ORGANIZATION OF THE ANESTHESIOLOGY DEPARTMENT

1. Anesthesiology Department Members
   a. Members of the Anesthesiology Department shall be Anesthesiologists on the Medical Staff and Certified Registered Nurse Anesthetists (CRNAs) on the Independent Allied Staff of PeaceHealth Southwest Medical Center.
   b. A full voting member is defined as an anesthesiologist who performs at least 200 cases per year of active patient care.

2. Anesthesia Committee Members
   The Anesthesia Committee shall be composed of five (5) Officers plus, the past Department Chair and two members at large of the Anesthesiology Department. The chief nurse anesthetist, the PACU supervisor, and an administrative representative are encouraged to participate in the Committee Meetings.

3. Officers
   Anesthesia Department officers shall be the Chair, Chair-Elect, OB/Anesthesia Services Director, Education Director, and the Anesthesia Representative from the Peer Review Committee. These officers are members of the Anesthesia Committee.

4. Officer Qualifications
   To qualify for election or appointment and while an active officer (Department Chair, Chair-Elect, OB/Anesthesia Services Director, Education Director, and Anesthesia Representative from the Multidisciplinary Peer Review Committee), the qualified officer or officer-elect shall be a full voting member of the Anesthesiology Department as defined in 1a., and a qualified doctor of medicine (MD) or doctor of osteopathy (DO).

5. Function of officers
   a. Chair
      The Chair of the Anesthesiology Department shall be responsible for the direction of all anesthesia services in the hospital as well as the overall supervision of clinical work in the department. He/She also shall be responsible for:
      (1) Planning, directing, and supervising all activities of anesthesia services throughout the hospital. This includes reviewing and granting requests for Anesthesia privileges throughout the hospital.
      (2) Evaluating the quality and appropriateness of the anesthesia services provided to patients as part of the hospital’s Performance Improvement Program. This includes tracking compliance of defined quality measures and reviewing individual cases and automatic rule violations as identified by the hospital’s Multidisciplinary Peer Review Committee.
      (3) Recommendations to administration and medical staff for new equipment.
      (4) Continuing medical education of the Anesthesiology Department.
      (5) Enforcement of the Anesthesia Committee Guidelines, Rules and Regulations.
      (6) Presiding over Anesthesia Committee and Department meetings.
      (7) Serving on the Executive Committee of the Medical Staff.

   b. Chair-Elect
      The Chair-Elect shall assume the responsibilities of the Chair in the event of the Chair’s absence. After the Chair’s term of office expires, the Chair-Elect shall succeed him/her.

   c. OB/Anesthesia Services Director
The OB/Anesthesia Services Director shall coordinate, supervise and evaluate OB anesthesia services and assist with planning, development and implementation of new services under the direction of the Chair of the Anesthesiology Department. The OB Director will assist in efforts to develop advanced competencies for staff of OB Anesthesia and review and recommend clinical policies applicable to OB Anesthesia.

d. **Education Director**  
The Education Director shall be responsible for developing and producing a medical education program. The program shall be directed toward the continuing education of the Anesthesiologists, the nurse anesthetists and the recovery room nurses.

6. **Election of Committee Members and Officers**  
The Chair, Chair-Elect, and Committee members will be elected by the Anesthesia Department for two-year terms. Nominations for Elected Officers and At-Large Committee members shall be accepted from and voted on by Active Clinical members of the Anesthesia Department. Elections shall take place in December. A year's term runs from February 1st to January 31st.

The Anesthesia Chair shall appoint an Education Director from qualified members of the Anesthesia Department.

The OB/Anesthesia Director is a contracted position with Columbia Anesthesia Group and a qualified member of the department will be appointed by Columbia Anesthesia Group.

The Anesthesia representative on the Multidisciplinary Peer Review Committee will be nominated by the Anesthesia Department Chair for appointment to the position by the Medical Staff President. The term is three years and is limited to two terms.

7. **Meetings**  
The Anesthesia Committee shall meet, at a minimum, quarterly. If there is no other business or peer review material to discuss, the Chair may elect to cancel a scheduled meeting. Its function shall be primarily that of patient care review and facilitation of interdepartmental policies.

The Anesthesia Department shall meet as needed.

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**ORGANIZATIONAL CHART OF ANESTHESIA SERVICES**

- Anesthesia Department Chair (Director of Anesthesia Services)
- Department of Anesthesia
- Sedation Policies
- OB Anesthesia
- OR and Interventional Director
- Special Pain Management areas
- Level II Level I (anesthesia) (not defined as anesthesia)
ANESTHESIA PRIVILEGES & PROTORING
Newly appointed physicians are reappointments will be monitored through the Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE) processes as outlined in the medical staff credentialing policies.

