ANESTHESIA AND PERIOPERATIVE CARE CLINICAL SERVICE
RULES AND REGULATIONS
2013
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I. ORGANIZATIONAL STRUCTURE AND ADMINISTRATIVE POLICIES

A. SCOPE OF SERVICE

1. OVERSIGHT - The Chief of the Anesthesia Service (Refer to Appendix A for detailed job description) is responsible for oversight of all anesthetic care at SFGH, all functions of the Post-Anesthesia Care Unit (PACU) related to the Anesthesia and Perioperative Care Clinical Services, administration of anesthesia faculty attending in the 4E Medical-Surgical ICU and administration of the Respiratory Care Service.

B. ORGANIZATION/STAFFING OF THE ANESTHESIA AND PERIOPERATIVE CARE SERVICE

1. CHIEF OF SERVICE - The Chief of the Anesthesia Service, or his/her designee, is responsible for ensuring the quality of anesthesia care. As necessary, assistance is invited from other services/departments, the Performance Improvement and Patient Safety Committee, or the appropriate SFGH administrative committee or organization (example: Executive Committee, OR Committee, Engineering, etc.).

To facilitate the administrative oversight of the varied clinical activities in the Department, the Chief has appointed the following clinical leaders (see Appendix B for Department of Anesthesia Organizational Chart):

- Clinical Director SFGH operating rooms
- Director of Obstetrical Anesthesia
- Director Of Quality Improvement
- Medical Director Post-Anesthesia care Unit (PACU)
- Medical Director Anesthesia Workroom
- Medical Director of Respiratory Therapy
- Medical Director of the Anesthesia Pre-Operative Clinic
- Medical Director Trauma Anesthesia

2. REGULAR SERVICE PROVISION – Anesthesia services at SFGH Medical Center are administered by a combination of fully credentialed, qualified anesthesiologists who are board certified or actively pursuing board certification, or the equivalent, as determined by the Chief of Anesthesia and Perioperative Care, or certified registered nurse anesthetists (CRNAs) and residents in the training program of the Department of Anesthesia and Perioperative Care, UCSF.

The scope of anesthesia services is determined by a continuing process of needs assessment and negotiation with SFGH and their clinical departments. The Chief of the Anesthesia Service, or his/her designee, is responsible to oversee and provide adequate coverage. The Department of Anesthesia and Perioperative Care will always provide qualified anesthesia personnel to meet the obligations of these agreements. Residents, fellows and CRNAs may administer anesthesia when under the supervision of an attending anesthesiologist who is immediately available if needed. This supervising attending anesthesiologist will be prepared to immediately conduct hands-on intervention if needed.

3. ON-CALL COVERAGE - A minimum of three physicians or two physicians and one nurse anesthetist will be in the hospital at all times. Of these, one physician will be available for
immediate emergencies and will coordinate the activities of the other two. One of the physicians will be available for obstetrical anesthesia.

4. **ON-CALL FACULTY ANESTHESIOLOGIST** - At all times, one member of the attending staff is in the hospital or is readily available and takes responsibility for all anesthetics administered. A second attending anesthesiologist is on-call for backup and will be called in to ensure adequate in-house coverage if the coordinating anesthesia attending is confronted with or anticipates work load which cannot be handled safely with the regular staff.

5. **ANESTHESIA SERVICE IN THE EVENT OF A DISASTER** - The Anesthesia Service functions within the scope of the overall hospital disaster plan. In the event of a mass casualty alarm, the on-call attending anesthesiologist will estimate the total need for additional faculty, nurse anesthetists and workroom technicians and initiate the disaster call-back list.

In the event of a disaster which inactivates the telephone system, it is the responsibility of all personnel (who are able so to do) to come to the hospital immediately when they become aware of the disaster.

6. **EMERGENCY PROCEDURES** - In any emergency that requires resuscitation or handling of any airway problem, the Anesthesia Service may be contacted through the on-call resident on beeper 341, immediately, or a “Code Blue” may be called via the operator. When a replacement pager is in use, the telephone operator, the Emergency Department and Delivery Room will be notified by the on-call anesthesia resident or faculty.

