committee – 1/06
Operating Board – 1/06
REVISED: Surgery Committee – 8/1/2007
Dept. of Surgery – 9/5/2007
Medical Executive Committee – 10/1/2007
Operating Board – 10/17//2007
REVIEWED: Anesthesia Section – 10//2007
Surgery Committee – 11/7/2007
Dept. of Surgery – 12/2007
Medical Executive Committee – 1/2008
Operating Board – 1/2008