

e. All health care practitioners (physicians) and nurses shall hold a valid license or certificate to perform their assigned duties.

f. All operating room personnel who provide clinical care in the office shall be qualified to perform services commensurate with appropriate levels of education, training, and experience. Additional requirements include:

Level 1

1.Practitioner	BLS course completed
2.Sedation assistant	BLS course completed
3.Post-anesthesia personnel	BLS course completed

Level 2

1.Practitioner	
If anesthesiologist provides anesthetic care:	No additional requirements for practitioner.
If supervising the sedation:	Must be Conscious Sedation credentialed ² ACLS course completed PALS course completed if pediatric patients
2.Sedation Assistant PA:	Conscious Sedation credentialed ² BLS & ACLS course completed PALS course completed if pediatric patients
RN	Conscious Sedation credentialed BLS & ACLS course completed PALS course completed if pediatric patients
CRNA	PALS course completed if pediatric patients Commensurate hospital experience
Anesthesiologist	Board certified or eligible ² recommended Commensurate hospital experience
3.Post-sedation personnel:	RN or PA BLS course completed ACLS course completed if practitioner not available immediately.

Level 3

1.Practitioner

² Completion of a CME course in conscious sedation, or have relevant training in a residency training program or have similar privileges granted by a hospital medical staff.

If anesthesiologist provides anesthetic care:	No additional requirements for practitioner
If supervising the sedation:	Must be Conscious Sedation credentialed ² ACLS course completed PALS course completed for pediatric patients
2. Anesthetic Assistant	
CRNA	PALS course completed for pediatric patients Commensurate with hospital experience
Anesthesiologist	Board certified or eligible recommended Commensurate with hospital experience
3. Post-Anesthesia Personnel	
RN	ACLS course completed PALS course completed for pediatric patients

g. The physician, or other health care provider supervising the administration of the anesthesia shall participate in ongoing continuous quality improvement and risk management activities.

IV. Facility and Safety

a. Facilities shall comply with all applicable federal, state, and local laws, codes and regulations pertaining to fire prevention and other safety issues.

V. Clinical Care – Patient and Procedure Selection

a. The physician or other health care provider supervising the administration of anesthesia shall be satisfied that the procedure to be undertaken is within the scope of practice of the health care providers and the capabilities of the facility. *This practitioner shall be specifically trained in sedation, anesthesia and rescue techniques appropriate to the type of sedation or anesthesia being provided, as defined in Appendix A, and to the office-based surgery being performed. Practitioners intending to produce a given level of sedation should be able to rescue patients whose level of sedation becomes deeper than initially intended.*

b. The procedure shall be of a duration and degree of complexity that will permit the patient to recover and be discharged from the facility.

c. Patients who by reason of pre-existing medical or other conditions may be at undue risk for complications shall be referred to an appropriate facility, such as a hospital or ambulatory surgery center, for performance of the procedure and the administration of anesthesia. The following guidelines serve to ensure that patients at higher risk for perioperative complications are identified and appropriately treated.

Physical Status (Appendix B)

<u>Level 1</u>	Not specified
<u>Level 2</u>	Limited to Physical Status I-III.
<u>Level 3</u>	Limited to Physical Status I-II.

Age

<u>Level 1</u>	Not specified
<u>Level 2</u>	If patient is < 4 years old, the anesthetic shall be administered by a physician, or CRNA with advanced training in pediatric airway management, beyond that provided by PALS.
<u>Level 3</u>	If patient is < 4 years old, a pre-operative evaluation by a qualified physician and written justification by the surgeon for performing the intended surgery in an office-based setting is required.

VI. Perioperative Care

- a. The physician, or other health care provider responsible for the administration of the anesthesia in Level II and III shall determine the medical status of the patient, develop a plan of anesthesia care and acquaint the patient or the responsible adult with the proposed plan.

