



Department of Anesthesiology and  
Pain Management  
Rules and Regulations

## I. Introduction

- 1.1 These Rules and Regulations are approved by the Medical Executive Committee and the Governing Board of CHA Hollywood Presbyterian Medical Center (HPMC).
- 1.2 Changes or additions may be made according to the Medical Staff Bylaws.
- 1.3 The Department of Anesthesiology and Pain Management exists in accordance with Medical Staff Bylaw Article 13.2-1 and is dedicated to maintaining and demonstrating acceptable ethical and medical standards in its patients', treatment, and under the direction of the Chair of the Department of Anesthesiology and Pain Management, and it shall be free to develop internal procedures, regulations, and standards which render the Department best able to meet patients' needs.

## II. Guidelines and Standards

- 2.1 Adoption of ASA and CMS guidelines and standards as recommended by the American Society of Anesthesiologists (ASA), The Joint Commission (TJC) and the Centers for Medicare and Medicaid Services (CMS) and CMS Conditions of Participation (CoP) are integrated throughout the rules and regulations for the Department and policies and procedures for the perioperative services of (HPMC).

## III. Membership

- 3.1 The Department of Anesthesiology and Pain Management shall consist of physicians who specialize in the administration of anesthesia as their principal medical specialty. They shall:
  - 3.1-1 Adhere to the philosophy that the administration of anesthesia is a distinct medical specialty requiring specialized education, unique requirements of judgment and professionalism, continuing education in anesthesia, and the proper character, ethics, and integrity.
  - 3.1-2 Be appointed to the Medical Staff and abide by the Bylaws and Rules and Regulations of the Medical Staff and this Department.
  - 3.1-3 Have their privileges delineated in accordance with ASA Guidelines for Delineation of Clinical Privileges in Anesthesiology (see attached privilege form).
  - 3.1-4 Be proctored on six cases by a minimum of two active Anesthesiologists / Pain Management physicians in the contracted group with reports of proctoring being placed in the physician's credentials file in the Medical Staff Office.
  - 3.1-5 Be approved by the Chair of the Department for requested privileges and to work with the contracted group.
  - 3.1-6 Be under the jurisdiction of the Department of Anesthesiology and Pain Management and the Credentials Committee for reappointment and review of clinical performance, including, but not limited to, ongoing professional practice evaluation (OPPPE).
  - 3.1-7 Be scheduled by the Chair or his or her designee to share on a fair and equitable basis in the responsibility for assuring 24-hour-a-day, 7-day-a-week availability of anesthesia care for contracted services with HPMC.

- 3.1-8 Attend quarterly Department meetings and quarterly Medical Staff meetings in accordance with Medical Staff-Bylaws requirements.

#### IV. Definition of Anesthesiology

- 4.1 Anesthesiology is the practice of medicine dealing with, but not limited to:
  - 4.1-1 The safeguarding and medical management of patients who are rendered unconscious and/or insensible to pain and emotional distress during surgical, obstetrical, or other medical procedures. According to ASA's Position Statement on the Medical Necessity of Anesthesiology Services, there is no circumstance when it is considered acceptable for a person to experience emotional or psychological duress or untreated pain amenable to safe intervention while under a physician's care.
  - 4.1-2 The support of life functions under the stress of anesthetic and surgical manipulations.
  - 4.1-3 The clinical management of the patient unconscious from whatever cause.
  - 4.1-4 The management of problems with pain relief.
  - 4.1-5 The management of problems in cardiac and respiratory resuscitation.
  - 4.1-6 The application of specific methods of respiratory therapy.
  - 4.1-7 The clinical management of various fluid, electrolyte, and metabolic disturbances.
  - 4.1-8 Determining the necessity of anesthesiology services for a particular patient with medical judgment based on all patient factors, procedure requirements, potential risks and benefits, requirements or preferences of the physician performing the surgery / procedure, and competencies of the involved practitioners. Further, the ASA does not support the determinations of medical necessity of anesthesiology services made independently by other organizations, such as healthcare specialty organizations or health insurance plans.

