HSS Palm Beach Ambulatory Surgery Center
Anesthesia Policies & Procedures

POLICIES & PROCEDURES

TITLE: ANESTHESIA CARE

Effective Date:	1/10/2020	Authorized by:	Governing Body
Reviewed Date:		Revised Date:	

POLICY: Anesthesia services are provided by practitioners appropriately credentialed, privileged, and approved by the Governing Board.

PROCEDURE:

Anesthesia involves the administration of a medication to produce a blunting or loss of pain perception (analgesia); voluntary and involuntary movements; and autonomic function, 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.

Definition of Anesthesia and Analgesia

	Minimal Sedation Anxiolysis	Moderate Sedation/Analgesia "Conscious Sedation"	Deep Sedation/Analgesia	General Anesthesia
Responsiveness	Normal response to verbal stimulation	Purposeful response to verbal or tactile stimulation	Purposeful response following repeated or painful stimulation	Unarousable even with painful stimulus
Airway	Unaffected	No intervention required	Intervention may be required	Intervention often required
Spontaneous Ventilation	Unaffected	Adequate	May be inadequate	Frequently inadequate
CV Function	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 physical coordination may be impaired, airway reflexes, and ventilatory and cardiovascular functions are unaffected.

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 responds purposefully following repeated or painful stimulation. The ability to maintain ventilatory function independently 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 may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

POLICIES & PROCEDURES

Because sedation is a continuum, it is not always possible to predict how an individual patient will respond. Hence, practitioners intending to produce a given level of sedation should be able to rescue[1] 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.

Regional Anesthesia is the delivery of an anesthetic medication at a specific level of the spinal cord and/or peripheral nerves, including epidurals and spinals and other central neuraxial nerve blocks. Given the potential for the conversion and extension of regional to general anesthesia in certain procedures, it is necessary that the administration of regional and general anesthesia be delivered by an anesthesiologist, or certified registered nurse anesthetist (CRNA)/certified anesthesiologist assistant (CAA)/trainee under direct supervision of an Anesthesiologist.

Monitored Anesthesia Care (MAC) includes anesthesia care by an anesthesiologist or CRNA/CAA/trainee under direct supervision of an anesthesiologist. Indicators 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 anesthesia. Deep Sedation/Analgesia is included in MAC.

Anesthesia must be administered only by a qualified anesthesiologist, or a CRNA/CAA/trainee under the direct supervision of an anesthesiologist.
Analgesia Services are not subjected to the above guidelines. Analgesia may be performed by qualified practitioners. In the case of moderate sedation, and deep sedation further qualification is identified by the sedation policy.

Rescue Capacity. Because sedation is a continuum, it not always possible to predict how an individual patient will respond. "Rescue: from a deeper level of sedation than intended requires an intervention by a practitioner with expertise in airway management and advanced life support. The qualified practitioner corrects the adverse physiologic consequences of the deeper-than-intended level of sedation and returns the patient to the originally intended level of sedation.

The American Society of Anesthesiologists (ASA) status IV patients should not receive sedation without an anesthesia provider present and should not be done in outpatient facilities. ASA III status patients should be carefully evaluated prior to proceeding with sedation without an Anesthesia Provider present.

[1] Rescue of a patient from a deeper level of sedation than intended is an intervention by a practitioner proficient in airway management and advanced life support. The qualified practitioner corrects adverse physiologic consequences of the deeper-than-intended level of sedation (such as hypoventilation, hypoxia and hypotension) and returns the patient to the originally intended level of sedation. It is not appropriate to continue the procedure at an unintended level of sedation

REFERENCES:

- Standard Operations Manual Appendix L – Guidance for Surveyors: Ambulatory Surgery Center for Medicare and Medicaid Services §416.42(a) (Rev.2015).
- *Distinguishing Monitored Anesthesia Care (MAC) from Moderate Sedation / Analgesia (Conscious Sedation)* American Society of Anesthesiologists (ASA) 10/17/2018
- The Accreditation Association for Ambulatory Care. 2018 Accreditation Handbook.

DATE ISSUED:
1/20

DATE REVIEWED/REVISED:

APPROVED BY:
Jean-Pierre P. Ouanes, D.O.

POLICIES & PROCEDURES

Effective Date:	2/26/2020	Authorized by:	Governing Body
Reviewed Date:		Revised Date:	

POLICY: ANESTHETIC SAFETY REGULATIONS

1. All operating room electrical and anesthesia equipment shall be inspected on no less than a semi-annual basis, and a written record of the results and corrective actions be maintained
2. Flammable anesthetic agents shall not be employed
3. Electrical equipment in anesthetizing areas shall be on an audiovisual line isolation monitor
4. Each anesthetic gas machine shall have pin-index system or equivalent safety system and a minimum oxygen flow safety device
5. All reusable anesthesia equipment in direct contact with the patient shall be cleaned or sterilized as appropriate after each use
6. The following monitors shall be applied to all patients receiving general anesthesia:
    a. Blood pressure cuff
    b. A continuous temperature device, readily available to measure the patient's temperature
    c. Pulse Oximeter
    d. Electrocardiogram
    e. An Inspired Oxygen Concentration Monitor and a Capnograph shall be applied to all patients receiving general anesthesia

REFERENCES:

- Ambulatory Surgical Center Licensure. Florida Department of State. Florida Administrative Code & Florida Administrative Register. Rule Chapter 59A-5. 59A-5.0085 Departments and Services. Page 6. https://www.flrules.org/gateway/ChapterHome.asp?Chapter=59a-5 accessed 2/26/2020

DATE ISSUED:
2/20

DATE REVIEWED/REVISED:

APPROVED BY:
Jean-Pierre P. Ouanes, D.O.

POLICIES & PROCEDURES

TITLE: ANESTHESIA ASSESSMENT

Effective Date:	1/10/2020	Authorized by:	Governing Body
Reviewed Date:		Revised Date:	

POLICY:
An anesthesiologist shall be responsible for developing a plan of anesthesia care after evaluation of the patient's needs desires, and physical standards. The anesthesiologist shall be responsible for documenting this evaluation on the appropriate form.

A pre-anesthesia assessment is conducted for each patient receiving anesthesia to determine relevant risk factors and to effectively implement the anesthesia plan of care.

A post-operative evaluation is performed and documented on each patient to determine if the patient is recovering appropriately.

PROCEDURE:
1. Anesthesia patients who are interviewed on a date prior to the date of surgery will be re-evaluated on the actual surgery date.

2. All patients are assessed immediately prior to surgery to evaluate the risk of anesthesia and of the procedure to be performed. The anesthesia documentation of risk of anesthesia and of the procedure is separate from the physician history and physical.

3. Pre-Anesthesia assessment criteria may be based upon the ASA Patient Classification System.

4. Post-operatively, a post-anesthesia assessment and documentation will be conducted and should contain the following information:
    a. Respiratory Function including:
        1. Respiratory rate
        2. Airway patency
        3. Oxygen saturation
    b. Cardiovascular Rhythm including
        1. Pulse
        2. Blood Pressure
    c. Mental status
    d. Temperature
    e. Pain
    f. Nausea/vomiting
    g. Postoperative Hydration

4. Periodic post-anesthesia assessments will be performed during the course of care based upon the patient's condition and need, and, at the discretion of the anesthesiologist.

5. The patient will be discharged by the anesthesiologist following a final post-anesthesia assessment in which the patient has met all discharge criteria required by the facility.

6. PACU staff cannot discharge the patient without a written or verbal discharge order from the anesthesiologist and a written discharge order signed by surgeon in accordance with applicable State health and safety laws, standards of practice, and ASC policy.

POLICIES & PROCEDURES

REFERENCES:

- Standard Operations Manual Appendix L – Guidance for Surveyors: Ambulatory Surgery Center for Medicare and Medicaid Services (Rev 137 4-1-15).
- The Accreditation Association for Ambulatory Care. 2019 Accreditation Handbook.

DATE ISSUED:
1/20

DATE REVIEWED/REVISED:

APPROVED BY:
Jean-Pierre P. Ouanes, D.O.

POLICIES & PROCEDURES

TITLE: ANESTHESIA DOCUMENTATION

Effective Date:	1/10/2020	Authorized by:	Governing Body
Reviewed Date:		Revised Date:	

POLICY: Documentation of anesthesia care at the facility is conducted on all patients receiving anesthesia and will be the responsibility of the anesthesiologist, CRNA, CAA or trainee caring for the patient.