7. **JEHOVAH’S WITNESSES** – Surgery that may involve any blood loss in a Jehovah’s Witness may only be scheduled following prior arrangement with the Department of Anesthesia by obtaining an Anesthesia consultation. This is to ensure that the patient and anesthesia provider understand the types of blood and fluid products available, that there is a clear understanding of the patients wishes regarding the type of products they will accept, and to ensure the availability of an anesthesiologist prepared to enter into an agreement not to transfuse blood, if that is what the patient desires.

8. **NURSE ANESTHETIST JOB DESCRIPTION (CRNA)**

See Section II.D. Affiliated Professionals

**C. DELIVERY OF ANESTHETIC CARE**

1. **OVERVIEW** - Anesthesia providers (as described above) will routinely administer anesthesia to all patients brought to surgery, except in those cases where the surgeon desires to administer local or topical anesthesia, or where no anesthesia is required. The Anesthesia Service will also provide anesthesia in other sections of the hospital (Labor & Delivery floor, radiology suite, emergency department, etc.) when appropriate. A uniform standard of anesthesia care will be followed wherever anesthesia services are delivered to patients.

2. **PRE-OPERATIVE ANESTHESIA EVALUATION** - Each patient will be evaluated either by clinic visit, in hospital visit or chart review by a member of the anesthesia care team within the 48 hours prior to surgery. Some of the individual elements contributing to the pre-anesthesia

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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. Pre-anesthesia evaluation and documentation shall be performed according to the guidelines (Basic Standards for Pre-Anesthesia Care described by the American Society of Anesthesiologists and shall take into account the patients medical condition and surgical urgency (Appendix C). If, in his/her opinion, additional diagnostic or therapeutic measures are necessary prior to surgery, he/she will discuss these measures with the responsible physician and with an anesthesia attending. These concerns will also be discussed with the anesthesia care team assigned to the case as soon as possible.

The preoperative note shall be reviewed, verified, and signed by the anesthesia care team on the day of surgery. It will include a notation of patient’s diagnosis, surgical or obstetrical procedure anticipated; pertinent history and physical; assessment of anesthetic problems; and choice of anesthesia type (general, MAC, neuroaxial block, peripheral regional anesthesia or a combination of these). On the day of surgery the anesthesia care team shall verify the identification of the patient, site and side of surgery, presence of consent and any changes to the previously obtained history and physical. All questions from the patient and/or family shall be answered and the preferred type of anesthesia explained and any alternatives discussed. In the case of emergency where the urgency of the situation precludes a complete preoperative evaluation, specific documentation of the emergent nature of the procedure should be made by the attending anesthesiologist.

3. CHOICE OF ANESTHESIA
   - Under most circumstances, the responsibility for the choice of anesthetic technique belongs to the anesthesiologist. When unusual circumstances cause the surgeon to have a special preference, this should be handled by prior consultation.

4. ADMINISTRATION OF ANESTHESIA
   - Immediately prior to the induction of anesthesia or intravenous sedation, with the patient in the OR or procedure room, the patient's condition will be reviewed by the anesthesia provider including measurement of vital signs, and assessment of airway status and response to pre-procedure medications. This physician or his/her assigned replacement will continue to be responsible for the safety of the patient throughout the anesthetic period.
   - It is expected that the attending anesthesiologist will be present for induction and emergence from anesthesia and any other critical parts of the procedure.

   A record will be kept of all events taking place during the induction of, maintenance of, and emergence from anesthesia. This record will include vital signs, the amounts and duration of all drugs, anesthetic agents, intravenous fluids, blood, and blood products given and placement of invasive catheters and description of anesthetic technique including methods of body warming. In addition the anesthesia record will document the estimated blood loss and urinary output when measured, any unusual events during the anesthesia period and the status of the patient at the conclusion of surgery in the PACU.

   Whenever there is a change of anesthesia care provider, for example at morning break, lunch break, or at shift changes, a formal handoff of patient care information will occur between the outgoing and incoming care provider as required by The Joint Commission (TJC) and in conformance with the Departmental Transition of Care Policy (Appendix D).