#### V. Purpose

- 5.1 The purpose of the Department of Anesthesiology and Pain Management shall be:
  - 5.1-1 To ensure that all patients admitted to the Hospital or treated in the outpatient department receive a quality of care consistent with acceptable ethical and professional standards in anesthesiology.
  - 5.1-2 To encourage and further the existence of anesthesiology as a distinct medical specialty.
  - 5.1-3 To initiate and maintain policies for the government of the Department of Anesthesiology and Pain Management consistent with the rendering of quality patient care.
  - 5.1-4 To maintain quality educational standards and technical proficiency among department members.

- 5.1-5 To properly organize, structure, manage, administer, and supervise the provision of anesthesia services at this Hospital in the interest of quality of patient care.

## VI. Departmental Organization, Administration, and Responsibility

- 6.1 The Department of Anesthesiology and Pain Management shall consist of a Chair and Vice Chair both of whom should be elected (or appointed) in accordance with the Medical Staff Bylaws.
- 6.2 The duly elected Chair of the Department of Anesthesiology and Pain Management is a permanent voting member of the Medical Executive Committee as stated in the Medical Staff Bylaws.
- 6.3 The Chair of the Department of Anesthesiology and Pain Management will serve as the Medical Center's CMS-mandated Director of Anesthesia Services. The Director of Anesthesia Services has the authority and responsibility for directing the administration of all anesthesia services, including moderate and deep sedation, throughout the Medical Center. The Director also has the responsibility for evaluating the quality and appropriateness of the anesthesia patient care as part of the Medical Center's Quality Assessment / Performance Improvement program.
- 6.4 The responsibilities of the Chair shall include:
  - 6.4-1 Those duties delineated for all Medical Staff Department Chairs in the Bylaws, Rules and Regulations of the Medical Staff of HPMC.
  - 6.4-2 Approval of privileges for all the individuals with primary anesthesia responsibility and pain management specialties. Privileges should be processed through established Medical Staff channels, be based on qualification, competence, and professional integrity, and be conditioned upon observance of the Medical Staff Bylaws and the Rules and Regulations governing the Department of Anesthesiology and Pain Management.
  - 6.4-3 The monitoring of the quality of anesthesia care rendered by anesthesiologists anywhere in the facility, including surgical, emergency, outpatient, and special procedure areas. The Department Chair shall be free to implement all changes which are necessary to ensure continuing high quality patient care.
  - 6.4-4 Development of regulations for anesthesia safety, electrical hazards, and infection control. He or she shall maintain and periodically review appropriate policy and procedure manuals.
  - 6.4-5 Insuring the retrospective evaluation of the quality of anesthesia care rendered throughout the facility. He or she shall review services rendered and offered and make appropriate recommendations to the Medical Staff.
  - 6.4-6 Recommending to Administration and the Medical Staff the type and amount of equipment necessary for administering anesthesia and for related resuscitative efforts, ensuring that ongoing review will be made of the available equipment.
  - 6.4-7 Participation in the development of any policies or standards which relate to the functioning of anesthesiologists and administration of anesthesia and moderate sedation in various departments or services of the Hospital.

- 6.4-8 The scheduling of participation in the Anesthesia Call Schedule by members of the Department. In the absence of the Chair, the Chair shall delegate such duties to another member of the Department to make such decisions.
- 6.4-9 Making appropriate recommendations to Administration and the Medical Center to encourage and ensure:
  - A. Proper supervision of Departmental operations and activities.
  - B. Simplification and facilitation of interdepartmental relationships.
  - C. Enhanced rapport between support staff and Department members.
  - D. Good morale within the Department.

## VII. Department of Anesthesiology and Pain Management Privileges

### 7.1 Education and Certification

- 7.1-1 As outlined in the attached privilege form for different classes and privileges.
- 7.1-2 Documentation of current Advanced Cardiac Life Support (ACLS) certification.
- 7.1-3 Applicants have the burden of producing information deemed adequate by the Medical Staff and Hospital for a proper evaluation of current competence, and other qualifications and for resolving any doubts.

7.2 If you wish to request a privilege that is not listed on the privilege form, you must submit your request in writing and provide documentation of training and current competence.