Minimal Preoperative Evaluation

<u>Level 1</u>	Review of medical record.
<u>Level 2</u>	Basic Standards for Pre-anesthesia/Sedation Care (Appendix C)
<u>Level 3</u>	Basic Standards for Pre-anesthesia Care (Appendix C)

- b. The physician, or other health care provider supervising the anesthetic shall be physically present during the intraoperative period.

VII. Monitoring and Equipment

1. At a minimum, all facilities shall have a reliable source of oxygen, suction, resuscitation equipment and emergency drugs.
2. Sufficient space shall be available to accommodate all necessary equipment and personnel and to allow for expeditious access to the patient, anesthesia machine (when present) and all monitoring equipment.
3. *In any location in which anesthesia is administered, there shall be appropriate anesthesia apparatus and equipment for monitoring of patients.*

Level 1 – Not specified

Level 2 & Level 3 – consistent with “Standards for Basic Anesthetic Monitoring” (Appendix E)

4. All equipment shall be maintained, tested, and inspected according to the manufacturer’s specifications.
5. Back-up power sufficient to ensure patient protection in the event of an emergency shall be available in facilities where Level 2 and Level 3 anesthetics are provided.
6. In an office where anesthesia services are to be provided to infants and children, the required equipment, medication and resuscitative capabilities shall be appropriately sized for these patients.

VIII. Discharge

- a. Discharge of the patient is a *physician, or other health care provider responsibility*. This decision shall be documented in the medical record.

Level 1 Patients must meet facility discharge criteria.

Level 2 The ASA Guidelines for Post Anesthesia Care (Appendix D) shall apply. At least one qualified person (III-f.) shall be in attendance in the PACU with additional staff as necessary for the patient acuity and volume of the facility.

Level 3 The ASA Guidelines for Post Anesthesia Care shall apply, and qualified personnel (III-f) with training in advanced resuscitative techniques (e.g. ACLS, PALS) *shall be present in the PACU* until the patient is discharged additional staff will be present as necessary for the patient acuity and volume of the facility.

- b. Practitioners who administer or supervise the administration of Level 1, Level 2, or Level 3 anesthesia services in an office shall ensure the following prior to discharge:
 1. That at least one practitioner shall remain on the premises until the patient meets discharge criteria or is transferred to another facility;
 2. That the patient shall be given written and verbal instructions for follow-up care and advice concerning complications;
 3. That the patient shall be discharged only into the company of a responsible individual *and*;
 4. That before the patient leaves the office or is transferred to another facility, the physician reviews and signs the post-anesthesia record, or the assistant or nurse in the recovery room ensures that the patient has met the facility's discharge criteria.

Recovery from surgery and anesthesia shall, in most instances, be sufficient to allow for discharge from facility. If prolonged recovery is anticipated the facility should have arrangements for readily available supervised prolonged stay or for transfer to an appropriate facility.

IX. Emergencies and Transfers

- a. All facility personnel shall be appropriately trained and regularly review the facility's written emergency protocols.
- b. There shall be written protocols for cardiopulmonary emergencies and other internal and external disasters such as fire.
- c. The facility shall have medications, equipment and written protocols available to treat malignant hyperthermia when triggering anesthetic agents are used.
- d. The facility shall have a written protocol in place for the safe and timely transfer of patients to a nearby pre-specified alternate care facility when extended or emergency services are needed to protect the health or well-being of the patient. Practitioner agrees to participate in Quality Assurance/Peer Review process of the hospital to which the patient was transferred and to make his/her records available to that process.

X. Quality Assurance and Reporting

- a. All Level 2 and Level 3 facilities shall maintain an accurate record of the number of patients treated and level of anesthesia that was provided to those patients.

- b. Records of unintended consequences shall be maintained and resultant outcomes documented. Unintended consequences include, but are not limited to:
1. Death of a patient within 24 hours of the surgery;
 2. Admission of a patient to another facility within 24 hours for treatment of complications of surgery or anesthesia;
 3. Bleeding episodes requiring transfusion within 24 hours of surgery;
 4. Life-threatening cardiorespiratory events and;
 5. Anaphylaxis or other serious adverse drug reaction.
 6. Critical equipment failure.
- c. Data regarding unintended consequences should be submitted to an entity recognized by the Washington State Department of Health as maintaining a Quality Improvement Program as provided for in RCW 43.70.150.