   Standards for Basic Intra-operative Monitoring established by the American Society of Anesthesiologists will be adhered to in all cases. (See Appendix E) The anesthesia record shall document the monitors utilized and the results of such monitoring.
It is department policy that all syringes or intravenous fluids containing medication for patient administration be appropriately labeled. Medications should be prepared daily, and discarded at the end of the work period.

A. All syringes will be labeled with drug name, concentration or total dose, the date and time of preparation and the initials of the anesthesia provider.

B. All syringes containing medications outdate 24 hours after they are drawn up, except for propofol, which outdates after 6 hours.

C. Labeling of the syringe is not required if the drug is drawn up and administered immediately by the individual who prepared the medication with no intervening tasks.

D. All vials from which medications are drawn will remain immediately available until the end of the case. Ampules will remain immediately available by disposal in the sharps box. All other vials will remain immediately available by placing in the designated slot in the medication and syringe management tray.

E. In all operating rooms or procedural areas when the anesthesia provider is not present, unused medications will reside inside the lockable anesthesia cart. Anesthesia carts may be left unlocked and non-controlled medications may be left in, or on, the top of unlocked anesthesia carts or anesthesia machines immediately prior to, during, and immediately following surgical cases in an operating room, so long as there are authorized operating room personnel in the immediate vicinity (see appendix F for detailed Policy and Procedure).

F. Anesthesia providers may carry medications on their person under the following circumstances:

1. When taking those drugs directly for administration at the patient’s bedside. These drugs may include but are not limited to analgesics, anxiolytics, sedatives, vasopressors, anti-emetics, beta-blockers, bronchodilators. Only drug sufficient for the anticipated patient need should be carried on the provider’s person.

2. When transporting a patient to or from an acute care unit.

3. The anesthesia provider is responsible for disposal of used medications between cases. At the conclusion of the work period the anesthesia provider is responsible for disposing of all used and unused medications.

4. SFGH high-alert medications (heparin and insulin) must be drawn up and the dose checked by two providers.

H. Controlled drugs must at all times be either under the direct control of the anesthesia provider or in an approved locked box or drawer in a secure area. Controlled drugs (narcotics/sedatives and ketamine) are obtained from Pharmacy or the operating room charge nurse using a locked box method. Dispensed drugs are entered in a Pharmacy Log sheet. Any unused medications in the syringes should be placed in plastic inside the narcotic box and returned to the Pharmacy or operating room charge nurse at end of the work period. A pharmacist will reconcile narcotic usage and returned medication with log sheet.

I. Anesthesia care providers will be familiar, and adhere to, the Operating Room Universal Protocol Policy and Procedure and will actively participate in the Rolling Timeout, Final Timeout and end of case debriefing.

5. **ANESTHESIA EQUIPMENT**
A. The anesthesia work place consists of an anesthetic machine, monitoring and an anesthesia cart.

B. The anesthesiologist shall inspect and test the anesthetic apparatus prior to use. The Anesthesia Apparatus Checkout Recommendations (Appendix G) will serve as a guide. In general, this will include checking:
   1. Reserve supply of oxygen
   2. Connected pipeline inlets
   3. Functioning, filled vaporizers
   4. Calibrated, functioning oxygen analyzers and respiratory gas and anesthetic analyzers
   5. That the Anesthesia machine is free of leaks
   6. That there are functioning inspiratory and expiratory valves (if a circle system is to be used)
   7. That there is non-exhausted CO₂ absorbent (if a circle system is to be used)
   8. That there is a functioning leak-free mechanical ventilator, where appropriate

C. If leaks or other faults are detected, the equipment must not be used until the fault is repaired.

D. The anesthesiologist shall also check the availability, readiness, cleanliness (sterility where appropriate) and working order of all other equipment used in the administration of anesthetic agents. This includes resuscitative equipment.

E. All reusable anesthesia equipment in direct contact with the patient shall be cleaned after each use (See Infection Control).