PROCEDURE:

1. Preoperatively, an anesthesia assessment will be documented and include the patient's medical history, any current conditions, allergies, current medications, previous anesthetic complications for patient or blood relative, and review of systems.

2. The anesthesiologist will develop an anesthesia plan of care and discuss with the patient and/or guardian.

3. A consent for administration of anesthesia will be obtained from the patient following the patient's consultation with the anesthesiologist and prior to administration of any sedation.

4. The patient will be examined pre-operatively & reevaluated in the operating room by a physician immediately prior to induction to evaluate the risk of anesthesia and of the procedure to be performed.

5. Perioperatively, an anesthesia record will be completed by the anesthesia caregivers during the procedure. This record will include pertinent time recordings including room and operation times, anesthetic agents and medications administered, intubation and airway equipment and supplies used, recording of vital signs including temperature (when appropriate), pulse, respirations, blood pressure, ETCO2, and oxygen saturation, IV fluids administered (including blood and blood products), estimated blood loss, urine output, anesthesia machine/equipment checks, monitoring equipment used, patient positioning, tourniquet documentation, type of anesthesia, procedure performed, surgeon, patient weight, pertinent lab values, ASA status, notes/comments, untoward events and post-operative condition. Assessment of the patient is an ongoing perioperative process. The record also contains signature notations for the anesthesiologist and, if applicable, the CRNA, CAA, or trainee.

6. Upon admission to PACU the provider will document admission vital signs, level of consciousness, and give a verbal report (hand-off) to the RN responsible for the patient's care.

7. Post-operatively, the anesthesia caregiver will document the following:
   a. Respiratory Function including:
      i. Respiratory rate
      ii. Airway patency
      iii. Oxygen saturation
   b. Cardiovascular Function including
      i. Pulse
      ii. Blood Pressure
   c. Mental status
   d. Temperature
   e. Pain
   f. Nausea/vomiting
   g. Postoperative Hydration

8. Before discharge from the ASC, each patient must be evaluated by an anesthesiologist in accordance with applicable State health and safety laws, standards of practice, and ASC policy,

POLICIES & PROCEDURES

REFERENCES:

- The Accreditation Association for Ambulatory Care. 2018 Accreditation Handbook.
- *Standards for Basic Anesthetic Monitoring* ASA Committee on Standards and Practice Parameters (CSPP) Last Amended: October 28, 2015
- Standard Operations Manual Appendix L – Guidance for Surveyors: Ambulatory Surgery Center for Medicare and Medicaid Services (Rev. 99, 1-31-15).

DATE ISSUED:
1/20

DATE REVIEWED/REVISED:

APPROVED BY:
Jean-Pierre P. Ouanes, D.O.

TITLE: CHOICE OF ANESTHESIA

Effective Date:	1/10/2020	Authorized by:	Governing Body
Reviewed Date:		Revised Date:	

POLICY: The Surgery Center has approved the following types of anesthesia for administration to patients: General anesthesia, Local Anesthesia, Monitored Anesthesia Care (MAC), and Regional Anesthesia & Analgesia.

PROCEDURE:
The choice of anesthetic procedure should be determined in collaboration with the anesthesiologist, surgeon and patient.

If the surgeon and/or patient requests a specific anesthetic, the anesthesiologist will weigh risks, benefits, and alternatives and select an anesthetic plan in collaboration with the surgeon and patient or designee.

REFERENCES:
- *Standard Operations Manual Appendix L – Guidance for Surveyors: Ambulatory Surgery Center for Medicare and Medicaid Services* §416.42(a) (Rev.2015).
- *The Joint Commission 2018 Accreditation Standards and Requirements for Ambulatory Surgery Centers*
- *The Accreditation Association for Ambulatory Care. 2018 Accreditation Handbook.*

DATE ISSUED:
1/20

DATE REVIEWED/REVISED:

APPROVED BY:
Jean-Pierre P. Ouanes, D.O.

POLICIES & PROCEDURES

TITLE: ANESTHESIOLOGIST'S PRESENCE IN THE FACILITY

Effective Date:	1/10/2020	Authorized by:	Governing Body
Reviewed Date:		Revised Date:	

POLICY: An anesthesiologist will remain in the facility until all patients have safely recovered from anesthesia and are discharged.

PROCEDURE:
In order to assess objectively, anesthetic recovery, the modified Aldrete scoring system will be used:

PACU SCORING GUIDELINES:
The modified Aldrete score below will be utilized in determining readiness for discharge.

Item	Answer choices (points)
Consciousness	Fully awake (2) Arousable (1) Not responding (0)
Mobility	Able to move four extremities on command (2) Able to move two extremities on command (1) Able to move 0 extremities on command (0)
Breathing	Able to breathe deeply (2) Dyspnea (1) Apnea (0)
Circulation	Systemic BP ≠ 20% of the preanesthetic level (2) Systemic BP between 20% and 49% of the preanesthetic level (1) Systemic BP ≠ 50% of the preanesthetic level (0)
Color	Normal (2) Pale, jaundiced, blotchy (1) Cyanotic (0)
O2 saturation	Maintaining O2 saturation >90% on room air (2) Needs inhalation to maintain O2 saturation >90% (1) O2 saturation <90% despite O2 supplementation (0)

Scores of 9 and above indicate that the patient can be discharged and the closer the score is to 12, the higher the chances for all anesthetics, regardless of administering method, to have worn off.

Patients may be discharged home after meeting the following discharge criteria:

1) Alert and oriented
2) Vital signs are stable
3) No emesis, nausea mild if present
4) Ambulating without dizziness
5) Pain controllable with oral analgesics

REFERENCES:

- *American Society of Anesthesiologist, "Standards for Post Anesthesia Care" October 2018*
- *Center for Medicare and Medicaid Services 2018 Standard Operations Manual Appendix L – Standard Operations Manual Appendix L* – CMS 2018-§416.42(a) - Standard: Anesthetic Risk and Evaluation (2) Before discharge from the ASC, each patient must be evaluated by a physician or by an anesthetist as defined at §410.69(b)
- CMS State Operations Manual Appendix L 416.47
- The Post-Anesthesia Recovery Score Revisited J A Aldrete PMID: 7772368 https://pubmed.ncbi.nlm.nih.gov/7772368-the-post-anesthesia-recovery-score-revisited/

DATE ISSUED:
1/20

DATE REVIEWED/REVISED:

APPROVED BY:
Jean-Pierre P. Ouanes, D.O.

POLICIES & PROCEDURES

TITLE: CRNA, CAA, & TRAINEE ANESTHESIA SERVICES

Effective Date:	1/10/2020	Authorized by:	Governing Body
Reviewed Date:		Revised Date:	

POLICY: The Surgery Center shall allow CRNAs, CAAs, and trainees under direct supervision of an anesthesiologist, who have been successfully appointed to the medical staff and are licensed in Florida to provide anesthesia services and analgesia. All CRNAs, CAAs and trainees may provide anesthesia services after receipt of medical staff and governing body approval of privileges requested and credentialing.

STAFFING:

1. To provide quality anesthesia care for both elective and emergency basis, CRNAs, CAAs and trainees are expected to assist the anesthesiologist in any requested fashion, use all common methods to render the patient insensitive to pain during an operative procedure and to support life functions while anesthesia is being administered.

2. An anesthesiologist must also be present in the facility when anesthesia is administered.

REFERENCES:

- *Standard Operations Manual Appendix L –Ambulatory Surgery Center for Medicare and Medicaid Services* §416.42(b) (Rev.2015
- *Distinguishing Monitored Anesthesia Care (MAC) from Moderate Sedation / Analgesia (Conscious Sedation)* American Society of Anesthesiologists (ASA) 10/17/2018
- The Accreditation Association for Ambulatory Care. 9-ECR - 2018 Accreditation Handbook.
- Ambulatory Surgical Center Licensure. Florida Department of State. Florida Administrative Code & Florida Administrative Register. Rule Chapter 59A-5. Page 6. https://www.flrules.org/gateway/ChapterHome.asp?Chapter=59a-5 accessed 2/26/2020

DATE ISSUED:
1/20

DATE REVIEWED/REVISED:

APPROVED BY:
Jean-Pierre P. Ouanes, D.O.

POLICIES & PROCEDURES

TITLE: CLASSIFICATION OF PHYSICAL STATUS -ANESTHESIA PATIENTS

Effective Date:	1/10/2020	Authorized by:	Governing Body
Reviewed Date:		Revised Date:	

POLICY: Patients will be assigned a physical status classification according to the complexity of the medial condition, based on the recommendations of the American Society of Anesthesiologists (ASA)

PROCEDURE:
The anesthesiologist will assess the patient and classify the patient according to the following criteria in Table I of this policy.