New Recommendation:

WSMA should continue to work with other appropriate entities to establish a non-punitive, confidential and anonymous reporting mechanism for all medical errors.

APPENDIX A

Continuum of Depth of Sedation

Definition of General Anesthesia and Levels of Sedation/Analgesia *

	<i>Minimal Sedation (Anxiolysis)</i>	<i>Moderate Sedation/Analgesia (“conscious sedation”)</i>	<i>Deep Sedation/Analgesia</i>	<i>General Anesthesia</i>
<i>Responsiveness</i>	Normal response to verbal stimulation	Purposeful** response to verbal or tactile stimulation	Purposeful** response following repeated or painful stimulation	Unarousable, even with painful stimulus
<i>Airway</i>	Unaffected	No intervention required	Intervention may be required	Intervention often required
<i>Spontaneous Ventilation</i>	Unaffected	Adequate	May be adequate	Frequently inadequate
<i>Cardiovascular Function</i>	Unaffected	Usually maintained	Usually maintained	May be impaired

Minimal Sedation (anxiolysis) is 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. Minimal sedation includes un-supplemented oral and intramuscular pre-operative medications.

Moderate Sedation/Analgesia (“conscious sedation”) is 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 is 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.

General Anesthesia is a drug-induced loss of 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

Practitioners intending to produce a given level of sedation should be able to rescue patients whose level of sedation becomes deeper than initially intended. Individuals administering Moderate Sedation/Analgesia (“conscious sedation”) should be able to rescue patients who enter a State of Deep Sedation/Analgesia, while those administering Deep Sedation/Analgesia should be able to rescue patients who enter a state of General Anesthesia.

* Monitored Anesthesia Care does not describe the continuum of depth of sedation, rather it describes “a specific anesthesia service in which an anesthesiologist has been requested to participate in the care of a patient undergoing a diagnostic or therapeutic procedure.”

** Reflex withdrawal from a painful stimulus is **NOT** considered a purposeful response.

may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

Because sedation is a continuum, it is not always possible to predict how an individual patient will respond.

APPENDIX B

AMERICAN SOCIETY OF ANESTHESIOLOGISTS PHYSICAL STATUS CLASSIFICATIONS

PS 1 There is no organic, physiological, biochemical or psychiatric disturbance. The pathological process for which the operation is to be performed is localized and is not a systemic disturbance.

PS 2 Mild to moderate systemic disturbance caused either by the condition to be treated surgically or by other pathophysiological processes.

PS 3 Severe systemic disturbance or disease from whatever cause, even though it may not be possible to define the degree of disability with finality.

PS 4 Indicative of the patient with severe systemic disorder already life threatening, not always correctable by the operative procedure.

PS 5 The moribund patient who has little chance of survival but is submitted to operation in desperation.

APPENDIX C

BASIC GUIDELINES FOR PRE-ANESTHESIA CARE

These guidelines apply to all patients who receive anesthesia. Under unusual circumstances, e.g. extreme emergencies, these standards may be modified. When this is the case, the circumstances shall be commented in the patient's record.

Guideline I: The supervising practitioner shall be responsible for determining the medical status of the patient, developing a plan of anesthesia care and acquainting the patient or the responsible adult with the proposed plan.

The development of an appropriate plan of anesthesia care is based upon:

1. Reviewing the medical record.
2. Interviewing and examining the patient to:
 - a. Discuss the medical history, previous anesthetic experiences and drug therapy.
 - b. Assess those aspects of the physical condition that might affect decisions regarding perioperative risk and management.
3. Obtaining and/or reviewing tests and consultations necessary to the conduct of anesthesia.
4. Determining the appropriate prescription of preoperative medications as necessary to the conduct of anesthesia.

