PROVIDENCE SAINT JOSEPH MEDICAL CENTER
DEPARTMENT OF SURGERY

ANESTHESIA SECTION
RULES AND REGULATIONS

In accordance with the Bylaws of the Professional Staff, Article VIII, Section 1, the Anesthesia Section is hereby organized under the Department of Surgery as follows:

I. CHARGES TO THE ANESTHESIA SECTION:

- A. Supervise, maintain, and evaluate the standard of practice of anesthesia in the Medical Center.
- B. Set rules and regulations for administration of anesthesia in the Medical Center.
- C. Determine the anesthesia privileges of staff members.
- D. Advise on purchase of anesthesia equipment and the construction of facilities.
- E. Participate in teaching.

II. POLICIES:

A. Sectional Composition and Function:

1. The Section shall function in accordance with Article VIII, of the Professional Staff Bylaws.
2. A quorum shall consist of a majority of the voting members.
3. Members of the Section shall consist of:
   a. Members of the Medical Staff in accordance with Article VII, Section 1 of the Professional Staff Bylaws.
   b. Voting members shall be Active and Associate Category members of the Professional Staff.
4. Sectional vote shall carry by simple majority of voting members.
5. Sectional Meetings:
   a. Meetings shall be held as often as necessary, to enhance communication with section members, discuss outcomes of patient care review functions, and for educational purposes.
   b. As appropriate, a review of mortality and morbidity cases and clinical review, as well as general business, will be conducted each meeting. Ad hoc meetings may also be called.
   c. A yearly meeting for election of Chairman will be held.

B. Section Organization:

1. The Anesthesia Medical Director is appointed by the hospital in accordance with Professional Staff criteria for Medical Directors and in accordance with State laws and acceptable standards of practice. The responsibilities of the Medical Director are delineated in the Anesthesia Services Policy which is included in these Rules and Regulations. The Anesthesia Section Chairman is part of the Professional Staff leadership and a member of the Surgery Committee. The duties of the Medical Director and Section Chairman may overlap; however, overall administrative responsibility is vested in the Medical Director.

2. The Chairman and Vice Chairman shall be selected in accordance with the Professional Staff Bylaws (Article VIII, Section 2 Subsection 2B).
3. The Chairman shall have responsibility for:
   a. Oversight of anesthesia care rendered in the Medical Center.
   b. Development of regulations concerning anesthetic safety.
   c. Retrospective evaluation of all anesthesia care, including: participation in the audit studies of the major clinical services and completion of audits of anesthesia related complications.
   d. To assist in developing and updating policies for and to participate in the Medical Center's program of Continuing Education.
   e. To assist in developing and updating policies for nursing services, members of the Professional Staff and anesthesiologists who perform moderate and deep sedation throughout the Medical Center and to provide consultation, or management of problems of acute and chronic respiratory insufficiency.
   f. Consultation on other diagnostic and therapeutic measures related to hospital patient care.

C. Scheduling of Anesthesia Coverage

1. This Policy shall apply to the scheduling of all anesthesia services.

2. In order to promote continuity in the personnel assigned to provide anesthesia services, to facilitate scheduling of anesthesiologists, to assure the availability of well-qualified anesthesiologists to cover all anesthesia practice venues at the Medical Center at all necessary times, and to assure that anesthesiologists are assigned in accordance with patient care and administrative considerations, the scheduling of anesthesia services, shall be administered in accordance with the preferential system described in this Rule.
3. The Active Staff members of the Anesthesia Section shall periodically determine the number of Section Members who shall be entitled to be scheduled on a regular, rotating basis (Rotating Staff) and the number of Section Members who shall be entitled to be scheduled on an irregular or as needed basis (Non-Rotating Staff). Such determinations shall require the affirmative vote of two-thirds of the Active Staff members of the Section.
4. The members of the Rotating Staff shall, by majority vote,
    a. Designate new Rotating Staff members from among the members of the Non-Rotating staff as needed; and
    b. Designate new Non-Rotating Staff Members.
5. The Section Chairman shall be responsible, in coordination with the Surgery Department Director, and subject to policies approved by the Section and the Executive Committee, to administer the anesthesia schedule.
6. Notwithstanding Sections 1 through 5 above, the scheduling process will be subject to the terms of any exclusive agreement for anesthesia services.

D. Anesthesia Privileges and Staffing:

1. Privileges and Category will be recommended every two years according to Article III Section 5 of the Professional Staff Bylaws, by the Anesthesiology Section.
2. Anesthesia privileges will be recommended by the Anesthesia Section as a whole to the Surgical Committee.
    a. Only physicians granted staff privileges in accordance with the Professional Staff Bylaws shall conduct or supervise anesthesia at Saint Joseph Medical Center.
    b. All members of the Anesthesia Section must show certification of continuing medical education as required by Professional Staff Bylaws.
3. Anesthesiologists must be able to perform all of the independent services required in the practice of anesthesiology. This includes the ability to:
    a. Perform accepted procedures commonly employed to render the patient insensible to pain for the performance of surgical and obstetrical procedures or other necessary, but pain-producing, clinical maneuvers.
    b. Support life functions during the period of anesthesia.
    c. Provide appropriate pre-anesthesia and post-anesthesia management for the patient.
    d. Provide consultation relating to various other forms of patient care, such as respiratory therapy and special problems in pain relief, unless these responsibilities are assigned to other physicians, who are specially trained and qualified and are assigned that responsibility.
    e. Participate in hospital education programs.
4. Anesthesia coverage will be determined by a call schedule composed and approved by the Section Chairman and Operating Room Director or designee and in accordance with approved policies of the Anesthesia Section. The scheduling process will be subject to the terms of any exclusive agreement for anesthesia services.
5. New applicants to the staff will either be Board Certified by the American Board of Anesthesiology or immediately eligible for examination by the American Board of Anesthesiology.

E. Patient Care:

1. During the preoperative visit there shall be a discussion of anesthesia plan and options, a disclosure of risks and an acceptance thereof by the patient or by a proper representative whenever possible. A pre-anesthetic assessment and note of the findings relating to anesthesia, of the plan of anesthesia and the acceptance thereof, shall be documented prior to the procedure as well as reassessment immediately prior to induction, recorded in the progress note or the appropriate space on the reverse of the anesthesia record. In these Rules and Regulations, any references to "anesthesia record," "progress note," or other reference to the patient chart or medical record shall include the electronic medical record (EMR) equivalent.
2. A complete history and physical examination and essential lab work should be available at the time of the anesthesiologist's visit. However, such documentation shall not replace the anesthesiologist's responsibility for personally evaluating the patient, nor prevent him from ordering further lab or radiological tests deemed essential to the safe conduct of the anesthesia.
3. Whenever a serious question is raised regarding the readiness of a patient for anesthesia for elective or emergency surgery, consultation shall be obtained with the operating surgeon as soon as possible. Such surgical procedures shall be postponed until such time as there has been an adequate re-evaluation.