ASA status IV patients are not appropriate for an ambulatory surgery setting. Only patients meeting the scope of service criteria will be eligible for services at this facility.

ASA PHYSICAL STATUS CLASSIFICATION SYSTEM
Last approved by the ASA House of Delegates on October 15, 2018

Table 1

ASA PS Classification	Definition	Examples, including, but not limited to:
ASA I	A normal healthy patient	Healthy, non-smoking, no or minimal alcohol
ASA II	A patient with mild systemic disease	Mild diseases only without substantive functional limitations. Examples include (but not limited to): current smoker, social alcohol drinker, pregnancy, obesity (30<BMI<40), well controlled DM/HTN, mild lung disease
ASA III	A patient with severe systemic disease	Substantive functional limitations; One or more moderate to severe diseases. Examples include (but not limited to): poorly controlled DM or HTN, COPD, morbid obesity (BMI ≥40), active hepatitis, alcohol dependence or abuse, implanted pacemaker, moderate reduction of ejection fraction, ESRD undergoing regularly scheduled dialysis, premature infant PCA < 60 weeks, history (>3 months) of MI, CVA, TIA, or CAD/stents.
ASA IV	A patient with severe systemic disease that is a constant threat to life	Examples include (but not limited to): recent (<3 months) MI, CVA, TIA, or CAD/stents, ongoing cardiac ischemia or severe valve dysfunction, severe reduction of ejection fraction, sepsis, DIC, ARD or ESRD not undergoing regularly scheduled dialysis.
ASA V	A moribund patient who is not expected to survive without the operation	Examples include (but not limited to): ruptured abdominal/thoracic aneurysm, massive trauma, intracranial bleed with mass effect, ischemic bowel in the face of significant cardiac pathology or multiple organ/system dysfunction
ASA VI	A declared brain-dead patient whose organs are being removed for donor purposes	

*The addition of “E” denotes Emergency surgery: (An emergency is defined as existing when delay in treatment of the patient would lead to a significant increase in the threat to life or body part)

REFERENCES:

- *Guidelines for Ambulatory Anesthesia and Surgery* American Society of Anesthesiologists (Approved by the ASA House of Delegates amended, and reaffirmed on October 17, 2018)
- Standard Operations Manual Appendix L – Guidance for Surveyors: Ambulatory Surgery Center for Medicare and Medicaid Services §416.42(a) (Rev.2015).
- The Accreditation Association for Ambulatory Health Care. 2018 Accreditation Handbook.

DATE ISSUED:
1/20

DATE REVIEWED/REVISED:

APPROVED BY:
Jean-Pierre P. Ouanes, D.O.

POLICIES & PROCEDURES

TITLE: GUIDELINES FOR PREOPERATIVE EVALUATION

Effective Date:	1/10/2020	Authorized by:	Governing Body
Reviewed Date:		Revised Date:	

Table 1: Ambulatory Surgery [1,2,3,4]

	Age 13-39 years	Age ≥ 40 years
Healthy No significant medical problems	None	None
Minor Systems Illness[3]	If Bleeding history PT/PTT If use of Coumadin PT/INR	CBC, Basic Metabolic Profile EKG age > 50 (≤ 50 if CAD)[3] If Bleeding history PT/PTT If use of Coumadin PT/INR
Major Systems Illness[3]	CBC, Comprehensive Metabolic Profile, PT/PTT, HbA1c (if Diabetic) EKG Medical Assessment[4]	CBC, Comprehensive Metabolic Profile, PT/PTT, HbA1c (if Diabetic) EKG Medical Assessment[4]

Patients are not eligible for surgery at the ASC if they have the following

1. Have implantable medical devices such as an AICD, insulin pump, spinal cord stimulator, intrathecal baclofen pump
2. Have been on daily prescription opioid therapy for six months or more
3. Obstructive Sleep Apnea (OSA) or a STOP-BANG score of 5 or greater and are non-compliant with CPAP (subject to anesthesia review)
4. Have diabetes with a HbA1c greater than 8%
5. Have any severe illnesses that are not optimized or well-controlled
6. Have a personal or family history of malignant hyperthermia or myopathy (muscle disease) such as Duchenne's Muscular Dystrophy, King Den borough Syndrome, Central Core disease/myopathy, multiminicore disease), or a positive genetic screen ryanodine receptor (RYR1) mutations
7. Have active (untreated MRSA or VRE) infection
8. Morbid Obesity (BMI > 40 kg/m^2), or Weight > 300 lbs (136 kg)

[1]Additional testing at discretion of surgeon, internist, or anesthesiologist.
[2]Pregnancy Testing guidelines as approved by Medical Board apply in all cases.
[3] See Table 2: "Patient Risk Criteria" for definition of "Minor Illness" and "Major Illness."
[4]If a medical consultation is required for a patient scheduled for *Ambulatory Surgery* this consultation should ideally be done by a medical provider who agrees to follow the patient post-operatively if necessary and that physician must perform the consultation on an approved medical consultation form or in standard format. Medical Assessment must be within 30 days of surgery. Chest x-ray valid for 6 months preop. ECG valid for 2 months preop. PT/INR in patients on Coumadin and patients should be advised to stop it 7 days prior to surgery. These patients should obtain a day-of PT/INR to confirm acceptable PT/INR.
[5] Uncontrolled Hypertension: 2017 ACC/AHA Guideline for the Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults. Recommendation → In planned elective major surgery and SBP ≥180mmHg or DBP ≥ 110 mmHg, deferring surgery may be considered. Harm → For patients undergoing surgery, abrupt preoperative discontinuation of beta blockers or clonidine is potentially harmful.
[6] 2014 ACC/AHA Guideline on Perioperative Cardiovascular Evaluation and Management of Patients Undergoing Noncardiac Surgery. Circulation. 2014;130:e278-e333.
[7] Predictors for morbidity or mortality after ambulatory surgery :1:1,000 (NSQIP 2005-2010), Anesthesiology 2013; 119:1310-21
A. COPD; B. History of CVA or TIA; C. Obesity (BMI>=50); D. Cardiac surgery or PCI; E. Prolonged operative time(>3h); F. Uncontrolled Hypertension; G. OSA

[8]ACC/AHA 2016 update. Incidence of MACE after PCI: 0 – 90 days: 17.1%; 91 – 180 days: 10%. Patient should wait to stop dual antiplatelet therapy for: Drug Eluding Stent: 6 months. Bare Metal Stent: 4 wks. Angioplasty: 2 wks.
[9]Pacemaker or ICD: must have battery life longer than 6 months, normal function, checked at least within 6 months. If using EMI and surgery closer than 6" from device, then cardiologist should be involved (magnet vs re-program). Check 2011 HRS guidelines. Heart Rhythm 2011 Jul;8(7):E1-18

Table 2: Patient Risk Criteria

	Minor System Illness	Major System Illness
Cardiovascular	Treated hypertension	-Uncontrolled hypertension [5,7] -Coronary artery disease [6,7] -History of coronary or vascular surgery [7] **-History of coronary artery intervention** after positive stress test or cardiac catheterization (not related to Acute Coronary Syndrome)[7,8] -CHF[6] -Arrhythmia[6] -Pacemaker[9] **-Poor functional capacity < 4 METs,** undergoing moderate to high risk procedures: need cardiac evaluation prior to elective surgery. [6,8]
Pulmonary	Treated asthma without wheezing – no recent hospitalization	-COPD[7] -Uncontrolled asthma - Obstructive Sleep apnea [7]
Renal	Nephrolithiasis. Treated recurrent urinary tract infection	Renal insufficiency. Dialysis. Renal Transplant
Gastrointestinal	Peptic ulcer disease. History of diverticulitis	Recent GI bleed. Ulcerative colitis. Crohn's disease. Intestinal obstruction.
Neuro	Multiple sclerosis – no recent flare Controlled seizure disorder (no seizure last 3 months)	CVA, [7] TIA[7] ALS, Myasthenia Gravis, Dementia, Parkinson's disease
Endocrine	Treated hypo/hyperthyroidism Treated hyperparathyroidism	Diabetes mellitus. Diabetes insipidus. Morbid Obesity BMI > 40
Hematologic	Solid tumors treated 1 year prior to admission	Leukemia Lymphoma Multiple Myeloma Aplastic anemia Polycythemia Vera Clotting disorder Von Willebrand's Disease Hemophilia A or B ITP/Thrombocytopenia Antiphospholipid syndrome Protein S or C Deficiency Family Hx of bleeding disorder
Psychiatric	Anxiety/depression – if controlled, no MAO inhibitors	Psychosis, Substance abuse (narcotics and alcohol). Use of MAO inhibitors
Connective Tissue	None	Lupus, Rheumatoid arthritis, Vasculitis. (e.g. Temporal arteritis, Wegener's granulomatosis, polyarteritis nodosa.) Dermatomyositis, Polymyositis Psoriatic Arthritis, Ankylosing Spondylitis, Reactive arthritis

Table 3: Pregnancy Testing Policy

PURPOSE:
1. To ensure optimal patient/fetus safety through pre-operative assessment and screening for unrecognized pregnancy.
2. To ensure that patients' rights are respected as evidenced by appropriate and timely assessment of pregnancy prior to exposure to medication, anesthesia and radiation.