The supervising practitioner shall verify that the above has been properly performed and documented in the patient's record.

APPENDIX D

GUIDELINES FOR POST-ANESTHESIA CARE

These guidelines apply to post-anesthesia care in all locations. These guidelines may be exceeded based on the judgment of the supervising practitioner. 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. Under appropriate circumstances, the supervising practitioner may waive the requirements marked with an asterisk (*); it is recommended that when this is done, it should be so stated (including the reasons) in a note in the patient's medical record.

Guideline I

ALL PATIENTS WHO HAVE RECEIVED GENERAL ANESTHESIA, REGIONAL ANESTHESIA OR SEDATION/ANALGESIA SHALL RECEIVE APPROPRIATE POST-ANESTHESIA MANAGEMENT.

1. A Post-anesthesia Care Unit (PACU) or an area that provides equivalent post-anesthesia care 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 *or supervising practitioner* responsible for the patient's care.
2. The medical aspects of care in the PACU shall be governed by policies and procedures, which have been reviewed and approved by the medical director or governing body.
3. The design, equipment and staffing of the PACU shall meet requirements of the facility's accrediting and licensing bodies.

Guideline II

A MEMBER OF THE ANESTHESIA CARE TEAM WHO IS KNOWLEDGEABLE ABOUT THE PATIENT'S CONDITION SHALL ACCOMPANY THOSE PATIENTS TRANSPORTED TO THE PACU. THE PATIENT SHALL BE CONTINUALLY EVALUATED AND TREATED DURING TRANSPORT WITH MONITORING AND SUPPORT APPROPRIATE TO THE PATIENT'S CONDITION.

Guideline 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 OF THE ANESTHESIA CARE TEAM WHO ACCOMPANIES THE PATIENT.

1. The patient's status on arrival in the PACU shall be documented.
2. Information concerning the pre-operative condition and the surgical/anesthetic course shall be transmitted to PACU personnel.

The member of the Anesthesia Care Team shall remain in the PACU until the PACU personnel accept responsibility for the care of the patient.

Guideline IV

THE PATIENT'S CONDITION SHALL BE EVALUATED CONTINUALLY IN THE PACU.

1. The patient shall be observed and monitored by methods appropriate to the patient's medical condition. Particular attention should be given to monitoring oxygenation, ventilation, circulation and temperature. During recovery from all anesthetics, a quantitative method of assessing oxygenation such as pulse oximetry shall be employed in the initial phase of recovery. *
2. An accurate written report of the PACU period shall be maintained. Use of an appropriate PACU scoring system is encouraged for each patient on admission, at appropriate intervals prior to discharge and at the time of discharge.
3. General medical supervision and coordination of patient care in the PACU should be the responsibility of the practitioner.
4. There shall be a policy to assure the availability in the facility of a practitioner capable of managing complications and providing cardiopulmonary resuscitation for patients in the PACU.

Guideline V

A PRACTITIONER IS RESPONSIBLE FOR THE DISCHARGE OF THE PATIENT FROM THE POST-ANESTHESIA CARE UNIT.

1. When discharge criteria are used, they must be approved by the medical director or governing body.
2. In the absence of the practitioner responsible for discharge, PACU personnel shall determine that the patient meets the discharge criteria. The name of the practitioner accepting responsibility for discharge shall be noted on the record.

APPENDIX E

GUIDELINES FOR BASIC ANESTHETIC MONITORING

These guidelines apply to all anesthesia care although, in emergency circumstances, appropriate life support measures take precedence. These guidelines 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 guidelines addresses only the issue of basic anesthetic monitoring, which is one component of anesthesia care. In certain rare or unusual circumstances, some of these methods of monitoring may be clinically impractical, and appropriate use of the described monitoring methods may fail to detect untoward clinical developments. Brief interruptions of continual monitoring may be unavoidable. Under extenuating circumstances, the responsible anesthesiologist may waive the requirements marked with an asterisk; it is recommended that when this is done, it should be so stated (including the reasons) in a note in the patient's medical record. These guidelines are not intended for application to the care of the obstetrical patient in labor or in the conduct of pain management.