F. Regular anesthesia carts are standardized according to the Anesthesia Cart Policy and are provided for every OR. Additionally, the following specially equipped carts are available:

   - Two Trauma Carts, one located in the Trauma OR #1 (in addition to a regular cart); a second Trauma cart is available in the designated Trauma Backup OR or kept in the trauma room one anteroom.
   - Three Obstetrical OR carts are available in each of the 3 Labor & Delivery operating rooms. An emergency airway cart is in Ob OR1
   - One epidural cart is maintained on ward 6C
   - Two fiberoptic carts, one designated as a difficult airway cart, are located in the OR anteroom
   - One regional anesthesia cart, located in the workroom
   - Three Pediatric Carts, located in the OR anteroom
   - One Malignant Hyperthermia (MH) cart, located in the anesthesia workroom

Except for the MH cart, carts will be stocked with drugs and supplies by OR workroom and pharmacy personnel according to established policy (See OR Workroom Policy and Procedures). Responsibilities for stocking and checking the contents of the MH cart are defined in the MH cart Policy & Procedure (Appendix H).

Comment [RS1]: Need to check the current number and types of carts with Kyra
G. Four Anesthesia Intubation Bags will be maintained for emergency airway procedures within the hospital. The contents and procedures for stocking and checking these bags are described in the Anesthesia Intubation Bags Policy and Procedure (Appendix I).

H. To ensure proper care of any surgical emergency case, designated Trauma and L&D ORs are prepared and checked at least once per day. Details of preparing and checking these areas are described in the Trauma Operating Room Preparedness Policy and Procedure (Appendix J) and Labor and Delivery Operating Room Preparedness Policy and Procedure (Appendix K).

G. Environmental Health & Safety personnel make regular checks of nitrous oxide levels in the Operating Rooms, including locations close to the machines and columns. A log of measured levels are maintained and made available to OR personnel. Efforts will be made to maintain nitrous oxide levels acceptably low by maintenance of fittings and of the scavenging system.

H. The presence of flammable materials and oxidizing agents makes the operating room a location for potential fires. In order to minimize the probability of fire, the SFGH Fire Safety in the OR Guidelines will be followed (Appendix L).

6. OTHER SPECIAL ANESTHESIA EQUIPMENT - Disposable anesthesia hoses and breathing bags are available and should be discarded after each use. Disposable anesthesia hoses, adapters, connectors, Y-pieces and other removable parts are to be replaced with clean or sterile equipment for each case. Plastic or rubber goods may be sterilized by either ethylene oxide or sterilized in perchloric acid. These items need not be sterile at the time of use as long as they are disinfected and stored in a clean manner.

Ventilators and canisters in daily use should be cleaned at monthly intervals.
Disposable endotracheal tubes are to be discarded after use. Other tubes may be re-sterilized with ethylene oxide if recommended by the manufacturer.
Disposable suction catheters are to be discarded after each use.
Anesthesia circuits will contain a filter to prevent contamination of those parts not replaced after each case (CO2 absorber, etc).

7. POST-ANESTHESIA CARE UNIT (PACU)

A. All patients who have had surgery and/or anesthesia who are not directly admitted to an intensive care unit should be admitted to the Post-Anesthesia Care Unit (PACU) for observation until fully recovered from anesthesia and until vital signs are stable. Infected (dirty) cases will be admitted to the PACU except for the following (who will require special arrangements): Infections requiring private room isolation: pulmonary tuberculosis if active untreated or during early treatment until judged clinically non-communicable by the Pulmonary or Infectious Disease Service; infections requiring strict private room precautions (i.e., chickenpox, mumps, diphtheria, herpes zoster, pertussis, rubella, rubeola).

B. Non-post-operative patients requiring special care and/or procedures may be admitted at the discretion of the responsible anesthesiologist after consultation with the PACU charge
nurse. This will be considered if all other special care units of the hospital are at capacity. The PACU is thus the unit of last resort for critical care patients.

C. Medical Orders for Postanesthesia care, including pain medication, are provided by the anesthesia care team who admits a patient to the PACU on the designated order form. The form is faxed to Pharmacy before PACU admission. Any changes or additions to the order form must be co-signed.