RATIONALE:
1. Elective orthopedic procedures expose a patient and fetus to a variety of processes, procedures and medications. These may include anesthetics, analgesics, antibiotics, fluoroscopy and positioning techniques. The literature is insufficient to inform patients, physicians, nurses and staff as to whether these factors cause harmful effects on early pregnancy. The literature does indicate that pregnant patients and their healthcare practitioners chose to postpone elective surgery in this setting.
2. During the first trimester, the subtlety of early signs and symptoms of pregnancy, a history of irregular menses, the use of contraceptives and misconceptions regarding pregnancy may result in an unrecognized pregnancy by the patient.
3. Patient history is often not helpful in determining early pregnancy.

PLAN:
1. Upon arrival in the pre-operative holding area, prior to surgery, a urine specimen will be obtained from all females of childbearing age. Childbearing age is defined as the age between when menses commence and cease. Menopause is defined as absence of menses for one year. Women who have had a hysterectomy, bilateral tubal ligation or bilateral salpingo-oophorectomy will be exempt from this process.
2. No one on the surgical team is authorized to waive a pregnancy test. The patient may elect to waive pregnancy test after being advised of the potential risks associated with anesthesia and surgery. This decision to waive will be discussed between the patient, surgeon and anesthesiologist and if any individual is uncomfortable with proceeding, the case will be cancelled. Full documentation of this event will be documented in the progress notes. Test results will be documented in EMR/chart prior to the patient being transferred to the 4th floor OR, Ambulatory OR, of Special Procedures Suite.
3. In the event of a positive urine HCG, the anesthesiologist and attending physician will be notified immediately. The attending physician will notify the patient of positive pregnancy results and document this discussion in the progress notes. The patient should be referred for an OB/GYN consultation. The surgery should be cancelled unless the planned procedure is emergent and delay would endanger life or limb.
4. Pre-op sedation, antibiotics and other medications will not be given until the urine HCG results are available.
5. The confidentiality of the test results will be strictly protected. If the patient is a minor, the surgeon will inform her in private without the presence of her parents. Quality Management and Risk Management will be informed and the OB/GYN consult will be arranged.
6. The initial pregnancy test results may be used up to 7 days preoperatively. If the patient's status necessitates a return to the OR within the same hospitalization, a second pregnancy test must be performed if the patient's length of stay has been greater than 7 days.

The confidentiality of the test results will be strictly protected. If the patient is a minor, the surgeon will inform her in private without the presence of her parents. Social Work will be informed and an OB/GYN consult arranged, if requested.

DATE ISSUED:
1/20

DATE REVIEWED/REVISED:

APPROVED BY:
Jean-Pierre P. Ouanes, D.O.

POLICIES & PROCEDURES

TITLE: NPO GUIDELINES

Effective Date:	1/10/2020	Authorized by:	Governing Body
Reviewed Date:		Revised Date:	

PURPOSE: To establish a feeding and Nothing by Mouth (NPO) schedule which will allow for adequate hydration but provide an empty stomach prior to induction of anesthesia.

POLICY:
Patients or legal guardians will be instructed to maintain the appropriate "nothing by mouth" status prior to the scheduled procedure time accorded to the recommended practice established by The American Society of Anesthesiologists *(Table 1)*

TABLE 1: Practice Guidelines for Preoperative Fasting of *Healthy Patients Undergoing Elective Procedures*

*A. Fasting Recommendations**	
Ingested Material	Minimum Fasting Period†
• Clear liquids‡	2h
• Breast milk	4h
• Infant formula	6h
• Nonhuman milk§	6h
• Light meal**	6h
• Fried foods, fatty foods, or meat	Additional fasting time (*e.g.*, 8 or more hours) may be needed

REFERENCES:
- Standard Operations Manual Appendix L – Guidance for Surveyors: Ambulatory Surgery Center for Medicare and Medicaid Services ((Rev. 137, 04-01-15)
- *An Updated Report by the American Society of Anesthesiologists Task Force on Preoperative Fasting and the Use of Pharmacologic Agents to Reduce the Risk of Pulmonary Aspiration Anesthesiology 3/2017, Vol.126, 376-393.*
- *Practice Guidelines for Preoperative Fasting and the Use of Pharmacologic Agents to Reduce the Risk of Pulmonary Aspiration: Application to Healthy Patients Undergoing Elective Procedures: An Updated Report by the American Society of Anesthesiologists Task Force on Preoperative Fasting and the Use of Pharmacologic Agents to Reduce the Risk of Pulmonary Aspiration.* *https://anesthesiology.pubs.asahq.org/article.aspx?articleid=2596245*

DATE ISSUED:
1/20

DATE REVIEWED/REVISED:

APPROVED BY:
Jean-Pierre P. Ouanes, D.O.

POLICIES & PROCEDURES

TITLE: GUIDELINES FOR SCREENING FOR PATIENTS WITH OBSTRUCTIVE SLEEP APNEA AND ELIGIBLITY FOR THOSE PATIETNS AT THE AMBULATORY SURGERY CENTER

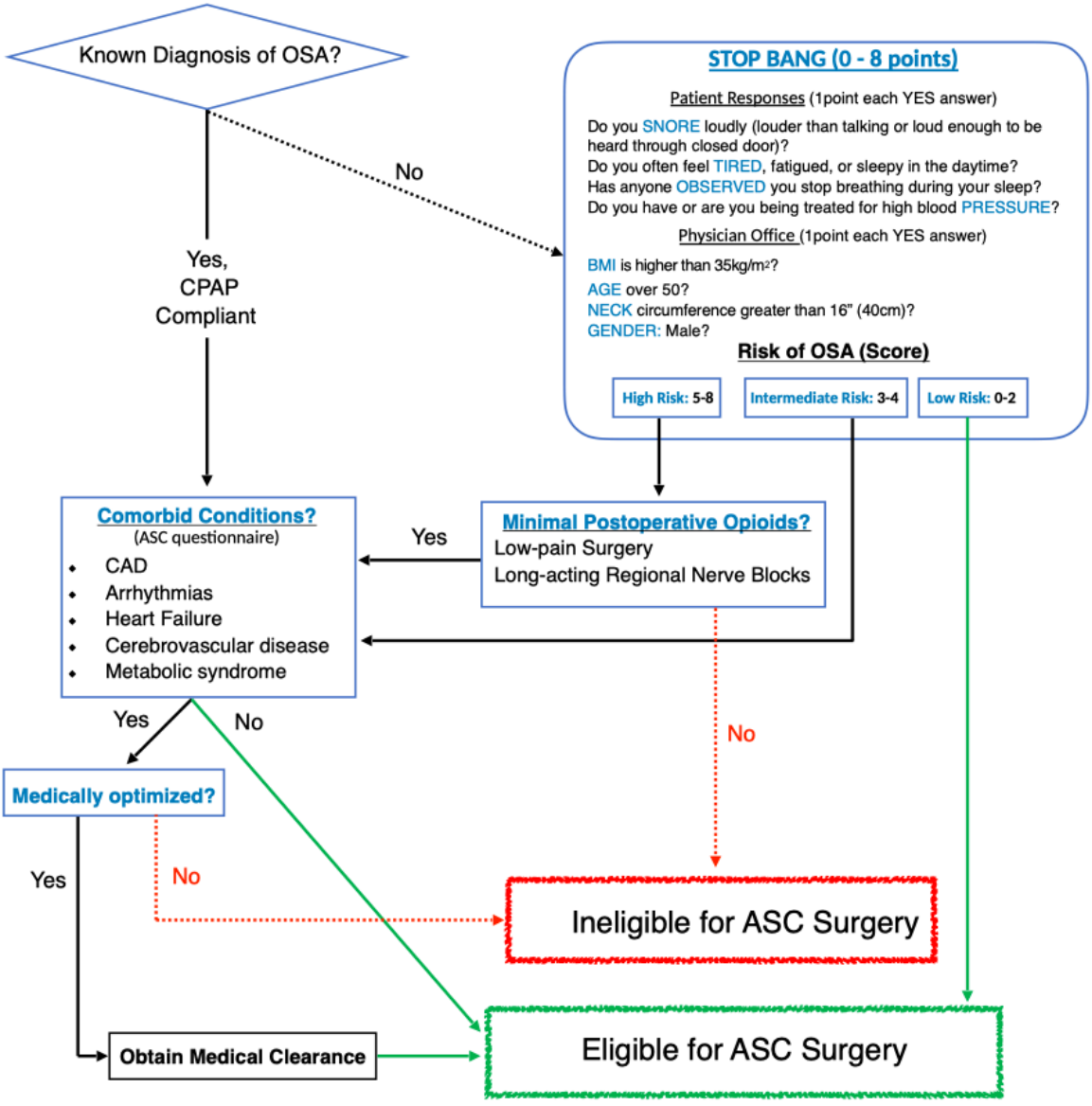
Effective Date:	2/18/2020	Authorized by:	Governing Body
Reviewed Date:		Revised Date:	