SCOPE OF ANESTHESIA COVERAGE
All services along the continuum of anesthesia care provided in the hospital are organized under the Anesthesia Department, which are directed by the Anesthesia Department Chair and are consistently implemented in every department and setting that provides any type of anesthesia services. The Anesthesia Department is responsible for participating in the development of policies and procedures governing the provision of all categories of anesthesia services, including specifying the minimum qualifications for privileges. The Anesthesia Department will be responsible to monitor and evaluate the quality and appropriateness of anesthesia patient care. A member of the department who is either a qualified doctor of medicine or doctor of osteopathy, and not the Department Chair, shall participate as a voting member on the hospital’s Multidisciplinary Peer Review Committee. The Department Chair will review the department’s compliance with defined quality measures, rule based violations as defined by the hospital’s Multidisciplinary Peer Review Committee, and cases as identified by the hospital’s Multidisciplinary Peer Review Committee.

The Anesthesiology Department shall be responsible for providing all primary anesthesia and pain management services at PeaceHealth Southwest Medical Center. This includes, but is not limited to, general and regional anesthesia in operating suites, obstetrics, emergency room, radiology and intensive care. Anesthesia services shall be available twenty-four (24) hours of the day and night for emergency cases. Consultations shall be available for respiratory, intensive care, and emergency resuscitation services.

Medical staff outside the Anesthesiology Department may request deep sedation also defined as level II sedation. Level II sedation is defined as anesthesia and as such falls under the direction of the Chair of the Anesthesiology Department. The specific qualifications for level II sedation are defined in the level I and level II sedation policy. The Chair of the Anesthesia Department shall ensure medical staff requesting such privileges meet the qualifications and ensure the quality of the level II sedation program by reviewing any cases identified by the hospital’s Multidisciplinary Peer Review Committee.

ANESTHESIA STAFFING
1. Anesthesia care shall be provided by anesthesiologists and CRNAs.

2. CRNAs shall work primarily under the medical direction of an anesthesiologist in a care team model.

3. Interventional Pain Management services will be provided by the interventional pain physicians, as well as by members of the anesthesia department. The Interventional Pain Clinic will be staffed by agreement of physician need, in close coordination with the Pain Clinic nursing supervisor. Interventional pain physicians are available on-call full-time for consultation with other providers, patient evaluation and interventions if appropriate.

ANESTHESIA PATIENT CARE POLICY
1. Pre-Anesthesia Evaluation
   Prior to performing any anesthetic, anesthesia provider must perform a pre-anesthesia evaluation as defined by CMS Condition of Participation.
   A pre-anesthesia evaluation must be performed within 48 hours prior to surgery or procedure requiring anesthesia services. A pre-anesthesia evaluation must be performed for each patient who receives general, regional, or monitored anesthesia care including level II sedation. The pre-anesthesia evaluation must be
completed and documented within 48 hours immediately prior to any inpatient or outpatient surgery or procedure requiring anesthesia services. 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 time frame.

The evaluation must be performed by someone qualified to administer anesthesia including a qualified anesthesiologist or a CRNA.

The pre-anesthesia evaluation of the patient includes, at a minimum:

- Review of the medical history, including anesthesia, drug and allergy history; and
- Interview, if possible given the patient’s condition, and examination of the patient.
- Notation of anesthesia risk according to ASA classification.
- Identification of potential anesthesia problems, particularly those that may suggest potential complications or contraindications to the planned procedure.
- Additional pre-anesthesia data or information, if applicable and as required in accordance with standard practice prior to administering anesthesia.
- Development of the plan for the patient’s anesthesia care and discussion with the patient of the risks and benefits of the delivery of anesthesia.

Surgeons may request a certain anesthesia type but the authority of the final anesthesia plan is at the medical discretion of the anesthesia provider.

NPO guidelines for elective cases are based on ASA guidelines – 8 hours for a heavy meal, 6 hours for a light meal, 4 hours for breast milk and 2 hours for clear liquids.

2. Review of Equipment
Prior to induction of anesthesia, the anesthesia provider shall check the working condition, safety, cleanliness, and availability of necessary anesthetic equipment and agents following, at very least, the FDA pre-anesthesia checklist.