7.3 Proctoring requirements including proctoring of six cases for Category I and II privileges and three cases for special procedures.

### 7.4 Qualifications

- 7.4-1 Agreement to abide by the ASA "Guidelines for the Ethical Practice of Anesthesiology."
- 7.4-2 Disclosure of any adjudicated violation of ASA "Guidelines for the Ethical Practice of Anesthesiology" or any adjudicated ethical violation reported by any medical society or osteopathic licensing organization.
- 7.4-3 Certification that "I am in good health and have no physical or mental limitation, including alcohol or drug use that could impair my ability to render quality patient care."
- 7.4-4 Disclosure of record of felony or fraud conviction.
- 7.4-5 Disclosure of any disciplinary action recorded by the National Practitioner Data Bank (NPDB) within the past five years.

## 7.5 Performance Improvement

7.5-1 Active participation in Ongoing Professional Performance Evaluation (OPPE) in accordance with The Joint Commission (TJC) and continuous quality improvement (CQI) in accord with MOCA Part IV.

7.5-2 Participation in ongoing peer review in accordance with the Medical Staff Bylaws.

## VIII. Amendments

8.1 Amendments, changes, additions, or deletions to these Rules and Regulations may be made after appropriate vote by the Department. After approval, they shall be submitted to the appropriate bodies for approval consistent with the Medical Staff Bylaws.

## IX. Patient Evaluations

### 9.1 Pre-Anesthesia Evaluation

9.1-1 Pre-anesthesia evaluation of the patient by an anesthesiologist is required for each patient who receives general, regional, or monitored anesthesia care. Except in emergency cases, this evaluation should be performed before preoperative medication has been administered, and prior to a patient arriving in the operating room for all outpatients and morning admissions.

9.1-2 The pre-anesthesia record entry should include the patient's previous medical history, drug allergies, pertinent lab data, other anesthetic experiences, any potential anesthetic problems, evaluation of risk, proposed techniques of anesthesia, documentation of a focused physical, including airway assessment (MP class, teeth, TMD), and assignment of ASA Classification of Risk.

9.1-3 The evaluation must be completed within the immediate 48 hours prior to the start of the administration of the anesthetic and an immediate reassessment of the patient will be completed and if any changes they will be documented as such.

9.1-4 Documentation that informed consent was secured from the patient is required. Patients will sign an acknowledgment and agreement to proceed with the planned anesthetics on a separate form from procedural consent when the patient is physically able to sign the documentation. In the case of a patient that is unable to consent for themselves, it is acceptable to proceed with the surgical consent signed by the designated family member or conservator and verbal consent for anesthesia.

9.1-5 When the anesthesiologist has serious concerns about the readiness of the patient for surgery, consultation with the operating surgeon shall be obtained as soon as possible. Any substantial conflict between the operating surgeon and anesthesiologist should be resolved and, if appropriate, disclosed to the patient prior to the administration of any anesthetic. The anesthesiologist, in consultation with the anesthesiologist in charge, shall avail him or herself of any consultation, laboratory determination, or diagnostic examination, necessary or desirable, consistent with the current standard of good medical practice.

### 9.2 Intra-operative record should include at a minimum

9.2-1 Name and Hospital identification number of the patient.

- 9.2-2 Name of practitioner who administers anesthesia and the provider completing the procedure.
  - 9.2-3 Name, dosage, routine, and time of administration of drugs and anesthetizing agents.
  - 9.2-4 Technique(s) used and patient position(s), including the insertion / use of any intravascular or airway devices.
  - 9.2-5 Names and amounts of IV fluids, including blood or blood products, if applicable.
  - 9.2-6 Time-based documentation of vital signs as well as oxygenation and ventilation parameters.
  - 9.2-7 Any complications, adverse reactions, or problems occurring during anesthesia, including time and description of symptoms, vital signs, treatments rendered, and the patient's response to treatment.
  - 9.2-8 Documentation of administration of appropriate prophylactic antibiotic within one hour of incision time, or as otherwise is accepted according to SCIP guidelines. If the surgeon deems it unnecessary to give the antibiotic the surgeon and the anesthesiologist will document any such decision and reasoning for it on the record or progress notes.
- 9.3 Post-anesthesia evaluation
- 9.3-1 An anesthesiologist shall make a post-anesthetic visit and record his or her findings in the chart. Complications of anesthesia, when recognized, shall be properly recorded in the chart.
  - 9.3-2 Includes both an immediate post-anesthetic evaluation and, when appropriate, a second evaluation after the patient has recovered completely from the anesthetic. The determination of complete recovery from the anesthetic is based on the clinical judgment of the Anesthesiologist.