PURPOSE: To provide a process for screening patients for with obstructive sleep apnea and providing guidance as to their eligibility at the ambulator surgery center.

The STOP-Bang questionnaire is a concise, effective, and reliable OSA screening tool. It can facilitate efficient allocation of resources in both diagnosing and treating previously unrecognized OSA. The probability of moderate to severe OSA increases in direct proportion to the STOP-Bang score, which makes the questionnaire an easily used tool for identifying patients at high risk for OSA.

See screening and ASC eligibility algorithm on next page.

Obstructive Sleep Apnea Pathway for HSS Florida Ambulatory Surgery Center



REFERENCES:
STOP-Bang Questionnaire Chung, Frances et al. CHEST, Volume 149, Issue 3, 631 - 638

DATE ISSUED:
2/20

DATE REVIEWED/REVISED:

APPROVED BY:
Jean-Pierre P. Ouanes, D.O

POLICIES & PROCEDURES

TITLE: ANESTHESIA APPARATUS CHECK

Effective Date:	2/18/2020	Authorized by:	Governing Body
Reviewed Date:		Revised Date:	

POLICY: Each anesthesia machine will be checked prior to the first case (Table 1) of the day and between cases (Table 2).

PROCEDURE:
Anesthesia machine checks will be performed daily, in accordance with manufacturer and Anesthesia Patient Safety Machine Checkout Guidelines.

TABLE 1

Recommended Essential Steps in a Pre-Anesthesia Checkout Procedure

TO BE COMPLETED DAILY, OR AFTER A MACHINE IS MOVED OR VAPORIZERS CHANGED

ITEM TO BE COMPLETED		RESPONSIBLE PARTY
Item #1:	Verify Auxiliary Oxygen Cylinder and Manual Ventilation Device (Ambu Bag) are Available & Functioning.	Provider and Tech
Item #2:	Verify patient suction is adequate to clear the airway.	Provider and Tech
Item #3:	Turn on anesthesia delivery system and confirm that ac power is available.	Provider or Tech
Item #4:	Verify availability of required monitors, including alarms.	Provider or Tech
Item #5:	Verify that pressure is adequate on the spare oxygen cylinder mounted on the anesthesia machine.	Provider and Tech
Item #6:	Verify that the piped gas pressures are ≥ 50 psig.	Provider and Tech
Item #7:	Verify that vaporizers are adequately filled and, if applicable, that the filler ports are tightly closed.	Provider or Tech
Item #8:	Verify that there are no leaks in the gas supply lines between the flowmeters and the common gas outlet.	Provider or Tech
Item #9:	Test scavenging system function.	Provider or Tech
Item #10:	Calibrate, or verify calibration of, the oxygen monitor and check the low oxygen alarm.	Provider or Tech
Item #11:	Verify carbon dioxide absorbent is fresh and not exhausted.	Provider or Tech
Item #12:	Perform breathing system pressure and leak testing.	Provider and Tech
Item #13:	Verify that gas flows properly through the breathing circuit during both inspiration and exhalation.	Provider and Tech
Item #14:	Document completion of checkout procedures.	Provider and Tech
Item #15:	Confirm ventilator settings and evaluate readiness to deliver anesthesia care. (ANESTHESIA TIME OUT)	Provider

TABLE 2

Recommended Essential Steps in a Pre-Anesthesia Checkout Procedure

TO BE COMPLETED PRIOR TO EACH PROCEDURE

SUBSET OF ITEMS IN THE DAILY CHECKLIST TO BE COMPLETED BETWEEN CASES		RESPONSIBLE PARTY
Item #2:	Verify patient suction is adequate to clear the airway.	Provider and Tech
Item #4:	Verify availability of required monitors, including alarms.	Provider or Tech
Item #7:	Verify that vaporizers are adequately filled and if applicable that the filler ports are tightly closed.	Provider
Item #11:	Verify carbon dioxide absorbent is not exhausted.	Provider or Tech
Item #12:	Breathing system pressure and leak testing.	Provider and Tech
Item #13:	Verify that gas flows properly through the breathing circuit during both inspiration and exhalation.	Provider and Tech
Item #14:	Document completion of checkout procedures.	Provider and Tech
Item #15:	Confirm ventilator settings and evaluate readiness to deliver anesthesia care. (ANESTHESIA TIME OUT)	Provider

Carestation 620/650/650c (A1)
Preoperative Checkout

Refer to the User's Reference manual for step-by-step instructions.

Every day before your first patient

- ☐ Check that necessary emergency equipment is available and in good condition.
- ☐ Check that the equipment is not damaged and that components are correctly attached.
- ☐ Check that the pipeline gas supplies are connected. If equipped with cylinders, check that there is sufficient reserve capacity and that the cylinder valve is closed.
- ☐ Connect scavenging and verify operation.
- ☐ Check vaporizer installation:
  - Make sure that the top of each vaporizer is horizontal (not on crooked).
  - Make sure each vaporizer is locked and cannot be removed.
  - Make sure the alarms and indicators operate correctly (Tec™ 6 Plus vaporizer).
  - Make sure that more than one vaporizer cannot be turned on at the same time.
  - Make sure that the vaporizers are adequately filled.
- ☐ Check that the breathing circuit and bag are correctly connected, not damaged, and the breathing system contains sufficient absorbent in the canister.
- ☐ Turn the System on.
- ☐ Perform a ***Full Test*** from the ***Checkout*** menu.
- ☐ Check that an adequate reserve O2 supply is available.
- ☐ Check that the ventilator functions correctly:
  - Connect a test lung to the patient breathing circuit connection.
  - Set the ventilator to VCV mode and the settings to TV to 400 ml, RR to 12, I:E to 1:2, Tpause to Off, and Pmax to 40 cmH2O.
  - Set the gas flow to the minimum settings.
  - Start a case.
  - Set the Bag/Vent switch to Vent.
  - Fill the bellows using O2 flush.
  - Check that mechanical ventilation starts. Check that the bellows inflate and deflate. Check that the display shows the correct ventilator data. Check that there are no inappropriate alarms.
- ☐ Unplug the AC power cord from the electrical outlet and check that mechanical ventilation continues while the system is running on battery power. After completing the check, plug the AC power cord into the electrical outlet. The mains indicator is lit when AC power is connected.
- ☐ Set the appropriate controls and alarm limits for the case.

Before every patient

Note This check does not need to be done before the first case of the day if the "*Every day before your first patient*" checklist was done.

☐ Check that the necessary emergency equipment is available and in good condition.

☐ Check vaporizer installation:

- Make sure that the top of each vaporizer is horizontal (not on crooked).
- Make sure each vaporizer is locked and cannot be removed.
- Make sure the alarms and indicators operate correctly (Tec 6 Plus vaporizer).
- Make sure that more than one vaporizer cannot be turned on at the same time.
- Make sure that the vaporizers are adequately filled.

☐ Check that an adequate reserve O2 supply is available.