D. It is the responsibility of the anesthesia provider to give a verbal report to the PACU nurse on each patient admitted.

E. The anesthesia provider should not leave the patient until completely satisfied that the patient can be safely attended by the nurse receiving the patient, whether this be in the PACU, or intensive care unit.

F. The anesthesia attending or his/her designee will follow the progress of each patient under his/her care in the PACU. He/she will be available for consultation concerning any complications in the post-operative period. The anesthesiologist or his/her designee must evaluate the patient for anesthetic complications following surgery. The responsible physician or dentist who discharges the patient from the hospital must inform Anesthesia of any unusual anesthetic related events that may occur post discharge.

G. In general, visitors are not allowed in the PACU. Exceptions will be made, for example, when the patient is very young, when a patient is in danger of dying, or when the patient must spend an unusual amount of time in the PACU. Under these circumstances, visitors will be allowed when the Charge Nurse approves.

H. In the case of an emergency in the PACU, the anesthesia resident or CRNA and attending on-call and the surgeon involved will be notified.

I. An anesthesia attending must evaluate each patient who has received anesthesia services and document readiness for discharge before the patient can leave the PACU. The patient must meet PACU discharge criteria (see PACU Nursing Policy and Procedures).

II. CREDENTIALING

A. MEMBERSHIP REQUIREMENTS

Membership on the Medical Staff of San Francisco General Hospital is a privilege which shall be extended only to those practitioners who are professionally competent and continually meet the qualifications, standards, and requirements set forth in SFGH Medical Staff Bylaws, Rules and Regulations and accompanying manuals as well as these Clinical Service Rules and Regulations.

B. NEW APPOINTMENTS

The process of application for membership to the Medical Staff of SFGH through the Anesthesia and Perioperative Care Clinical Service Department is in accordance with SFGH Bylaws, Rules and Regulations and accompanying manuals as well as these Clinical Service Rules and Regulations.
1. Attending staff appointed to the Medical Staff will be proctored at the beginning of service. This will include:
   a) Observation of the appointee discharging his/her usual clinical responsibilities, and
   b) Observation of the appointee in his/her discussion of clinical problems with housestaff or CRNA’s.
   c) A sufficient number of times will be used to reach a conclusion as to competence.

2. At the end of three (3) months, the proctor will submit a report to the Chief of Anesthesia Service. This report will include:
   a) The nature of observations made
   b) The time period of observations,
   c) A recommendation may be made for a further period of proctoring if this is thought to be necessary.

3. When intensive care privileges are to be included, proctoring will include observations of care given by the appointee by a member of the Anesthesia ICU attending staff.

4. Proctoring reports will form a part of the Chief of Anesthesia Service’s recommendation for appointment to the staff.

5. Quality of care issues in regard to faculty are discussed in several ways (See Section IX.D. Clinical Indicators). This information is used for reappointment.

6. Attending staff are evaluated on an ongoing basis in various ways.
   a) Initially, the proctoring protocol is followed.
   b) Through Faculty Reappointment every two years
   c) Through twice yearly Ongoing Professional Performance Evaluation. (See Appendix N, Anesthesia OPPE)

C. REAPPOINTMENTS

The process of reappointment to the Medical Staff of SFGH through the Anesthesia and Perioperative Care Clinical Service is in accordance with SFGH Bylaws, Rules and Regulations and accompanying manuals as well as these Clinical Service Rules and Regulations.

1. REAPPOINTMENT CRITERIA

The criteria for faculty reappointment shall include review of his or her clinical care, licensure status, professional judgment and performance, and review of health status as indicated. The reappointment process will include review of case management by the Departments Director of Quality improvement as reflected in the twice yearly OPPE. The following information will be collected and reviewed.

   a) A review of the number and type of cases done by each faculty will be generated from the operating room records to allow the Chief of Anesthesia Service to review the work performed by each faculty member and adequacy of clinical experience.
b)  Further, a review of the postoperative complications will be summarized as part of the OPPE process and the appropriate faculty member’s cases with problems will be noted (physician specific). These will be based on Joint Commission mandated clinical indicators.

c)  A file will be generated for each faculty member to allow a review by the Chief of Anesthesia Service. Documentation of licensure will include current state license, DEA license and appropriate CME course work will be reviewed.

d)  There will also be an ongoing review of cases listed for possible M & M discussion. This will be discussed at regular monthly conferences and as needed at faculty meetings. These will be kept on file and available for review at the time of reappointment. Finally, the Chief of Anesthesia Service shall file individual memos, comments or other documentation relating to an individual physician’s clinical care and competence, so that he will be able to document and re-certify the individual at reappointment time.