Whenever the anesthesiologist finds it necessary to withdraw from a case, he shall so state his reasons in writing in the medical records.

4. Guidelines for Anesthesia Safety
   a. The anesthesiologist shall be in constant attendance and monitoring the patient during anesthesia.
   b. The methods of monitoring employed shall be recorded in the chart.
   c. The Anesthesia Services Policy (a part of these Rules and Regulations) describes the required elements of patient monitoring.
   d. The Anesthesia Services Policy (a part of these Rules and Regulations) describes the requirements for anesthesia equipment.
   e. The technique of administration and the quantity or percentage of drugs or gases employed shall be charted.
5. All drugs must be properly labeled.
6. During local anesthesia, not in the presence of an anesthesiologist, vital signs shall be monitored and recorded.
7. Patients shall not be removed from the operating room until the person administering anesthesia is satisfied with the patient's condition.
8. All patients undergoing operative, manipulative or diagnostic procedures under any form of anesthesia (regional, general or monitored anesthesia care, shall be taken to the PACU before being returned to their rooms, ICU, CCU, etc., except when in the judgement of the surgeon and/or anesthesiologist, it is in the best interest of the patient to be taken to an area other than the PACU.
9. The responsibility for patients in the PACU is a joint one shared by the surgeon and the anesthesiologist; requests for assistance by PACU personnel shall evoke immediate and appropriate response on the part of the physicians involved. If no anesthesiologist is involved in the care of the patient, the surgeon or other physician operator shall perform the duties in the recovery room for which an anesthesiologist would normally be responsible.
10. The care of the post-anesthesia patient shall not be delegated by the anesthesiologist or surgeon to the post-anesthetic care facility nurse until the anesthesiologist or surgeon has ascertained that the patient's condition is such that the patient may safely be transferred from the immediate supervision of a physician to that of a post-anesthesia care facility.
11. Decision relative to discharge of patients from the PACU should be made by a physician. Discharge from the PACU is to be accomplished according to PSJMC Policy/Procedure Manual: Acute section, number PCP T-4: "Transfer Criteria from the Post Anesthesia Recovery Areas."
12. Post-Operative discharge criteria for Short Stay & Day Surgery patients shall be according to policies described in the SFV Policy/Procedure Manual: Patient Care Provider, number SFV-PCP-D16: "Discharge of the Outpatient Following an Operative, Invasive Procedure (Standardized Procedure)".
13. Anesthesia shall not be induced on any patient until the operating surgeon is present in either the operating suite, Special Procedures area, or is available in the hospital. It is the attending anesthesiologist's prerogative to determine when it is necessary for the operating surgeon to be physically present in the operating suite before induction of anesthesia.
14. The anesthesiologist is responsible for recording a post-anesthetic visit that includes at least one note describing the presence or absence of anesthesia related complications. This evaluation/visit must be done after the patient has sufficiently recovered to be able to participate in the process. Requirements are further described in the Anesthesia Services Policy.
15. Responsibility for post operative visits and notes may be delegated to any member of the Anesthesia Section.

ANESTHESIA SERVICES POLICY

III. Introduction:

Providence St. Joseph Medical Center is vitally interested in the safe administration of anesthesia throughout the facility. The Anesthesia Medical Director and the Section of Anesthesia have the responsibility for developing policies and procedures governing the provision of all categories of anesthesia services, including specifying the minimum qualifications for each category of practitioner who is permitted to provide anesthesia services. The hospital's governing body approves the specific anesthesia service privileges, including type and complexity of procedures, for each practitioner who furnishes anesthesia services, addressing the type of supervision required, if applicable. The United States Code of Federal Regulations, Title 42, requires that hospital anesthesia services be provided in a well-organized manner under the direction of a qualified Doctor of Medicine or osteopathy. The regulations specify that the anesthesia service is responsible for all anesthesia administered in the hospital.

IV. Purpose:

The purpose of these policies and procedures is to establish the standards and expectations for all patients receiving anesthesia services at Providence Saint Joseph Medical Center (PSJMC), including but not limited to general anesthesia, regional anesthesia, deep sedation/analgesia, moderate sedation/analgesia, minimal sedation/anxiolysis, local anesthesia and topical anesthesia. These policies and procedures apply to all locations in the hospital where anesthesia services are administered, including all departments in all campuses and off-site locations where anesthesia services are provided.

These policies have been developed in collaboration with other hospital disciplines (surgery, pharmacy, nursing, biomedical engineering) that are involved in delivering these services to patients in the various areas of the hospital and off-site locations.

The authorities for these policies include the U.S. Code (42CFR482.52), California Administrative Code Title 22 (22 CCR §70233) and the Interpretive Guidelines of the Centers for Medicare and Medicaid Services. Anesthesia services are an integral part of surgery. The Surgical Services Conditions of Participation (42CFR482.52) require provision of surgical services in accordance with acceptable standards of practice. Parts of this policy are adaptations of documents developed by the Committee on Quality Management and Departmental Administration of the American Society of Anesthesiologists. Additional references are made to policies of The American College of Emergency Physicians.

V. Scope of 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, under the direction of a qualified Doctor of Medicine (MD) or doctor of osteopathy (DO). Areas where anesthesia services are furnished may include (but are not limited to):

A. Operating room suite(s), both inpatient and outpatient;
B. Cardiac Physiology Laboratory (Cath Lab)
C. Gastroenterology Laboratory (GI Lab)
D. Emergency Department
E. Critical Care Areas including the Neonatal ICU
F. Recovery Rooms (PACU)
G. Obstetrical suite(s)
H. Clinics (pain management clinic, etc.)
I. Radiology department, including diagnostic radiology as well as CT and MRI
J. Special procedures area (interventional radiology, e.g., endovascular procedures by surgeons and radiologists, biliary procedures by radiologists and gastroenterologists
K. Roy & Patricia Disney Family Cancer Center
L. In this policy, references to anesthesia section, anesthesia committee or anesthesia department are equivalent.