☐ Check that the breathing circuit is correctly connected, not damaged, and the breathing system contains sufficient absorbent in the canister.

☐ Select ***Checkout*** and perform a ***Circuit Leak*** test.

☐ Check that the ventilator functions correctly:

- Connect a test lung to the patient breathing circuit connection.
- Set the ventilator to VCV mode and the settings for TV to 400 ml, RR to 12, I:E to 1:2, Tpause to Off, and Pmax to 40 cmH2O.
- Set the gas flow to the minimum settings.
- Start a case.
- Set the Bag/Vent switch to Vent.
- Fill the bellows using O2 flush.
- Check that mechanical ventilation starts. Check that the bellows inflate and deflate. Check that the display shows the correct ventilator data. Check that there are no inappropriate alarms.
- Make sure that the alarms function. See the "*Alarm tests*".

☐ Set the appropriate controls and alarm limits for the case.

REFERENCES:

- Anesthesia Patient Safety Machine Checkout Guidelines. APSF Newsletter Vol 23, No1, p6-7. 2008 https://www.apsf.org/wp-content/uploads/newsletters/2008/spring/pdf/APSF200803.pdf
- Standard Operations Manual Appendix L-Guidance for Surveyors: Ambulatory Surgery Center for Medicare and Medicaid Services (Rev. 99, 1-31-18).
- The Joint Commission 2018 Accreditation Standards and Requirements for Ambulatory Surgery Centers
- The Accreditation Association for Ambulatory Care. 2018 Accreditation Handbook.
- Guidelines for Pre-Anesthesia Checkout Procedures; American Society of Anesthesiology; 3/13

DATE ISSUED:
2/20

DATE REVIEWED/REVISED:

APPROVED BY:
Jean-Pierre P. Ouanes, D.O.

POLICIES & PROCEDURES

TITLE: CARE, CLEANING & STORAGE OF ANESTHESIA EQUIPMENT

Effective Date:	1/10/2020	Authorized by:	Governing Body
Reviewed Date:		Revised Date:	

POLICY: All equipment disbursed is considered clean and ready for patient use.

PROCEDURE:

1. **GlideScope System** [Combined GlideScope & Fiberoptic bronchoscope]
   Disposable GlideScope blades and disposable GlideScope fiberoptic scopes will be used and disposed of after use.
   a. Set-Up: When an anesthesiologist requests a fiberoptic scope set up a nurse or additional anesthesia provider will bring the GlideScope system, assembles the scope and connect both the fiberoptic scope and GlideScope blades to the GlideScope system. Additionally, they will connect suction to the fiberoptic scope. The nurse or nurse or additional anesthesia provider remains in the room to provide support until he/she is dismissed by the anesthesiologist.
   b. Removal and Transfer: After the intubation process is complete and the anesthesiologist no longer needs the GlideScope system in the room, the nurse or additional anesthesia provider removes the GlideScope system wipes down the GlideScope system using Super-Sani cloth and left wet for 2 minutes prior to next use or being sent for storage..
2. **Ultrasound Probes**
   Ultrasound probes must be cleaned and sanitized after each use. Following each use of an ultrasound probe, it should be wiped down with Sani-Cloth AF3 (or another an ultrasound-approved germicidal wipe) and left wet for 3 minutes prior to next use or being sent for storage. *Duration of wetness are wipe specific.

DATE ISSUED:
1/20

DATE REVIEWED/REVISED:

APPROVED BY:
Jean-Pierre P. Ouanes, D.O.

POLICIES & PROCEDURES

TITLE: LIPID RESCUE PROTOCOL

Effective Date:	1/10/2020	Authorized by:	Governing Body
Reviewed Date:		Revised Date:	

PURPOSE: To be prepared to administer lipids appropriately to reverse local anesthetic systemic toxicity if needed, particularly during administration of regional blocks.

POLICY:
Lipid emulsion (Intralipid) has been shown to be effective in the reversal of local anesthetic systemic toxicity by extracting lipophilic local anesthetics from aqueous plasma or tissues or by counteracting local anesthetic inhibition of myocardial fatty acid oxygenation. It is the policy of the surgery center to be prepared for this emergency, should it occur.

PROCEDURE:

1. Educate all staff regarding the possibility of systemic toxicity, including seizures, electrocardiogram abnormalities, and cardiac arrest, resulting from the administration of local anesthetic agents.

2. Intralipids will be easily identified and readily accessible in a known location.

3. In the event of local anesthetic-induced cardiac arrest which is unresponsive to standard therapy, and in addition to standard cardio-pulmonary resuscitation, Intralipids 20% should be given IV according to protocol established by *The American Society of Regional Anesthesia and Pain Medicine. (See next two pages for protocol)*

AMERICAN SOCIETY OF REGIONAL ANESTHESIA AND PAIN MEDICINE

CHECKLIST FOR TREATMENT OF LOCAL ANESTHETIC SYSTEMIC TOXICITY (LAST)

The Pharmacologic Treatment of LAST is Different from Other Cardiac Arrest Scenarios

- **Reduce** individual **epinephrine** boluses to ≤ 1 mcg/kg
- **Avoid** vasopressin, calcium channel blockers, beta blockers, or other local anesthetics

- Stop injecting local anesthetic
- Get help
  - Consider lipid emulsion therapy at the first sign of a serious LAST event
  - Call for the LAST Rescue Kit
  - Alert the nearest cardiopulmonary bypass team - resuscitation may be prolonged
- Airway management
  - Ventilate with 100% oxygen / avoid hyperventilation / advanced airway device if necessary
- Control seizures
  - Benzodiazepines preferred
  - **Avoid** large doses of **propofol**, especially in hemodynamically unstable patients
- Treat hypotension and bradycardia – **If pulseless, start CPR**

Lipid Emulsion 20% (Precise volume and flow rate are not crucial)	
Greater than 70 kg patient	Less than 70 kg patient
Bolus 100 mL Lipid Emulsion 20% rapidly over 2-3 minutes • Lipid emulsion infusion 200-250 mL over 15-20 minutes	**Bolus 1.5 mL/kg Lipid Emulsion 20%** rapidly over 2-3 minutes • Lipid emulsion infusion ~0.25 mL/kg/min (ideal body weight)
If patient remains unstable: • Re-bolus once or twice at the same dose and double infusion rate; be aware of dosing limit (12mL/kg) • Total volume of lipid emulsion can approach 1 L in a prolonged resuscitation (e.g., > 30 minutes)	

- Continue monitoring
  - At least 4-6 hours after a cardiovascular event
  - Or, at least 2 hours after a limited CNS event
- Do not exceed 12 mL/kg lipid emulsion (particularly important in the small adult or child)
  - Much smaller doses are typically needed for LAST treatment
- See reverse side of this checklist for further details

Risk Reduction (Be sensible)

- Use the least dose of local anesthetic necessary to achieve the desired extent and duration of block.
- Local anesthetic blood levels are influenced by site of injection and dose. It is important to identify patients at increased risk of LAST prior to using local anesthetics, e.g., infants <6 months old, small patient size, advanced age and frailty, heart failure, ischemic heart disease, conduction abnormalities, or rhythm disorders, metabolic (e.g., mitochondrial) disease, liver disease, low plasma protein concentration, acidosis, and medications that inhibit sodium channels. Patients with very low ejection fraction are more sensitive to LAST and may be especially prone to elevated local anesthetic levels associated with 'stacked' injections.
- Consider using a pharmacologic marker and/or test dose, e.g. epinephrine 2.5 to 5 mcg/mL (total 10-15 mcg). Know the expected response, onset, duration, and limitations of a "test dose" in identifying intravascular injection.
- Aspirate the syringe prior to each injection while observing for blood in the syringe or tubing
- Inject incrementally, while observing for signs and inquiring for symptoms of toxicity between each injection.
- Consider discussing local anesthetic dose as part of the pre-procedural or pre-surgical pause ("time out").