3. Intra-Operative Anesthesia Care
While anesthetized, the patient shall be continuously and vigilantly monitored. At a minimum, the Standards for Basic Intraoperative Monitoring, as written by the ASA will be followed. An anesthesia record shall be fully completed for each case, which shall include the recording of all pertinent events taking place during the induction of, maintenance of, and emergence from anesthesia, including the dosage and duration of all anesthetic agents, other drugs, intravenous fluids, intra operative lab values, blood or blood components, the technique or techniques used, unusual events during the anesthesia period and the status of the patient at the conclusion of anesthesia.

4. Post-Anesthesia Recovery Room
The patient is turned over to Recovery Room personnel for care when his/her condition is deemed safe for doing so by the anesthesia provider. Recovery Room personnel are then advised of the patient’s pertinent medical and drug history and of any issues or important problems in the patient's anesthetic care or condition. Established Recovery Room Policies and Procedures will be followed. The patient is discharged from the Recovery Room when he/she meets criteria under the standing Recovery Room Orders.
5. Post-Anesthesia Care

As defined by CMS, a post-anesthesia evaluation must be completed by a qualified anesthesiologist or CRNA.

The evaluation is required any time general, regional, or monitored anesthesia including level II sedation has been administered by the patient.

The calculation of the 48-hour timeframe begins at the point the patient is moved into the designated recovery area. The evaluation generally should not be performed immediately at the point of movement from the operative area to the designated recovery area. Rather, accepted standards of anesthesia care indicate that the evaluation should 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. While the evaluation should begin in the PACU/ICU or other designated recovery location, it may be completed after the patient is moved to another inpatient location as long as it is completed within 48 hours.

For those patients who are unable to participate in the post anesthesia evaluation, a post anesthesia evaluation should be completed and documented within 48 hours with notation that the patient was unable to participate. The documentation should include the reason for the patient’s inability to participate as well as expectations for a recovery time.

The elements of an adequate post-anesthesia evaluation should be clearly documented and conform to current standards of anesthesia care, including:

- Respiratory function, including respiratory rate, airway patency, and oxygen saturation.
- Cardiovascular function, including pulse rate and blood pressure
- Mental status
- Temperature
- Pain
- Nausea and vomiting; and
- Postoperative hydration.

All continuous epidurals will require daily evaluation and documentation.

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### PAIN MANAGEMENT PATIENT CARE POLICY

1. Pre-Intervention Evaluation

Each provider is responsible for a pre-op H&P, and to make an assessment and plan. This includes interviewing and evaluating patients, reviewing charts and making a pre-procedure summary. This should include the patient’s drug history, potential anesthesia/interventional pain management problems and choice of interventional technique. The NPO guidelines for interventional pain management are three (3) hours unless the patient receives level I sedation, level II sedation, or anesthesia. In this case, the NPO guidelines are as defined above and in the sedation policies.

2. Review of Condition Prior to Procedure
The chart and the patient’s condition shall be reviewed again prior to a procedure. This should include review of the medical record with regard to completeness, pertinent laboratory/radiologic data, premedication parameters, together with an appraisal of any changes in the patient’s condition as compared with that noted on the previous visits.

Anesthesia and operative permit, signed by a legally responsible party shall accompany all patients to surgery except in extenuating emergencies.

3. Procedure
Nursing staff is under the supervision of the interventional pain physician, as is medication administration. The standards for monitoring will follow those of level I sedation. A procedure note is to be dictated/written for each procedure.

4. Post Procedure Recovery Room
Patients are to be monitored according to the Pain Clinic protocol, with a physician available.

### ANESTHESIA POLICY FOR SPECIAL AREAS
(E.R., X-Ray, ICU, Labor & Delivery)
The standard of anesthesia care shall be uniform in all anesthetizing locations. The same standards of anesthesia care that apply in the operating suite shall apply in Special Areas. The term "Special Areas" refers to Radiology, ICU, ER, and Labor and Delivery Areas.

### OUTPATIENT SURGERY
"Outpatient Surgery" is the title for all surgical procedures done on an outpatient or short stay basis at PeaceHealth Southwest Medical Center. Candidates for "Outpatient Surgery" may receive local, general, regional, IV or no anesthesia, as appropriate for the surgical procedure and the patient. Patients who only require local anesthesia or sedation given by the operating physician must satisfy criteria set by the Surgery Department Rules and Regulations governing outpatient procedures. The following criteria are for "Outpatient Surgery" patients who require anesthesia service from members of the Department of Anesthesia.

**CRITERIA:**
1. Patient should not have solids eight (8) hours prior to surgery, or clear liquids two hours prior to surgery.
2. Patient must arrange to be accompanied to the hospital and driven home by a responsible adult.
3. An H&P is required.
4. The final decision as to whether or not the patient is to receive "Outpatient Anesthesia" rests with the attending anesthesia provider.