D. PRACTITIONER PERFORMANCE PROFILES

The Anesthesia and Perioperative Care Clinical Service Practitioner Performance Profiles are maintained by the Chief of Anesthesia Service. This includes items C.1. (a – d) above.

E. AFFILIATED PROFESSIONALS

The process of appointment and reappointment to the Affiliated Professionals through the Anesthesia and Perioperative Care Clinical Service is in accordance with SFGH Bylaws, Rules and Regulations and accompanying manuals as well as these Clinical Service Rules and Regulations.

1. NURSE ANESTHETIST JOB DESCRIPTION (CRNA)

   a) Characteristics of Job - Under the supervision of physician anesthesiologists, CRNAs administer anesthesia, other central nervous system depressants and necessary additional medications in the operating suite, delivery rooms, and other diagnostic and treatment areas. They may respond to cardiopulmonary emergencies in the Emergency Department and other patient care areas. They maintain records of anesthesia and other drugs administered, of resuscitations carried out, and of each patient’s responses to these measures.

   b) Responsibilities of Job – CRNAs are responsible for: 1) carrying out established methods and procedures in administering anesthetics, including both elective and emergency operations and procedures; 2) monitoring patients physiological status, using current electronic and other equipment; 3) preparing detailed medical and technical records relative to anesthetics administered and patient’s reactions. The nature of work involves sustained physical effort and manual dexterity with some exposure to health and accident hazards. Rotation on night and weekend call may be required.

   c) Minimum Qualifications:

      1) Training and experience: requires completion of high school, supplemented by graduation from an accredited school of nursing and two years of special certified
training in anesthesia, or an equivalent combination of training and experience. Current ongoing experience with a broad range of anesthetist’s duties is essential.

2) Knowledge, abilities and skills: requires thorough knowledge of various types and methods of administering anesthesia; standard operating room methods, equipment and procedures; anesthesia equipment, instruments and drugs used in various types of surgery.

3) Requires ability and skill to detect unfavorable patient reactions and apply prompt remedial measures.

4) License: requires possession of current valid license as a registered nurse issued by the State Board of Nursing Examiners, and current certification by the American Association of Nurse Anesthetists (or evidence of eligibility for the first six months employment.)

F. STAFF CATEGORIES

Anesthesia and Perioperative Care Clinical Service attending staff fall into the same staff categories which are described in Article III of the SFGH Bylaws, Rules and Regulations and accompanying manuals as well as these Clinical Service Rules and Regulations.

III. DELINEATION OF PRIVILEGES

A. DEVELOPMENT OF STAFF PRIVILEGE CRITERIA

Anesthesia privileges are developed in accordance with SFGH Medical Staff. All requests for clinical privileges will be evaluated and approved by the Chief of Anesthesia.

B. PRIVILEGE CATEGORIES

Staff Privileges for the Anesthesia and Perioperative Care Clinical Service are categorized as follows:

1. TYPE I PRIVILEGES: Basic Privileges

   MINIMUM CRITERIA: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Anesthesia or a member of the Clinical Service prior to 10/17/00. Preoperative evaluations of patients at all levels of American Society of Anesthesia classification including emergencies. Management of procedures for rendering these patients insensible to pain and emotional stress before, during and after surgical, obstetric and certain medical interventions. These procedures include all anesthetic and sedative techniques including local infiltration, regional anesthesia, MAC, and general anesthesia. They also include special skills necessary for support of life functions during an anesthetic, in the post anesthesia care unit, and elsewhere in the hospital. These include airway management, hemodynamic monitoring/management, mechanical ventilation and resuscitation.