Detection (Be vigilant)

- Monitor the patient during and after completing injection. Clinical toxicity can be delayed 30 minutes or longer.
- Use standard American Society of Anesthesiologists (ASA) monitors.
- Communicate frequently with the patient to query for symptoms of toxicity.
- Consider LAST in any patient with altered mental status, neurological symptoms or signs of cardiovascular instability after a regional anesthetic (e.g., change in HR, BP, ECG). Consider LAST even when the local anesthetic doses is 1) small (susceptible patient), 2) atypically administered (subcutaneous, mucosal, topical), 3) administered by the surgeon, or 4) after recent tourniquet deflation.
- Central nervous system signs (may be subtle, atypical, or absent)
  - Excitation (agitation, confusion, vocalization, muscle twitching, seizure)
  - Depression (drowsiness, obtundation, coma, or apnea)
  - Non-specific (metallic taste, circumoral numbness, diplopia, tinnitus, dizziness)
- Cardiovascular signs (occasionally the only manifestation of severe LAST)
  - Initially may be hyperdynamic (hypertension, tachycardia, ventricular arrhythmias), then
    - Progressive hypotension
    - Conduction block, bradycardia or asystole
    - Ventricular arrhythmia (ventricular tachycardia, Torsades de Pointes, ventricular fibrillation or asystole)
- Sedation may abolish the patient's ability to recognize or report LAST-related symptoms.

Treatment

Suggested components of a "LAST Rescue Kit"

- 1 L (total) lipid emulsion 20%
- Several large syringes and needles for administration
- Standard IV tubing
- ASRA LAST Checklist

- Administer lipid emulsion at the first sign of a serious LAST event.
- Lipid emulsion can be used to treat LAST caused by any local anesthetic.
- Standard dose epinephrine (1 mg) can impair resuscitation from LAST and reduce the efficacy of lipid rescue. Use smaller doses than typical for ACLS, e.g., ≤ 1mcg/kg boluses, or for treating hypotension.
- Propofol should not be used when there are signs of cardiovascular instability.
- Prolonged monitoring (2-6 hours) is recommended after any signs of LAST, since cardiovascular depression due to local anesthetics can persist or recur after treatment.
  - If LAST event is short-lived and without signs of cardiovascular instability, one may consider proceeding with surgery after an uneventful ~30 minute interval of monitoring.

Please report LAST events to www.lipidrescue.org

The Third American Society of Regional Anesthesia and Pain Medicine Practice Advisory on Local Anesthetic Systemic Toxicity. Executive Summary 2017. Reg Anesth Pain Med 2018;43:113-123

The ASRA LAST™ smart phone app can be purchased from The Apple App Store or Google Play

REFERENCES:

- Standard Operations Manual Appendix L – Guidance for Surveyors: Ambulatory Surgery Center for Medicare and Medicaid Services (Rev. 99, 1-31-15).
- The Accreditation Association for Ambulatory Care. 2018 Accreditation Handbook.
- *The Third American Society of Regional Anesthesia and Pain Medicine Practice Advisory on Local Anesthetic Systemic Toxicity:* Executive Summary 2017. Joseph M. Neal, MD, Michael J. Barrington, MBBS, FANZCA, PhD†, Michael R. Fettiplace, MD, PhD, Marina Gitman, MD, Stavros G. Memtsoudis, MD, PhD, Eva E. Mörwald, MD‖, Daniel S. Rubin, MD and Guy Weinberg, MD
- Checklist for Treatment of Local Anesthetic Systemic Toxicity (*LAST*) The American Society of Regional Anesthesia and Pain Medicine (ASRA), 2018 https://www.asra.com/advisory-guidelines/article/3/checklist-for-treatment-of-local-anesthetic-systemic-toxicity

DATE ISSUED:
1/20

DATE REVIEWED/REVISED:

APPROVED BY:
Jean-Pierre P. Ouanes, D.O.

POLICIES & PROCEDURES

TITLE: INTUBATED PATIENT

Effective Date:	1/10/2020	Authorized by:	Governing Body
Reviewed Date:		Revised Date:	

POLICY: Patients that are in respiratory failure or insufficient ventilator activity may be intubated by the anesthesiologist, or CRNA, CAA or trainee under the direction of an anesthesiologist. The nurse may be needed to assist in this procedure.

PROCEDURE:
The following steps should be followed:

1. Assemble needed supplies and equipment as determined appropriate by the anesthesiologist: (Below is a standard list that may be modified by the anesthesiologist)
    a. Laryngoscope with working light
    b. Videolaryngoscope
    c. Laryngoscope blades - straight and curved
    d. Endotracheal tubes - assorted sizes
    e. Stylette
    f. Tongue blades
    g. Oral airways - assorted sizes
    h. 10 cc syringe without needle
    i. Adhesive tape - 1" and ½"
    j. Oxygen connectors for ET tube
    k. Suction equipment
    l. Suction catheters - assorted sizes
    m. Ambu bag
    n. Sterile saline irrigation - 250 ml.
    o. Oxygen source
    p. Flexible video bronchoscope
    q. Cricothyroidotomy kit
    r. End title CO2 monitoring
2. The nurse must be in attendance and may be asked to assist the anesthesiologist.
3. After the procedure is completed, the nurse should record the time of intubation, by whom, and the patient's present respiratory status.
4. Extubation criteria and equipment checklist are in accordance with ASA recommendations.
5. Extubation criteria, equipment checklist and equipment maintenance are in compliance with local, state and Joint Commission requirements.

REFERENCES:

- Standard Operations Manual Appendix L – Guidance for Surveyors: Ambulatory Surgery Center for Medicare and Medicaid Services (Rev. 99, 1-31-15).
- The Accreditation Association for Ambulatory Care. 2018 Accreditation Handbook.
- *Advancing Patient Safety in Airway Management* American Society of Anesthesiologists-ASA-March 2018

DATE ISSUED:
1/20

DATE REVIEWED/REVISED:

APPROVED BY:
Jean-Pierre P. Ouanes, D.O.

POLICIES & PROCEDURES

TITLE: PROPOFOL MANAGEMENT

Effective Date:	1/10/2020	Authorized by:	Governing Body
Reviewed Date:		Revised Date:	

POLICY: The anesthesia provider will manage the use of propofol, according to best practice standards as endorsed by the Medical Director and accrediting agencies. Individuals requesting privileges must be an anesthesiologist, or CRNA/CAA/trainee under the direct supervision of an anesthesiologist.

PURPOSE:
To provide guideline for the administration and management of propofol.

PROCEDURE:
Propofol will be administered only by an anesthesiologist, or CRNA/CAA/trainee under the direct supervision of an anesthesiologist, who must be credentialed in provision of anesthesia at the Surgery Center.

1. The anesthesia provider, subscribing to guidelines assuring safe medication process will use vials of propofol for single patient use only.

2. During the administration of propofol, patients should be monitored using American Society of Anesthesiologists (ASA) guidelines.

3. Age/size appropriate equipment must be immediately available for the maintenance of a patent airway, oxygen enrichment and artificial ventilation in addition to circulatory resuscitation.

REFERENCES:
- *Practice Guidelines for Moderate Procedural Sedation and Analgesia 2018 -* American Society of Anesthesiologists March, 2018)
- *Advisory on Granting Privileges for Deep Sedation to Non-Anesthesiologist Physicians* – American Society of Anesthesiologists October 25, 2017)
- *Standard Operations Manual Appendix L-Guidance for Surveyors: Ambulatory Surgery Center for Medicare and Medicaid Services (Rev. 99, 1-31-15).*
- *The Accreditation Association for Ambulatory Care. 2018 Accreditation Handbook.*

DATE ISSUED:
1/20

DATE REVIEWED/REVISED:

APPROVED BY:
Jean-Pierre P. Ouanes, D.O.

POLICIES & PROCEDURES

TITLE: PACU DISCHARGE SCORING

Effective Date:	1/10/2020	Authorized by:	Governing Body
Reviewed Date:		Revised Date:	

POLICY: The function of PACU is to provide the concentrated and comprehensive care necessary in the immediate post anesthetic period for patients who have had surgical, diagnostic or therapeutic procedures.

PROCEDURE:

1. The anesthesiologist or his/her designee shall assume overall medical responsibility in the Post Anesthesia Care Unit (PACU). Individual post anesthetic patient care shall be the responsibility of the anesthesiologist.
2. The anesthesiologist should be readily available for consultation and remain physically available in the facility until the last PACU patient has achieved acceptable discharge parameters and met discharge criteria.

PACU SCORING GUIDELINES:

The modified Aldrete score below will be utilized in determining readiness for discharge.

Item	Answer choices (points)
Consciousness	Fully awake (2) Arousable (1) Not responding (0)
Mobility	Able to move four extremities on command (2) Able to move two extremities on command (1) Able to move 0 extremities on command (0)
Breathing	Able to breathe deeply (2) Dyspnea (1) Apnea (0)
Circulation	Systemic BP ≠ 20% of the preanesthetic level (2) Systemic BP between 20% and 49% of the preanesthetic level (1) Systemic BP ≠ 50% of the preanesthetic level (0)
Color	Normal (2) Pale, jaundiced, blotchy (1) Cyanotic (0)
O2 saturation	Maintaining O2 saturation >90% on room air (2) Needs inhalation to maintain O2 saturation >90% (1) O2 saturation <90% despite O2 supplementation (0)

Scores of 9 and above indicate that the patient can be discharged and the closer the score is to 12, the higher the chances for all anesthetics, regardless of administering method, to have worn off.