VI. How the Hospital's Anesthesia Services needs will be met:

Anesthesia services shall be delivered in a manner that is consistent with the needs and the resources of the hospital (including all departments in all campuses and off-site locations where anesthesia services are provided).

A. General anesthesia, regional anesthesia (e.g., spinal anesthesia, epidural anesthesia, IV regional anesthesia and major nerve block anesthesia), and Monitored Anesthesia Care (as defined by the American Society of Anesthesiologists) are provided by the anesthesia group. The anesthesia group consists of physicians (MD and DO) specializing in anesthesiology. The anesthesia group also may provide pain medicine consultations and procedures.
B. In addition to anesthesiologists, other physicians may, by virtue of training and experience, be granted privileges to provide and/or supervise sedation/analgesia.
C. Physicians, podiatrists and dentists who are members of the Professional Staff are granted privileges to order and supervise minimal sedation/anxiolysis as well as local infiltration anesthesia and peripheral nerve block anesthesia.

VII. Medical Director:

Anesthesia services throughout the hospital (including all departments in all campuses and off-site locations where anesthesia services are provided) must be organized into one anesthesia service, under the direction of a qualified Doctor of Medicine (MD) or doctor of osteopathy (DO). Consistent with the requirement at §482.12(a)(4) for it to approve Professional Staff bylaws and rules and regulations, the hospital's governing body approves, after considering the Professional Staff's recommendations, Professional Staff rules and regulations establishing criteria for the qualifications for the director of the anesthesia services. The medical director is appointed by the hospital in accordance with Professional Staff criteria for medical directors and in accordance with State laws and acceptable standards of practice. The medical director's responsibilities include:

A. Establishing staffing schedules and planning, directing, and supervising all activities of the service.
B. Development of perioperative policies, clinical protocols, forms, reports and records.
C. Consultation in developing preoperative testing requirements.
D. Recommendations to Hospital Administration in the development, management and budgeting of the Department.
E. Participation in the development and implementation of effective quality assurance and utilization review programs.

VIII. Quality Assessment/Performance Improvement:

In order to assure the provision of safe care to patients, the anesthesia service is integrated into the hospital's required Quality Assessment/Performance Improvement program.

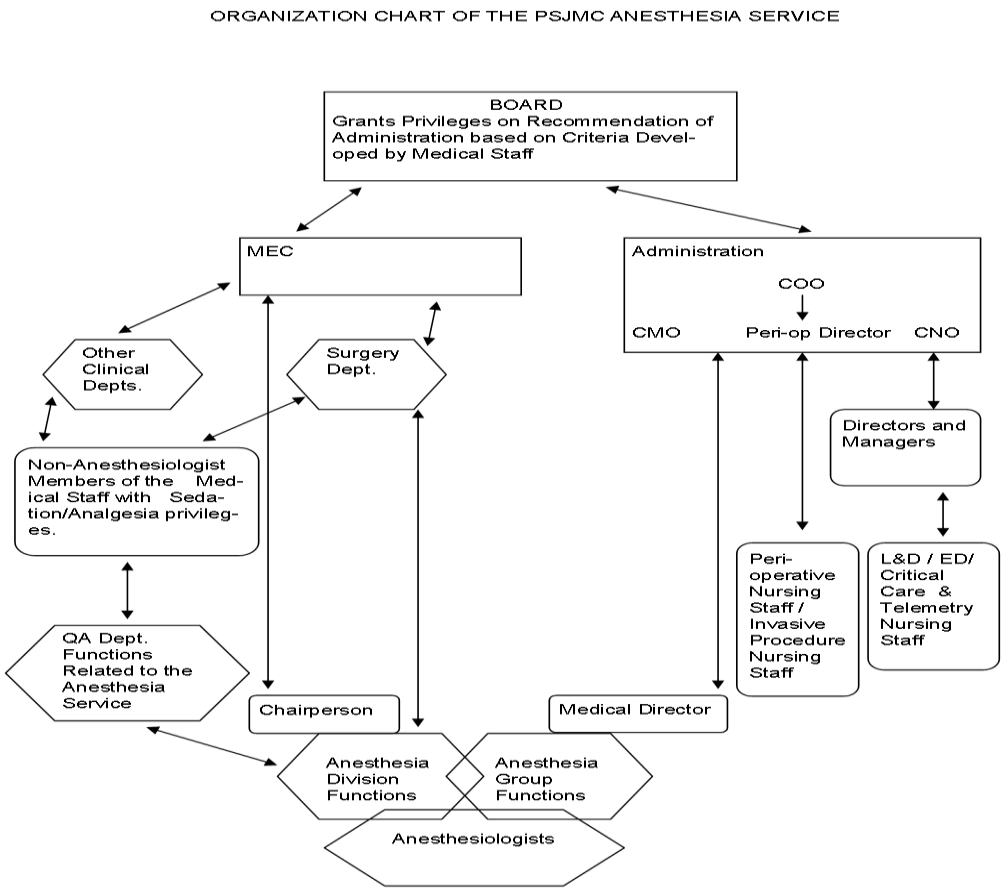
A. Characteristics of the Anesthesia Service
   1. The Anesthesia Section is a part of the Department of Surgery in accordance with the Department of Surgery Rules and Regulations and the General Professional/AHP Staff Rules and Regulations.
   2. The Department of Surgery is organized as provided in the Bylaws of PSJMC Professional/AHP Staff.

B. Characteristics of the Quality Assessment/Performance Improvement Program
   1. The Anesthesia Section is fully integrated into the PSJMC Quality Assessment/Performance Improvement Program.
   2. Issues involving patient care, patient safety, and peer review are referred to or identified by the Quality Improvement (QI) Department.
   3. For issue resolution, the QI Department follows the PSJMC Professional Staff Peer Review Process which is approved by the Medical Executive Committee.

C. Reporting Requirements
   1. Coordinated by QA Department
   2. QA is accomplished in Anesthesia Section Meetings
   3. QA related to procedures with an anesthesiologist (operating rooms including procedure rooms, etc.): Anesthesia Committee approved indicators for procedures attended by an anesthesiologist.
   4. QA related to Procedural Sedation: Anesthesia Committee approved indicators for procedural sedation.

D. The anesthesia services policies and procedures will undergo periodic re-evaluation that includes analysis of adverse events, medication errors and other quality or safety indicators related not only to anesthesia, but also to the administration of medications in clinical applications that the hospital has determined involve analgesia rather than anesthesia. (QAPI CoP, §482.21).