2. TYPE II PRIVILEGES: Specific Privileges
MINIMUM CRITERIA: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Anesthesia with special qualifications in Critical Care Medicine or a member of the Clinical Service prior to 10/17/00. Under special circumstances, the recommendation of the Chief of Anesthesia and Perioperative Care may be required. Basic Type I privileges and management of patients in critical care units.

3. TYPE III PRIVILEGES - Special Privileges
   - ACUPUNCTURE
   - TRANSESOPHAGEAL ECHOCARDIOGRAPHY FOR PERIOPERATIVE MONITORING
   - TRANSESOPHAGEAL ECHOCARDIOGRAPHY FOR PERIOPERATIVE COMPREHENSIVE EXAMINATION

   MINIMUM CRITERIA: Please refer to Appendix - N

Proctoring Requirements for Privileges
Prior to recommendation for appointment or reappointment to the Medical Staff, the appropriateness of privileges will be reviewed by the Chief of Anesthesia Service, based on his own observations and on advice from other staff members who have personally observed the applicant’s clinical performance as delineated in Appendix N, Anesthesia Privileges for SFGH.

C. ANNUAL REVIEW OF CLINICAL SERVICE PRIVILEGE REQUEST FORM
   The Anesthesia and Perioperative Care Clinical Service Privilege Request Form shall be reviewed annually.

D. DEVELOPMENT OF PRIVILEGE CRITERIA
   Refer to Section III A – Development of Staff Privilege Criteria

E. CLINICAL PRIVILEGES AND MODIFICATION/CHANGE TO PRIVILEGES
   The process for modification/change to the privileges for members of the Anesthesia Service is in accordance with the SFGH Medical Staff Bylaws, Rules and Regulations and accompanying manuals.

IV. PROCTORING AND MONITORING – See Section II A and B, and IX
   A. REQUIREMENTS
      Monitoring (Proctoring) requirements for the Anesthesia and Perioperative Care Clinical Service shall be the responsibility of the Chief of the Anesthesia Service.

   B. ADDITIONAL PRIVILEGES
      Request for additional privileges for the Anesthesia and Perioperative Care Clinical Service shall be in accordance with the SFGH Bylaws, Rules and Regulations and accompanying manuals as well as these Clinical Service Rules and Regulations.
C. REMOVAL OF PRIVILEGES

Request for removal of privileges for the Anesthesia and Perioperative Care Clinical Service shall be in accordance with the SFGH Bylaws, Rules and Regulations and accompanying manuals as well as these Clinical Service Rules and Regulations.

V. EDUCATION

The Anesthesia and Perioperative Care Service offers an extensive lecture series for 1st, 2nd, and 3rd year residents. A well-organized course structure is provided for medical student rotations. In addition, all members of the staff can attend UCSF department courses for CME credits: Fiberoptic Workshops (annually), Obstetric Anesthesia (yearly), Changing Practices of Anesthesia (yearly), Anesthesia Grand Rounds (monthly), and multiple national meetings.

VI. ANESTHESIA AND PERIOPERATIVE CARE CLINICAL SERVICE HOUSESTAFF TRAINING PROGRAM AND SUPERVISION

Attending faculty shall supervise house staff in such a way that house staff assume progressively increasing responsibility for patient care according to their level of training ability and experience.

A. ROLE, RESPONSIBILITY AND PATIENT CARE ACTIVITIES OF THE HOUSE STAFF:

1. The resident physician shall be responsible for preoperative evaluation, planning and administration of an anesthetic, and postoperative care of assigned patients. This will be done under the supervision of an attending faculty member. It is expected that all cases will be discussed with the attending anesthesiologist prior to the induction of anesthesia.

2. Decisions regarding the progressive involvement and independence of the resident in the above mentioned patient care activities are made following close observation of the skills and knowledge base of the resident.