## X. Safety Regulations

### 10.1 Electrical and Anesthesia Hazard Regulations

- 10.1-1 Anesthesia machines provided by the HPMC must be inspected every three months by qualified technicians. Documentation of these inspections will be maintained in the Biomedical Department.
- 10.1-2 Vaporizers, ventilators, and all monitors, including oxygen analyzers and automatic blood pressure devices shall be inspected prior to use.
- 10.1-3 Anesthesia machines, equipment, and administration must conform to the safety standards set by the National Fire Prevention Association. With the exception of certain radiologic equipment and light fixtures more than five feet above the floor, all electrical equipment in anesthetizing areas shall be on an audiovisual line isolation monitor.
- 10.1-4 When this device indicates a hazard, the Hospital engineer shall be notified immediately. Following completion of the procedure, the operating room from which the signal emanated should not be used until the defect is remedied.

10.1-5 The condition of all operating room electrical equipment must be inspected regularly every six months; EKG monitors every three months. A written report of the results and any corrective action shall be maintained in the Biomedical Department.

## 10.2 Air Pollution Regulations

10.2-1 Every anesthesia gas machine must be provided with a gas scavenging system which vents to the air exhaust of the operating room or Hospital suction (vacuum) system. There must be a method to evaluate the exhaust system by a scheduled monitoring system. Documentation of this will be maintained by each department.

10.2-2 Every anesthesiologist must be familiar with techniques for limiting pollution of the operating room with gases, including tight fit of masks and/or tracheal tubes, and avoidance of spillage of agents in anesthetizing locations. Rate, volume, and mechanisms of air exchange in the surgical and obstetrical suites should be known by anesthesia personnel, as well as humidity control.

## 10.3 Safety during Anesthetic Period

10.3-1 Prior to administration of anesthesia, the anesthesiologist shall check their machine, equipment, and medications for sterility, cleanliness, availability, and working condition.

10.3-2 Universal time out shall be conducted with all members of the surgical team immediately prior to start of the procedure.

10.3-3 All reusable equipment shall be cleaned according to standard protocols as soon as possible after completion of a procedure and all monitors should be cleaned with appropriate solutions prior to use on a subsequent patient.

10.3-4 Anesthesia machines must have a pin-index safety system, gas scavenging system, and an oxygen pressure interlock system or fail safe system.

10.3-5 Anesthesia should not commence until an RN is in the room, operating surgeon is readily available and appropriately marked the surgical site, as necessary.

10.3-6 The anesthesiologist shall be present at all times with the patient during the anesthetic procedure and is in general, not to leave the room unless relieved by another qualified person.

### 10.3-7 Monitoring and Equipment

- A. Standard ASA monitors include NIBP, ECG monitoring, Pulse Oximetry, End-tidal CO<sub>2</sub> monitoring (all General and MAC cases), and temperature (when expected fluctuations in temperature will occur); Standard ASA monitors are to be used on all patients receiving an anesthetic.
- B. Labor epidurals do not require standard ASA monitoring throughout the administration of the infusion.
- C. As clinically indicated: foley urethral catheter, temperature monitoring (oral/skin/esophageal/rectal), fetal monitoring, invasive arterial blood pressure, central venous pressure, thermo dilution pulmonary artery catheter, peripheral nerve

stimulator with use of muscle relaxants, EEG monitoring, bi-spectral sensor (BIS) monitoring.

- D. Difficult airway cart.
- E. Malignant hyperthermia treatment cart.
- F. Local anesthetic toxicity treatment.

#### 10.4 Fire Marshall Regulations

10.4-1 Fire Marshall rules of safety for equipment shall be followed at all times.