XI. Organizational Chart for Anesthesia Services:



X. Definitions of the Categories of Anesthesia:

"Anesthesia" involves the administration of medications 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 lose consciousness, but does not perceive pain to the extent that may otherwise prevail.

Analgesia and anesthesia comprise a continuum of states ranging from minimal sedation to general anesthesia. This policy also includes the categories of topical and local analgesia. The additional definitions below illustrate differences among the various types of anesthesia services. Not all of the definitions are considered "anesthesia." The definitions are generally based on American Society of Anesthesiologists definitions found in its most recent set of practice guidelines.

A. Anesthesia

1. 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 where loss of consciousness is required for the safe and effective delivery of surgical services. General anesthesia includes total intravenous anesthesia (TIVA).

2. Regional anesthesia: is used when loss of consciousness may not be desired but sufficient analgesia and loss of voluntary and involuntary movement is required. Regional anesthesia is the delivery of anesthetic medication at a specific level of the spinal cord and/or to peripheral nerves. It includes epidurals and spinals and other central neuraxial nerve blocks as well as peripheral nerve blocks. Given the potential for the conversion of central neuraxial regional anesthesia and major nerve block anesthesia to general anesthesia in certain procedures, it is necessary that the administration of these forms of regional anesthesia be delivered by an anesthesiologist.
3. Monitored anesthesia care (MAC): Anesthesia care that includes the monitoring of the patient by an anesthesiologist. 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. MAC may include the administration of sedative and analgesic medications. When deep sedation/analgesia is included in MAC and the patient loses consciousness and protective airway reflexes, this is considered general (TIVA) anesthesia. An example would be a screening colonoscopy where there is a decision to use propofol, so as to decrease movement and improve visualization for this type of invasive procedure.
4. Moderate/Deep Sedation administered or supervised by a physician other than an anesthesiologist is not considered to be MAC as defined by the American Society of Anesthesiologists because the ASA maintains that MAC is a service that can only be provided by anesthesia providers. Deep Sedation administered or supervised by a physician other than an anesthesiologist is considered to be MAC as defined by CMS Interpretive Guidelines.
5. Although the distinction between deep sedation and general anesthesia may be tenuous, this policy does not categorize deep sedation as "anesthesia" because physicians with privileges for deep sedation do not have privileges to intentionally administer general anesthesia.

B. Sedation/Analgesia

1. Nationally recognized guidelines:
   a. American Society of Anesthesiologists:
      Statement on Granting Privileges for Administration of Moderate Sedation to Practitioners who are not Anesthesia Professionals
   b. American Society of Anesthesiologists:
      Distinguishing Monitored Anesthesia Care ("MAC") from Moderate Sedation / Analgesia (Conscious Sedation)
   c. American College of Emergency Physicians:
      Clinical Policy: Procedural Sedation and Analgesia in the Emergency Department
   d. American College of Emergency Physicians:
      Clinical Policy: Critical Issues in the Sedation of Pediatric Patients in the Emergency Department
2. Anesthesia exists along a continuum. For some medications there is no bright line that distinguishes when their pharmacological properties bring about the physiologic transition from the analgesic to the anesthetic effects. Furthermore, each individual patient may respond differently to different types of medication.
3. Notwithstanding, only anesthesiologists may intentionally administer general anesthesia (Reference: American Society of Anesthesiologists, Statement on Granting Privileges for Deep Sedation to Non-Anesthesiologist Sedation Practitioners).
4. 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 by a physician who is expressly privileged for deep sedation/analgesia as specified in 42 CFR 482.52(a).
5. 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. Moderate sedation/analgesia is not considered to be "anesthesia."
6. Rescue Capacity: Because sedation is a continuum, it is not always possible to predict how an individual patient will respond. Further, no clear boundary exists between some of these services. Hence, hospitals must ensure that procedures are in place to rescue patients whose level of sedation becomes deeper than initially intended, for example, patients who inadvertently enter a state of deep sedation/analgesia when moderate sedation was intended. "Rescue" from a deeper level of sedation than intended requires an intervention by a practitioner (physician or registered nurse) with expertise in airway management and advanced life support.

The qualified practitioner corrects adverse physiologic consequences of the deeper-than-intended level of sedation and returns the patient to the originally intended level of sedation.

a. Rescue capacity is not only required as an essential component of anesthesia services, but is also consistent with the requirements under the Patients' Rights standard at §482.13(c)(2); "The patient has the right to receive care in a safe setting."
b. Practitioners should possess the skills required to rescue a patient one (1) level greater than the intended level of sedation. Reference: American College of Emergency Physicians
   i. Clinical Policy: Procedural Sedation and Analgesia in the Emergency Department
   ii. Annals of Emergency Medicine, February 2005

7. Minimal sedation: A drug-induced state during which patients respond normally to verbal commands. Although cognitive function and coordination may be impaired, ventilation and cardiovascular functions are unaffected. For example, a patient undergoing an MRI or CT scan may receive minimal sedation with an oral medication to decrease the anxiety while undergoing these types of radiologic examinations.
8. Local anesthesia: Medication injected to render part of the body insensitive to pain without affecting consciousness. This may be subcutaneous injection or extremity nerve block.
9. Topical anesthesia: Medication applied to skin or mucosa to render part of the body insensitive to pain without affecting consciousness.
10. Despite the names, "local" and "topical" are not considered to be "anesthesia" as defined herein.

XI. Policies for Administration of the Categories of Anesthesia Services:

A. General and Regional Anesthesia
1. Pursuant to State scope of practice laws and regulations, general anesthesia must be administered only by practitioners who are qualified and privileged to administer general anesthesia.
2. Pursuant to State scope of practice laws and regulations, neuraxial regional anesthesia and major nerve block anesthesia must be administered only by practitioners who are qualified and privileged to administer general anesthesia.
3. Procedural sedation (MAC) in the operating rooms must be administered only by practitioners who are qualified and privileged to administer general anesthesia.

B. Deep Sedation
1. Pursuant to State scope of practice laws and regulations, and due to the significant risk that patients may enter a state of general anesthesia, deep sedation must be administered only by practitioners who are qualified and privileged to administer deep sedation.
2. The supervising doctor is responsible for all aspects involved in the continuum of care: pre-procedure, intra-procedure, and post-procedure.
3. While a patient is sedated, the responsible doctor must be physically present in the procedure suite.
4. Deep Sedation privileges require as a prerequisite current privileges for moderate sedation.
5. Deep Sedation is subject to the PSJMC Emergency Department Deep Sedation Medication Administration Policy PSJ-ED-S18.