Note that "continual" is defined as "repeated regularly and frequently in steady rapid succession:" whereas "continuous" means "prolonged without any interruption at any time."

Under appropriate circumstances, the supervising practitioner may waive the requirements marked with an asterisk (*); it is recommended that when this is done, it should be so stated (including the reasons) in a note in the patient's medical record.

Guideline I

Qualified anesthesia personnel shall be present in the room throughout the conduct of all general anesthetics, regional anesthetics and monitored care.

Objective

Because of the rapid changes in patient status during anesthesia, qualified anesthesia personnel shall be continuously present to monitor the patient and provide anesthesia care. In the event there is a direct known hazard, e.g. radiation, to the anesthesia personnel, which might require intermittent remote observation of the patient, some provision for monitoring the patient must be made. In the event that an emergency requires the temporary absence of the person primarily responsible for the anesthetic, the best judgement of the anesthesiologist will be exercised in comparing the emergency with the anesthetized patient's condition and in the selection of the person left responsible for the anesthetic during the temporary absence.

Guideline II

During all anesthetics, the patient's oxygenation, ventilation, circulation, and temperature shall be continually evaluated.

Oxygenation

Objective

To ensure adequate oxygen concentration in the inspired gas and the blood during all anesthetics.

Methods

1. Inspired gas: During every administration of general anesthesia using an anesthesia machine, the concentration of oxygen in the patient breathing system shall be measured by an oxygen analyzer with a low oxygen concentration limit alarm in use.
2. Blood oxygenation: During all anesthetics, a quantitative method of assessing oxygenation such as pulse oximetry shall be employed. Adequate illumination and exposure of the patient are necessary to assess color.

Ventilation

Objective

To ensure adequate ventilation of the patient during all anesthetics.

Methods

1. Every patient receiving general anesthesia shall have the adequacy of ventilation continually evaluated. Qualitative clinical signs such as chest excursion, observation of the reservoir breathing bag and auscultation of breath sounds are useful. Continual monitoring for the presence of expired carbon dioxide shall be performed unless invalidated by the nature of the patient, procedure or equipment. Quantitative monitoring of the volume of expired gas is strongly encouraged.

2. When an endotracheal tube or laryngeal mask is inserted, its correct positioning must be verified by clinical assessment and by identification of carbon dioxide in the expired gas. Continual end-tidal carbon dioxide analysis, in use from the time of endotracheal tube/laryngeal mask placement, until extubation/removal or initiating transfer to a postoperative care location, shall be performed using a quantitative method such as capnography, capnometry or mass spectroscopy.
3. When ventilation is controlled by a mechanical ventilator, there shall be in continuous use a device that is capable of detecting disconnection of components of the breathing system. The device must give an audible signal when its alarm threshold is exceeded.
4. During regional anesthesia and monitored anesthesia care, the adequacy of ventilation shall be evaluated, at least, by continual observation of qualitative clinical signs.

Circulation

Objective

To ensure the adequacy of the patient's circulatory function during all anesthetics.

Methods

1. Every patient receiving anesthesia shall have the electrocardiogram continuously displayed from the beginning of anesthesia until preparing to leave the anesthetizing location.
2. Every patient receiving anesthesia shall have arterial blood pressure and heart rate determined and evaluated at least every five minutes.
3. Every patient receiving general anesthesia shall have, in addition to the above, circulatory function continually evaluated by at least one of the following: palpation of a pulse, auscultation of heart sounds, monitoring of a tracing of intra-arterial pressure, ultrasound peripheral pulse monitoring, or pulse plethysmography or oximetry.

Body Temperature

Objective

To aid in the maintenance of appropriate body temperature during all anesthetics.

Methods

Every patient receiving anesthesia shall have temperature monitored when clinically significant changes in body temperature are intended, anticipated or suspected.