### XI. Post Anesthesia Care Unit

11.1 The same standards apply to the OB PACU.

#### 11.2 Organization

11.2-1 The Recovery Room shall be under the medical supervision of the Chair of the Department of Anesthesiology and Pain Management with the surgeon responsible for the overall management of the patient.

11.2-2 The appropriate consultants will be called by either the surgeon or anesthesiologist when considered necessary.

11.2-3 The Department of Anesthesiology and Pain Management shall direct the Recovery Room nurses as to the proper standards of Recovery Room care in conjunction with nursing management.

11.2-4 The Post Anesthesia Care Unit (PACU) Procedures shall be followed in any area of the Hospital being used as PACU, except for the ICU. Standardized Procedure Policy and Procedures require review by the Chair of the Department at a minimum of every three years. Standardized Procedure will be reviewed annually for clinical accuracy. Standardized Procedure competency will be completed annually by the PACU charge nurse / supervisor and reviewed by the Anesthesia Department.

- A. Extubation of endotracheal tubes by the trained Registered Nurse.
- B. Discharge criteria, PACU.

#### 11.3 Admission, Care, and Discharge

11.3-1 All patients shall be placed in the Post Anesthesia Care Unit (PACU) after receiving any general, regional, or MAC except the following:

- A. Patients may go directly to SICU/MICU/CICU if desired by the physician, in consultation with the nursing supervisor.
- B. Patients under local anesthesia only may bypass PACU as deemed appropriate by the primary physician.

- C. Fast-track patients that received MAC and meet criteria for bypassing stage 1 recovery as deemed appropriate by the anesthesiologist.

11.3-2 Patients shall be accompanied to the PACU by the anesthesiologist and circulating RN.

11.3-3 The anesthesiologist must inform the PACU RN of:

- A. Surgical procedure performed.
- B. Anesthesia agents and technique, including status of muscle relaxant reversal and any significant residual drug effect.
- C. Brief review of anesthetic and surgical course including fluid management, blood loss, and any special problem that occurred during the procedure.
- D. The patient's preoperative physical status with a brief report, underlying diseases, and recent medications.
- E. Whether or not the patient has a foley catheter, and if so, the status of urine output.
- F. Any area / issue to which the nurse should pay particular attention.
- G. PACU orders will be given to the PACU RN and verbal orders / telephone orders are only for emergencies and times when the provider is unable to return to the PACU.

11.3-4 When the patient first enters the PACU, the immediate responsibility of the nurse is to check the patient airway, while briefly ascertaining the level of consciousness, administering oxygen with the appropriate techniques and amounts, and taking the patient's vital signs.

11.3-5 The anesthesiologist shall remain in the PACU until the nurse verbally relates to him or her the patient's first signs and until he or she feels the patient status is well enough for him or her to leave the patient in the care of the nurse. The nurse should feel free to request the anesthesiologist remain in the Recovery Room if he or she is unsure of the patient's status.

11.3-6 Vital signs should be taken and recovered every five minutes x 3, and every 15 minutes thereafter unless the patient's condition warrants more frequent determinations.

11.3-7 RN will follow standard discharge criteria for discharge from PACU under the order of the surgeon or anesthesiologist.

11.3-8 The PACU is not to be used as a substitute for routine postoperative floor care (e.g. outpatients requiring longer observation need to be admitted for further care, monitoring and care of patients after coronary catheterization lab and angiography suite for groin monitoring and management that is appropriate in other locations).

11.3-9 The responsibility of the patients in the PACU is a joint one by the surgeon and anesthesiologist and any requests by PACU personnel shall evoke immediate and appropriate response on the part of the physicians involved.

11.3-10 If no anesthesiologist was involved in the care of the patient (moderate sedation and local anesthetic only patients) the surgeon shall perform those duties in the PACU for which an anesthesiologist would normally have been responsible.

## XII. Policies and Procedures

### 12.1 General Procedures

12.1-1 Elective surgery cases shall be assigned daily by the Chair of the Department of Anesthesiology and Pain Management.