C. Medication Restrictions
1. Medications such as propofol (Diprivan), etomidate (Amidate), ketamine (Ketalar) and methohexital (Brevital) may only be administered by practitioners who are qualified and privileged to administer anesthesia or deep sedation (ASA, ACEP).
2. Propofol (Diprivan), specifically, may not be administered as a component of procedural sedation except by practitioners qualified and privileged to administer anesthesia or deep sedation (CMS).
3. The propofol restriction does not apply to patients requiring sedation for mechanical ventilation.

D. Moderate Sedation
1. Pursuant to State scope of practice laws and regulations, moderate sedation must be administered by a privileged and qualified physician sedation/analgesia provider, or a licensed registered nurse, advanced practice nurse or physician assistant (PA) who is trained in compliance with all relevant local, institutional, state and/or national standards, policies or guidelines to administer prescribed sedating and analgesic medications and monitor patients during moderate sedation.
2. The supervising doctor is responsible for all aspects involved in the continuum of care: pre-procedure, intra-procedure, and post-procedure.
3. While a patient is sedated, the responsible doctor must be physically present in the procedure suite.
4. Privileged Sedation nurses and sedation physician assistants may only work under the direct supervision of a properly trained and privileged medical doctor (M.D. or D.O.). Only physicians who are qualified by education, training and licensure to administer moderate sedation may supervise the administration of moderate sedation.
5. Although the supervising doctor is primarily responsible for pre-procedure patient evaluation, supervised sedation practitioners must be trained adequately in pre-procedure patient evaluation to recognize when risk may be increased.

6. Moderate Sedation is subject to the PSJMC Sedation/Analgesia, Moderate Policy PSJ-PCP-S19.
7. All providers of moderate sedation are required to have at least the following knowledge and competencies:
    a. Proper medication dosages, administration techniques, adverse reactions and counter interventions.
    b. Airway management and basic life support techniques.
    c. Advanced Cardiac Life Support (ACLS), (PALS) for pediatric patients is required for Registered Nurses.
    d. Ability to assess total patient care including, but not limited to, respiratory rate, oxygen saturation, blood pressure, cardiac rate and level of consciousness.

E. Minimal Sedation
1. Pursuant to State scope of practice laws and regulations, minimal sedation must be ordered by a privileged and qualified physician sedation/analgesia provider and administered by a licensed registered nurse, advanced practice nurse or physician assistant (PA) who is trained in compliance with all relevant local, institutional, state and/or national standards, policies or guidelines to administer prescribed sedating and analgesic medications and monitor patients during minimal sedation ("anxiolysis"). Sedation nurses and sedation physician assistants may only work under the supervision of a properly trained and privileged medical doctor (M.D. or D.O.).
2. The supervising doctor is responsible for all aspects involved in the continuum of care: pre-procedure, intra-procedure, and post-procedure.

F. Local and Topical Anesthesia
1. Before the use of local/topical anesthesia, patient allergies and sensitivities should be investigated including previous reactions.
2. Cardiovascular conditions should be considered before using local anesthetics containing epinephrine.
3. Dose limitations should be calculated and potential toxicity considered.

G. Qualifications of Personnel
1. Staff administering drugs for analgesia must be appropriately qualified, and drugs must be administered in accordance with accepted standards of practice.
    a. Nursing personnel are assigned to provide care based on the specialized qualifications and competence of the nursing staff available. §482.23(b)(5)
    b. Drugs and biologicals must be prepared and administered in accordance with Federal and State laws. §482.23(c)
    c. When intravenous medications are administered by personnel other than Doctor of Medicine or osteopathy, the personnel must have special training for this duty. §482.23(c)(3)

XI. Privileges:

The Anesthesia Section is responsible for developing policies and procedures governing the provision of all categories of anesthesia services, including specifying the minimum qualifications for each category of practitioner with recommendation to the Department of Surgery who in turn, recommends to the Medical Executive Committee. The hospital's governing body must approve the specific anesthesia service privileges for each practitioner who furnishes anesthesia services, addressing the type of supervision, if any, required. The privileges granted must be in accordance with State law and hospital policy.

A. Clinical privileges in anesthesiology are granted to physicians and other providers that are qualified by training to render patients insensible to pain and to minimize stress during surgical, obstetrical and certain medical procedures. Clinical privileges are also granted to practitioners who are not anesthesia professionals to administer sedative and analgesic drugs to establish a level of deep, moderate or minimal sedation.

B. Every practitioner administering anesthesia must have current licensure and, as applicable, current certifications.

C. The type and complexity of procedures for which the practitioner may administer anesthesia must be specified in the privileges granted to the individual practitioner as follows:

D. Anesthesiologists:
1. General anesthesia, including total intravenous anesthesia (TIVA).
2. Monitored Anesthesia Care (MAC) including the continuum of all types of sedation.
3. Regional anesthesia including neuraxial regional anesthesia (e.g., spinal and epidural anesthesia).
4. Regional anesthesia including major peripheral nerve blocks.
5. Regional anesthesia and analgesia for obstetric patients including labor and delivery and cesarean section.

E. Physicians other than anesthesiologists (with appropriate credentialing):
1. Emergency Department physicians:
    a. Procedural sedation (including moderate sedation and deep sedation) is a core competency of Emergency Physicians (American College of Emergency Physicians 2/10/2011)
    b. The recognition, by individual facilities, of procedural sedation as a core competency of Emergency Physicians is supported by the American Society of Anesthesiologists (1/20/2011)
2. Pulmonologists:
    a. Deep sedation for tracheal intubation
    b. Moderate sedation

c. Criteria for Deep Sedation privileges are described below
d. Criteria for Moderate Sedation privileges are described below

3. Other physicians (for example, gastroenterologists, neonatologists and cardiologists) with appropriate training and experience:
   a. Moderate sedation
   b. Criteria for Moderate Sedation privileges are described below
4. All physicians, podiatrists, oral surgeons and dentists:
   a. Minimal Sedation (outside of the operating rooms)
   b. Local Anesthesia
   c. Topical Anesthesia
   d. Regional Anesthesia, excluding neuraxial and major peripheral nerve blocks
5. Privileges for Moderate Sedation require:
   a. Documented training and/or experience in administration and monitoring for moderate sedation
   b. Compliance with the criteria for Moderate Sedation specified by
      i. The Department of Surgery Delineation of Privileges
      ii. The Department of Medicine Delineation of Privileges
      iii. The Emergency Medicine Delineation of Privileges
   c. Moderate Sedation is subject to the PSJMC *Sedation/Analgesia, Moderate* Policy PSJ-PCP-S19.
6. Privileges for Deep Sedation require:
   a. Documented training and/or experience in administration and monitoring for deep sedation.
   b. Currently also hold privileges for moderate sedation.
   c. Compliance with the criteria for Deep Sedation specified by
      i. The Department of Surgery Delineation of Privileges
      ii. The Department of Medicine Delineation of Privileges
      iii. The Emergency Medicine Delineation of Privileges
7. Deep Sedation is subject to the PSJMC Emergency Department *Deep Sedation Medication Administration* Policy PSJ-ED-S18.