### RECOVERY ROOM POLICIES
1. **Medical Direction of the Recovery Room**
The responsibility for the overall medical direction of the recovery room is under the Chair of Anesthesia.

   He/she shall work with the Head Nurse of the Recovery Room to develop, revise and update the Recovery Room Policies of the Anesthesia Department as necessary.

2. **Standard of Care**
The standard of recovery room care is uniform for all patients. All patients are recovered in the recovery room by qualified recovery room personnel. Whenever the recovery room is being utilized, at least two qualified recovery room nurses must be present, one of whom must be an R.N.

CONTINUING MEDICAL EDUCATION POLICY
1. Each Anesthesiology Department member is responsible for his/her own continuing medical education, as required by licensing laws.

2. Audits of anesthesia care and pain management care shall be conducted on a regular basis.

3. Cases of perioperative morbidity and mortality shall be reported to and reviewed by the Anesthesia Committee via the hospital’s Multidisciplinary Peer Review Committee.

4. Anesthesiology Department members shall be available for in-service teaching to hospital personnel as requested by the Department or Education Director.

5. Nurse anesthetists shall be responsible for their own continuing medical education, as required by state licensing laws.

BOOKING POLICY FOR MAIN O.R.
1. Requests for a particular anesthesiologist, by patient or surgeon, will be honored when assigning cases, insofar as is practical.

2. If backup is needed, only the first call anesthesiologist authorizes calling the second or third call crew.

3. Patient scheduling in the Pain Clinic is to be determined by agreement of the Interventional Pain Physicians and nursing supervisor.

CALL SCHEDULES AND VACATIONS FOR MAIN O.R.
1. A call schedule shall be maintained by Columbia Anesthesia Group and provided to the hospital. There will be a first, second, third, and cardiac call during the weekdays and first, second, and cardiac call on the weekends.

2. Adequate anesthesia staffing will be maintained in order to run the usual number of operating rooms, as well as anesthesia staffing for the Family Birth Center. The number of rooms to be staffed will be jointly determined by the Surgery, OB GYN, and Anesthesiology Committees and the operating room supervisor.

3. All members in the Department of Anesthesia shall take Anesthesia call as assigned by Columbia Anesthesia Group.

4. Operating room daily assignments are determined by Columbia Anesthesia Group.
   a. Operating rooms will be assigned by case load relative to call position.
   b. Operating rooms shall not be assigned by the patient’s insurance plan or ability to pay.
   c. An anesthesiologist 60 years old and who has worked at PeaceHealth Southwest Medical Center for at least (10) years may be exempt from first call.

5. Each anesthesiologist is responsible for the completion of his/her cases that are assigned. He/she may elect to reassign cases to other available and willing anesthesiologists. As rooms finish, higher call anesthesiologists should offer to finish case lists of lower call anesthesiologists, who in turn are encouraged to give unfinished work to available higher call individuals at their discretion.
6. The first, second, and cardiac call anesthesiologists shall be available for 24 hour periods (0700-0700). The third call anesthesiologist shall be available Monday through Thursday 0700-0700, and 0700-2300 on Friday. The Cardiac call anesthesiologists will also assume trauma (third) call responsibilities from Friday 2300 to Monday 0700.

8. The daily OR assignments shall be finalized on the preceding business day by Columbia Anesthesia Group as early as possible.

9. Add-on and emergency surgical cases will be done by all anesthesiologists in the department. These cases will be assigned by OR charge nurse and will be assigned with consideration to call position. Anesthesia Department members who are not fulfilling their assigned call duties should be reported to the Anesthesia immediately.

10. Call coverage is to be provided for Pain Management on a full-time basis. The schedule will be determined by the Pain Physicians, and a copy of this schedule distributed to the appropriate departments. Vacation schedules are likewise to be determined by the Pain physicians, in a manner to ensure that full-time coverage of the clinic and call schedule is provided. Acute Pain Service is a separate call and will be maintained by Columbia Anesthesia Group.

Approvals: Annual Reviews: 9/95, 10/97, 10/99, 8/00, 4/01, 2/02, 4/02, 11/02, 7/04, 9/05, 10/08, 9/10
Anesthesia Committee Approval: 9/05, 8/9/06, 12/08, 2/10, 2/12, 2/12/16
Executive Committee Approval: 10/4/05, 9/5/06, 2/3/09, 3/2/10, 9/7/10, 4/3/12, 4/5/16
Board of Directors Approval: 10/22/05, 9/20/06, 2/18/09, 3/17/10, 9/15/10, 4/18/12, 4/20/16