12.1-2 The assigned anesthesiologist or Chair of the Department of Anesthesiology and Pain Management shall be responsible for assigning anesthesiologists to the surgery schedule of the day and coordinate with surgery nurse in charge to assure an efficient running surgery schedule. Surgery nursing service shall coordinate with the anesthesiologist responsible for assigning anesthesia when cases are added, so anesthesia assignments can be completed in a timely manner. The anesthesiologist responsible for anesthesia assignments for the day shall ensure the following:

- A. Surgery schedule shall be workable and reasonable time wise.
- B. Anesthesiologists must be notified of any additional cases assigned after completion of the anesthesia assignment.
- C. After anesthesiologists are assigned to cases, the assignments shall not be changed unilaterally unless the proposed changes are accepted by the involved parties.
- D. Surgery or GI Lab time and room shall not be blocked or closed for anesthesia unless the Department Chair and involved nurse's service are consulted.
- E. Surgeons shall not be asked to move up or down their cases booked already unless limited rooms or anesthesia coverage problems dictate. Surgeons may be asked to move up their case, if time warrants, in order to run an efficient OR. It will only be voluntary.

12.1-3 Surgery Call anesthesiologist shall be readily available in 30 minutes and must be notified of all the cases which require anesthesia services especially during off hours (night, weekend, and holidays).

12.1-4 Emergencies will be so designated by the attending surgeon and shall take precedence over urgent or elective cases. An emergency case is defined as a condition threatening loss of life, limb, or an organ of the body. An urgent case is defined as a condition when undue delay is hazardous. An elective is one when surgery can be scheduled electively in regular work hours.

12.1-5 Surgery cases are scheduled by a surgery scheduling clerk under the supervision of the director of Surgery Nursing and coordinated by the Chair of the Department of Anesthesiology and Pain Management or his or her designee on the regular hours of the week, or scheduled by the in-house administrative nursing supervisor and coordinated by an anesthesiologist on call at night, weekends, and holidays.

- 12.1-6 Anesthesiologists shall be assigned to cases by the Chair on a fair and equitable basis. Special request for a specific anesthesiologist is discouraged due to frequent conflict of fair and equitable rotation and interfering with the efficiency in running the surgery schedule. However, the patient and surgeon request may be accommodated whenever available and feasible. The request shall be made directly to the scheduling clerk at the time of booking.
- 12.1-7 The anesthesiologist must be in continuous attendance during the patient's operative procedure.
- 12.1-8 Parents can stay with a child at the discretion of the anesthesiologist, preoperatively and postoperatively, after conferring with the nursing staff.
- 12.1-9 The Anesthesiology Technician is under the direction of the Chair of the Department and is supervised by the Surgery charge nurse and/or manager.
- 12.1-10 Vacation and time off policy for anesthesiologists shall be handled by the Chair of the Department of Anesthesiology and Pain Management to ensure availability of anesthesiologists. This plan is to assure optimal anesthesia care and follow-up of surgical patients scheduled for elective surgery.
- A. Elective surgery cases are assigned to anesthesiologists from the daily call schedule.
  - B. Each anesthesiologist is responsible for the perioperative care of his or her assigned patients.
  - C. Should an anesthesiologist give up the assigned cases, the anesthesiologists shall be assigned by moving up in sequence if there are enough available anesthesiologists from the daily Anesthesia Availability List.
  - D. If not, the originally assigned anesthesiologist shall be responsible to arrange anesthesia coverage for the patients.
  - E. Inpatients: Surgery should be booked by 3:00 PM the day before surgery to ensure preoperative anesthesia evaluation of the patient can be completed the day prior to surgery.
  - F. AM admission patients, Outpatients and Inpatients booked late: Patients will best be served if a History and Physical, an up-to-date overall medical evaluation, or current cardiopulmonary status and appropriate laboratory data are available on admission or at the time of initial visit by the assigned anesthesiologist.
  - G. If a patient had any previous anesthesia problems or unusual medical conditions during surgery, it shall be communicated directly to the assigned anesthesiologist or a message left which might affect the delivery or outcome of the anesthesia planned for the surgery. Communication shall be made directly to the assigned anesthesiologist or a message left to the person who is booking the case.