XII. Delivery of Services and Required Documentation:

A. Delineation of pre-anesthesia and post-anesthesia staff responsibilities
   1. Pre-anesthesia patient evaluation is the responsibility of a physician who has privileges for the applicable Category of Anesthesia Service.
   2. Post-anesthesia patient evaluation is the responsibility of a physician who has privileges for the applicable Category of Anesthesia Service.

B. Pre-Anesthesia Evaluation
   1. A pre-anesthesia evaluation must be performed for each patient who receives general, regional or monitored anesthesia.
   2. While current practice dictates that the patient receiving moderate sedation be monitored and evaluated before, during, and after the procedure by trained practitioners, a pre-anesthesia evaluation is not required.
   3. Because deep sedation is considered by CMS to be monitored anesthesia care (MAC), a pre-anesthesia evaluation must be performed.
   4. The PSJMC Deep Sedation Evaluation form (or EMR equivalent) contains the required elements needed for pre-deep sedation evaluation and must be completed by a physician having deep sedation privileges.
   5. Deep sedation administered solely for the purpose of establishing a secure airway (e.g., "rapid sequence intubation") (RSI) is not subject to the documentation requirements for deep sedation.
   6. In the event of extreme urgency, some or all of the elements of the Pre-Sedation Evaluation may not be completed.
   7. For patients receiving moderate or deep sedation, the Informed Consent Operative / Procedure note or Deep Sedation Evaluation (or EMR equivalent) must include:
      a. The sedation plan (Deep or Moderate)
      b. The ASA Classification
      c. Airway assessment
      d. A statement that the patient is determined to be an appropriate candidate for moderate/deep sedation
      e. Signature, date and time
   8. The requirements of 42CFR482.52 (b)(1) do not permit delegation of the pre-anesthesia evaluation to practitioners who are not qualified to administer anesthesia (or deep sedation).
   9. The pre-anesthesia evaluation must be completed and documented within 48 hours prior to any inpatient or outpatient surgery or procedure requiring anesthesia services.
   10. The delivery of the first dose of medication(s) for the purpose of inducing anesthesia, as defined above, marks the end of the 48 hour timeframe.

11. In accordance with current standards of anesthesia care, some of the individual elements contributing to the pre-anesthesia evaluation may be performed prior to the 48-hour timeframe. However, under no circumstances may these elements be performed more than 30 days prior to surgery or a procedure requiring anesthesia services. Review of these elements must be conducted, and any appropriate updates documented, within the 48-hour timeframe.
12. The pre-anesthesia evaluation of the patient includes, at a minimum:
    a. Elements that must be performed within the 48-hour time frame.
        i. Review of the medical history, including anesthesia, drug and allergy history.
        ii. Interview, if possible given the patient's condition, and examination of the patient.
    b. Elements that must be reviewed and updated as necessary within 48 hours, but which may also have been performed within 30 days in preparation for the procedure.
        i. Notation of anesthesia risk according to established standards of practice (e.g., ASA classification of risk, more accurately known as ASA Physical Status).
        ii. Identification of potential anesthesia problems, particularly those that may suggest potential complications or contraindications to the planned procedure (e.g., difficult airway, ongoing infection, limited intravascular access).
        iii. Additional pre-anesthesia evaluation, if applicable and as required in accordance with standard practice prior to administering anesthesia (e.g., stress tests, additional specialist consultation).
        iv. Development of the plan for the patient's anesthesia care, e.g. general vs. regional anesthesia, and any special post-operative care considerations as well as discussion with the patient (or patient's representative) of the risks and benefits of the delivery of anesthesia.
13. The CMS requirement for an evaluation/re-evaluation within 48 hours prior to anesthesia is separate from the Joint Commission Standard PC.03.01.03 that all patients need to be re-evaluated immediately prior to administering anesthesia, deep sedation or moderate sedation.

C. Patient consent: After determining that the patient is an appropriate candidate for anesthesia, the following will be discussed with the patient or the patient's family or designated decision maker:
1. The plan for anesthesia
2. Alternatives when applicable
3. Risks involved
4. Documentation of reasons for not discussing the plan, risks, and alternatives in extraordinary circumstances where risk to life or limb precludes any delay.
   Intraoperative Anesthesia Record: There must be an intraoperative anesthesia record or report (or EMR equivalent) for each patient who receives general anesthesia (including TIVA), regional or monitored anesthesia care (MAC). While current practice dictates that the patient receiving moderate sedation or deep sedation be monitored and evaluated before, during, and after the procedure by trained practitioners, an intraoperative anesthesia report is not required. Current standard of care stipulates that an intraoperative anesthesia record, at a minimum, includes:
5. Name and hospital identification number of the patient
6. Name(s) of practitioner who administered anesthesia
7. Name, dosage, route and time of administration of drugs and anesthesia agents
8. Techniques(s) used and patient position(s), including the insertion/use of any intravascular or airway devices
9. Name and amounts of IV fluids, including blood or blood products if applicable
10. Timed-based documentation of vital signs as well as oxygenation and ventilation parameters
11. Any complications, adverse reactions, or problems occurring during anesthesia, including time and description of symptoms, vital signs, treatments rendered, and patient's response to treatment
12. Compliance with Title 22 requires documentation on the anesthesia record (or EMR equivalent) that immediately prior to induction of anesthesia, the patient has been re-evaluated verification of:
    a. The patient's identity
    b. Presence of a signed surgical consent
    c. Presence of the surgeon's attestation of informed consent
    d. Correct procedure
    e. Correct site and side
    f. Current history and physical examination (within 30 days), re-evaluated and updated within 24 hours
13. The Procedural Sedation Record (or EMR equivalent) will be used when an anesthesiologist is not in attendance (i.e., for moderate and deep sedation).
14. Measurement and documentation of vital signs in the operating room immediately prior to induction.
15. Immediately prior to induction of anesthesia, the operating room personnel will conduct a pre-induction briefing, using the current printed WHO Surgical Safety Check List, Pre-Induction elements.