POLICIES & PROCEDURES

REFERENCES:

- The Post-Anesthesia Recovery Score Revisited J A Aldrete PMID: 7772368 https://pubmed.ncbi.nlm.nih.gov/7772368-the-post-anesthesia-recovery-score-revisited/
- Standard Operations *Manual Appendix L – Ambulatory Surgery Center for Medicare and Medicaid Services* §416.52(c)2 (Rev.2015).
- *Position Statement on Perioperative Safe Staffing-* AORN-2014
- Standard Operations *Manual Appendix L – Ambulatory Surgery Center for Medicare and Medicaid Services* §416.42(a)2 (Rev.2015).
- Modified PADSS (Post Anaesthetic Discharge Scoring System) for monitoring outpatients discharge. https://www.ncbi.nlm.nih.gov/pubmed/23165318

DATE ISSUED:
1/20

DATE REVIEWED/REVISED:

APPROVED BY:
Jean-Pierre P. Ouanes, D.O.

POLICIES & PROCEDURES

TITLE: PATIENTS WITH NO RIDE HOME AFTER ANESTHESIA

Effective Date:	1/10/2020	Authorized by:	Governing Body
Reviewed Date:		Revised Date:	

PURPOSE: Driving under the influence of medications is a hazard to patients and the public at large; Florida ASC has an obligation to protect the patient and the public.

POLICY: Patients having anesthesia/sedation are must be accompanied by a responsible adult who can either drive them home, or go home with them in a car service and provide care at home.

The patient may not go home alone in a car service, and the procedure may be canceled if the patient does not have a responsible adult to escort them home.

If the procedure can be done under local infiltration without sedation, and there is no anesthesiologist involvement, the case may proceed and the patient may leave unaccompanied at the discretion of nursing and the surgeon.

REFERENCES:
- Standard Operations Manual Appendix L –Ambulatory Surgery Center for Medicare and Medicaid Services §416.52(c) (Rev.2015).
- The Accreditation Association for Ambulatory Care. 2018 Accreditation Handbook.

DATE ISSUED:
1/20

DATE REVIEWED/REVISED:

APPROVED BY:
Jean-Pierre P. Ouanes, D.O.

POLICIES & PROCEDURES

TITLE: UNINTENDED ANESTHESIA AWARNESS

Effective Date:	1/10/2020	Authorized by:	Governing Body
Reviewed Date:		Revised Date:	

PURPOSE:
To establish a process for preventing and dealing with unintended intraoperative awareness during general anesthesia.

BACKGROUND:
Unintended intra-operative awareness occurs when a patient becomes cognizant of some or all events during surgery, or other procedure, performed under general anesthesia, and has direct recall of those events. This does not include times before the induction of anesthesia is complete, or during intended emergence.

The incidence of awareness during general anesthesia is reported to be greater in patients for whom a smaller than usual dose of general anesthetic is necessary to decrease dangerous side effects (e.g., hemodynamic instability). Procedures identified as typically falling into this category are some cardiac, obstetrics, and major trauma cases. Because unintended intra-operative awareness during general anesthesia is not always preventable, health care practitioners should be prepared to anticipate, acknowledge, and manage this occurrence with compassion and diligence.

Monitoring patients during general anesthesia to prevent intra-operative awareness can be challenging. Despite a variety of available monitoring methods, awareness is difficult to recognize while it is occurring. Typical indicators of physiologic and motor response, such as hypertension, tachycardia, or movement are often masked by the use of neuromuscular blocking agents to achieve necessary muscle relaxation during the procedure, as well as the concurrent administration of other drugs necessary to the patient's management, such as beta-blockers or calcium channel blockers.

POLICY:
1. Equipment Maintenance:
   Periodic maintenance of the anesthesia machines and its vaporizers will be performed and documented (no less than quarterly).
2. Pre-operative Identification:
   Certain procedures may entail a higher risk of unintended intra-operative awareness and some patients with certain characteristics may be at an increased risk for the occurrence of intra-operative awareness. These include:
   - Cardiac surgery patients
   - Acute trauma patients with hypovolemia
   - Cesarean section patients under general anesthesia
   - Patients undergoing emergency surgery
   - ASA Physical Status 4 and 5 patients
   - Patients with impaired cardiovascular status
   - Patients with anticipated difficult intubation
   - Patients with a history of awareness
   - Patients with a history of heavy alcohol intake
   - Patients with a history of chronic use of benzodiazepines, opioids or both

   (Note many of these surgeries or patients should not be performed in the ASC setting.)
   Patients considered by the anesthesiologist to present significantly higher risk for an awareness experience, should be informed of the potential for awareness in preoperative discussions with their physician or anesthesiologists.
3. Reducing the risk of intra-operative awareness during general anesthesia:

The appropriate anesthesia techniques and mediation are determined by clinical judgment based on each patient's unique circumstances.

4. Education of clinical staff:
   This policy should be available to all members of the clinical staff.

Managing an Episode of Unintended Intraoperative Awareness During General Anesthesia

When an anesthesiologist learns that a patient may have had unintended intra-operative awareness of the surgical procedural or events during general anesthesia, the anesthesiologist should explore, document, and report the experience and provide for any necessary follow-up care. When other personnel learn that a patient may have experienced unintended intra-operative awareness during general anesthesia, the personnel should inform the anesthesiologist of record about the suspected occurrence.

PROCEDURE:

If an episode of unintended intra-operative awareness during general anesthesia occurs or is suspected, the anesthesiologist who was responsible for the patient's care, or a qualified designee, should interview the patient and document the details of the patient's experience in the medical record. If the anesthesiologist determines that unintended intra-operative awareness during the general anesthesia has occurred the following steps may serve to mitigate serious patient sequelae:

- Assure the patient's credibility of his or her account and sympathize with the patient's experience
- Explain what happened and why, if a reason can be given (e.g., the necessity to administer light anesthesia in the presence of significant cardiovascular instability)
- Offer the patient support, including referral to a psychiatrist, psychologist, or other counseling services, if appropriate
- Document any referrals or treatment provided to the patient in the medical record
- Notify the patient's surgeon and nurse
- Enter the event for the purpose of performance improvement

REFERENCES:

- Standard Operations Manual Appendix L – Guidance for Surveyors: Ambulatory Surgery Center for Medicare and Medicaid Services (Rev. 99, 1-31-15).
- The Accreditation Association for Ambulatory Care. 2018 Accreditation Handbook.https://www.jointcommission.org/assets/1/6/Speak_Up_Anesthesia_infographic_final.pdf-2019

DATE ISSUED:

1/20

DATE REVIEWED/REVISED:

APPROVED BY:

Jean-Pierre P. Ouanes, D.O.

TITLE: IMPAIRED ANESTHESIA PROVIDER

Effective Date:	1/10/2020	Authorized by:	Governing Body
Reviewed Date:		Revised Date:	

POLICY: An impaired anesthesia provider is not permitted to provide health care services to patients or be present in the Florida ASC. Appropriate services will be provided to the provider to ensure that the impairment is adequately addressed.

DEFINITIONS:
An impaired anesthesia provider is one who meets one of the following criteria:

1. Exhibiting signs and symptoms of substance abuse (alcohol or drugs).
2. Unable to perform job responsibilities due to emotional trauma or personality change.
3. Has a mental impairment subsequent to a medical or other problem.

PROCEDURE:

1. If the provider is identified as meeting any of the above criteria, any staff person must report this to the Medical Director or Administrator immediately.
2. The Medical Director or Administrator will assess the provider with an available physician, to ascertain the type of impairment and the effect on job responsibilities.
3. The provider can be referred to his/her private physician or, as indicated, 911 emergency services may be called.
4. The provider may return to his/her staff position after receiving appropriate medical clearance in writing, and, as indicated, continuing medical care.
5. Reporting will be submitted as appropriate to the state licensing boards by the Medical Director and Administrator.

DATE ISSUED:
1/20

DATE REVIEWED/REVISED:

APPROVED BY:
Jean-Pierre P. Ouanes, D.O.