16. Immediately prior to incision or its equivalent, the operating room personnel will conduct a Surgical Pause using the current printed WHO Surgical Safety Check List "Time-Out" elements.
17. For procedures not performed in the operating rooms, personnel will conduct a pre-procedure pause (AKA: Time-Out) as specified in the Procedure Verification Checklist (or EMR equivalent).

D. Post-anesthesia Evaluation: A post-anesthesia evaluation must be completed and documented for any surgery or a procedure requiring anesthesia services. The evaluation is required any time general, regional, or monitored anesthesia care has been administered to the patient. While current practice dictates that the patient receiving moderate (conscious) sedation be monitored and evaluated before, during, and after the procedure by trained practitioners, a post-anesthesia evaluation is not required.

1. The evaluation must be completed and documented by any practitioner who is qualified to administer anesthesia.
2. Although §482.12(c)(1)(i) provides broad authority to physicians to delegate tasks to other qualified medical personnel, the more stringent requirements of §482.52(b)(3) do not permit delegation of the post-anesthesia evaluation to practitioners who are not qualified to administer anesthesia.
3. Because deep sedation is considered by CMS to be monitored anesthesia care (MAC), a post-sedation evaluation must be performed.
4. Deep sedation administered solely for the purpose of establishing a secure airway (e.g., rapid sequence intubation) (RSI) is not subject to the documentation requirements for deep sedation.
5. The evaluation must be completed no later than 48 hours after an inpatient surgery or procedure requiring anesthesia services.
6. For outpatients and same day procedures, documentation of the evaluation must be completed within the 48 hour timeframe.
7. The calculation of the 48-hour timeframe begins at the point the patient is moved into the designated recovery area.
8. The evaluation can occur in the PACU/ICU/Second Stage PACU or other designated recovery location.
9. The evaluation generally would not be performed immediately at the point of movement from the operative area to the designated recovery area.
10. Accepted standards of anesthesia care require that the evaluation may not begin until the patient is sufficiently recovered from the acute administration of the anesthesia so as to participate in the evaluation, e.g., answer questions appropriately, perform simple tasks, etc.
11. When post-operative sedation is necessary for the optimum medical care of the patient (e.g., ICU), the evaluation may be performed without the patient's participation.
12. For those patients who are unable to participate in the post-anesthesia evaluation (e.g., postoperative sedation, mechanical ventilation, etc.), a post-anesthesia evaluation must be completed and documented within 48 hours with notation that the patient was unable to participate. This documentation should include the reason for the patient's inability to participate as well as expectations for recovery time, if applicable. For those patients who require long-acting regional anesthesia to ensure optimum medical care of the patient, whose acute effects will last beyond the 48-hour timeframe, a post-anesthesia evaluation must still be completed and documented within 48 hours. However, there should be a notation that the patient is otherwise able to participate in the evaluation, but full recovery from regional anesthesia has not occurred and is not expected within the stipulated timeframe for the completion of the evaluation.
13. The elements of an adequate post-anesthesia evaluation should be clearly documented and conform to current standards of anesthesia care, including:
    a. Respiratory function, including respiratory rate, airway patency, and oxygen saturation
    b. Cardiovascular function, including pulse rate and blood pressure
    c. Mental status
    d. Temperature
    e. Pain
    f. Nausea and vomiting
    g. Postoperative hydration (urine output)
    h. Depending on the specific surgery or procedure performed, additional types of monitoring and assessment may be necessary.

E. The PSJMC Deep Sedation Evaluation form (or EMR equivalent) contains the required elements needed for post-deep sedation evaluation.

XIII. Infection control measures:

A. References are to PSJMC Policy/Procedure Manual
B. PSJ-Periop-A1 Attire: Surgical
C. PSJ-Periop-A3 Anesthesia Equipment and Supplies
D. PSJ-Periop-A4 Aseptic Technique and Surgical Conscience
E. PSJ-Periop-S6 Skin Preparation, Patient
F. PSJ-Periop-I2 Instrument Cleaning and Processing

G. PSJ-Periop-S9 Sterilization, Instrumentation

XIV. Medication Security:

Medications security is achieved by lockable storage and controlled access to all Scheduled medications (Pyxis).

XV. Safety practices in all anesthetizing areas:

A. Compliance with NPSG 03 Medication Labeling
B. References below are to PSJMC Policy/Procedure Manual
C. PSJ-Periop-F3 Fire Safety
D. PSJ-SAFE-F11 Fire Alarm Response
E. PSJ-Periop-E3 Electrical Safety
F. PSJ-Periop-P2 Positioning the Surgical Patient
G. PSJ-Periop-M3 Medication Handling and Administration, Safe
H. PSJ-Periop-S2 Sharps, Surgical Passing of
I. CA-IP-3015 Sharps Disposal
J. PSJ-Periop-F1 Fluid Warming, Irrigation
K. SFV-PCP-H11 Hypothermia and Shivering
L. PSJ-Periop-T4 Temperature and Humidity, Room

XVI. Protocol for supporting life functions, e.g., cardiac and respiratory emergencies:

A. References are to PSJMC Policy/Procedure Manual
B. PSJ-Periop-C6 Code Blue
C. CA-PERIOP-1300 Malignant Hyperthermia

XVII. Equipment requirements (monitoring, inspection, testing and maintenance):

A. Appropriate sections of PSJMC Policy/Procedure Manual

XVIII. World Health Organization Surgical Safety Checklist:

A. The provisions of this section apply only to operating rooms (including c-section rooms) Cardiac Physiology Laboratory (when used for implantable devices such as pacemakers, ICDs) and Special Procedures (ERCPs, peripheral vascular stents). Other areas use the Procedure Verification Checklist or EMR equivalent).
B. Each operating room and each location for performance of invasive procedures shall have a copy of the approved WHO checklist.
C. Procedure areas may have checklists that omit items not germane to specific locations.
D. The appropriate checklist shall be used for each procedure.
E. Before induction of anesthesia or sedation, the elements of the Pre-Induction Briefing shall be verified by the team by positive verbal response.
F. Before the incision or equivalent process, the elements of the time-out / surgical pause shall be verified by the team by positive verbal response.

XIX. Anesthesia Equipment:

A. Anesthesia Machines shall have:
    1. Oxygen analyzers
    2. Pressure and disconnect alarms
    3. Medical gas pin-index safety systems
    4. Gas scavenging systems
    5. Backup oxygen supply
    6. Oxygen pressure interlock system
B. In the event of an alarm from the line isolation monitor, Biomedical Engineering will be notified immediately. If possible, electrical equipment will be disconnected in an attempt to immediately find the cause of the alarm condition.

XX. ASA Standards for Basic Anesthesia Monitoring:

A. Adapted from the American Society of Anesthesiologists
    1. Approved by the ASA House of Delegates on October 21, 1986, and last amended on October 20, 2010.
    2. Committee of Origin: Standards and Practice Parameters.

3. (†) Note that "continual" is defined as "repeated regularly and frequently in steady rapid succession" whereas "continuous" means "prolonged without any interruption at any time."
4. (*) 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.

B. 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.

C. 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 judgment 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.

D. During all anesthetics, the patient's oxygenation, ventilation, and circulation shall be continually evaluated.
1. Oxygenation
   a. 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.(*)
   b. Blood oxygenation: During all anesthetics, a quantitative method of assessing oxygenation such as pulse oximetry shall be employed.(*) When the pulse oximeter is utilized, the variable pitch pulse tone and the low threshold alarm shall be audible to the anesthesiologist or the anesthesia care team personnel.(*) Adequate illumination and exposure of the patient are necessary to assess color.(*)
2. Ventilation
   a. 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.(*)
   b. 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.(*) When capnography or capnometry is utilized, the end tidal CO_2 alarm shall be audible to the anesthesiologist.(*)
   c. 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.
   d. During regional anesthesia and monitored anesthesia care, the adequacy of ventilation shall be evaluated by continual observation of qualitative clinical signs and/or monitoring for the presence of exhaled carbon dioxide unless precluded or invalidated by the nature of the patient, procedure, or equipment.
3. Circulation
   a. Every patient receiving anesthesia shall have the electrocardiogram continuously displayed from the beginning of anesthesia until preparing to leave the anesthetizing location.(*)
   b. 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.
   c. Patients transferred from the operating room or a procedure area directly to the ICU should be monitored with electrocardiogram and pulse oximetry.

d. Every patient receiving anesthesia shall have arterial blood pressure and heart rate determined and evaluated at least every five minutes.(*)

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

XXI. Non-operating Room Anesthetizing Locations:

A. Adapted from the American Society of Anesthesiologists
   1. Approved by the ASA House of Delegates on October 15, 2003, and amended on October 16, 2013.
   2. Committee of Origin: Standards and Practice Parameters

B. These guidelines apply to all anesthesia care involving anesthesiology personnel for procedures intended to be performed in locations outside an operating room. These are minimal guidelines which may be exceeded at any time based on the judgment of the involved anesthesia personnel. These guidelines encourage quality patient care but observing them cannot guarantee any specific patient outcome. These guidelines are subject to revision from time to time, as warranted by the evolution of technology and practice. ASA Standards, Guidelines and Policies should be adhered to in all non-operating room settings except where they are not applicable to the individual patient or care setting.

C. There should be in each location a reliable source of oxygen adequate for the length of the procedure. There should also be a backup supply. Prior to administering any anesthetic, the anesthesiologist should consider the capabilities, limitations and accessibility of both the primary and backup oxygen sources. Oxygen piped from a central source, meeting applicable codes, is strongly encouraged. The backup system should include the equivalent of at least a full E cylinder.

D. There should be in each location an adequate and reliable source of suction. Suction apparatus that meets operating room standards is strongly encouraged.

E. In any location in which inhalation anesthetics are administered, there should be an adequate and reliable system for scavenging waste anesthetic gases.

F. There should be in each location:
   1. A self-inflating hand resuscitator bag capable of administering at least 90 percent oxygen as a means to deliver positive pressure ventilation.
   2. Adequate anesthesia drugs, supplies and equipment for the intended anesthesia care.
   3. Adequate monitoring equipment to allow adherence to the "Standards for Basic Anesthetic Monitoring."
   4. In any location in which inhalation anesthesia is to be administered, there should be an anesthesia machine equivalent in function to that employed in operating rooms and maintained to current operating room standards.

G. There should be in each location, sufficient electrical outlets to satisfy anesthesia machine and monitoring equipment requirements, including clearly labeled outlets connected to an emergency power supply.

H. In any anesthetizing location determined by the health care facility to be a "wet location" (e.g., for cystoscopy or arthroscopy or a birthing room in labor and delivery), either isolated electric power or electric circuits with ground fault circuit interrupters should be provided. .(National Fire Protection Association. Health Care Facilities Code 99; Quincy, MA: NFPA, 1993).

I. There should be in each location, provision for adequate illumination of the patient, anesthesia machine (when present) and monitoring equipment. In addition, a form of battery-powered illumination other than a laryngoscope should be immediately available.

J. There should be in each location, sufficient space to accommodate necessary equipment and personnel and to allow expeditious access to the patient, anesthesia machine (when present) and monitoring equipment.

K. There should be immediately available in each location an emergency cart with a defibrillator, emergency drugs and other equipment adequate to provide cardiopulmonary resuscitation.

L. There should be in each location adequate staff trained to support the Anesthesiologist. There should be immediately available in each location, a reliable means of two-way communication to request assistance.

M. For each location, all applicable building and safety codes and facility standards, where they exist, should be observed.

N. Appropriate post-anesthesia management should be provided (see Standards for Post-Anesthesia Care). In addition to Anesthesiologist, adequate numbers of trained staff and appropriate equipment should be available to safely transport the patient to a post-anesthesia care unit.

These Rules and Regulations of the Anesthesia Section were adopted by the Department of Surgery of Providence Saint Joseph Medical Center, Burbank, California, as presented at the Executive Committee meeting of April 15, 2015.

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Alexander Koretz, M.D., Chairman
Anesthesia Section

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Shahan V. Yacoubian, M.D., Chairman
Department of Surgery

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Manzur S. Kuraishi, M.D.
Chief of Staff

_____
Karl Keeler
Chief Executive