B. RESIDENT EVALUATION PROCESS:

1. Each of the staff completes a written evaluation and this is entered into an electronic departmental database. The summary of these evaluations is presented to the house staff by the Chief of Service, Clinical Director, or resident rotation director at the end of each rotation. General recommendations are then passed on to a faculty advisor and a report on clinical competence is submitted every 6 months to the American Board of Anesthesia. The period of time at SFGH is closely scrutinized for quality of care. Clinical comments are made to the house staff on a daily basis when needed.

2. Didactic Educational Activities

a) Tuesday afternoon conferences are directed at topics of clinical relevance to the practice of anesthesia at SFGH, as well as reviews of recent journal articles relevant to the clinical cases seen at SFGH and are run by faculty members.

b) Monthly Wednesday morning M/M Conference includes evaluation and discussion of all department wide deaths, as well as significant complications, near misses and appropriate
cases with an emphasis on specific problems and/or possible changes in practice and improved care.

c) All residents are required to attend weekly didactic sessions and grand rounds.

3. Ability to write patient care orders:
House staff members may write patient care orders following management discussions with an attending.

VII. ANESTHESIA AND PERIOPERATIVE CARE CLINICAL SERVICE CONSULTATION CRITERIA

A. In cases in which the patient has a significant systemic disease or an unusual surgical problem consultation is required. Previously mentioned, this includes patients who are Jehovah’s Witness. All consultations must be in writing and signed by the consultant. This consultation may be accomplished by a visit to the preoperative clinic or by an individual consultation regarding an inpatient or a patient in clinic.

B. Consultation is not required in the case of extreme emergency when, in the opinion of the attending physician, the life of the patient would be jeopardized by the delay necessary to obtain qualified consultation. In such emergency cases, the physician shall record the emergency situation, which required this action.

C. When a member of the medical staff has discussed a case preoperatively, or given advice about the patient, or where consultation is the result of a clinical conference, this should be so stated in the chart.

VIII. DISCIPLINARY ACTION

The San Francisco General Hospital Medical Staff Bylaws, Rules and Regulations and accompanying manuals will govern all disciplinary action involving members of the SFGH Anesthesia and Perioperative Care Clinical Service.

IX. PERFORMANCE IMPROVEMENT/PATIENT SAFETY (PIPS) and UTILIZATION MANAGEMENT

The overall responsibility for Performance Improvement/Patient Safety and Utilization Management rests with the Chief of the Anesthesia and Perioperative Care Clinical Service. Design and implementation and other portions of the programs will be delegated to members of the department, recognizing that this is a department-wide responsibility.

A. GOALS AND OBJECTIVES

The Chief of the Anesthesia Service, or his/her designee, is responsible for ensuring resolution of quality care issues. As necessary, assistance is invited from other departments, the Performance/Improvement Patient Safety (PIPS) Committee, or the appropriate SFGH administrative committee or organization (example: Executive Committee, OR Committee, Engineering, etc.).
1. To insure appropriate care of all patients receiving anesthetic care or intervention. It is understood that this care is provided chiefly in the OR and PACU, but includes other areas such as the Emergency Room, intensive care units, obstetrical suite, GI suite, and Radiology.

2. To minimize morbidity and mortality as well as to avoid unnecessary days of inpatient care. Efficiency in delivery of service is also a prime objective.

B. RESPONSIBILITY

1. Anesthetic morbidity and mortality is identified, by postoperative visits, reports submitted into the division’s M&M database, and Unusual Occurrence reports. A record of this is kept for individual anesthetists, and major problems are highlighted. This is maintained within the Anesthesia and Perioperative Care Clinical Service. These are reviewed regularly to determine adequacy of care. Specific problems are tabulated for faculty reappointment database. The Chief and his/her designees also review near miss reports made by CRNAs, residents, and faculty contemporaneously and appropriate follow-up and/or corrective actions are taken.

2. Monthly staff meetings address organizational as well as performance improvement and patient safety issues. Minutes are submitted to the Medical Staff Office. The minutes outline topics covered, and “track” ongoing problems. Performance improvement and patient safety issues are discussed at most meetings.

3. As topics arise from M&M Conference, notices from other departments of physicians, patients, or administration, a member of the attending staff undertakes further evaluation. This may take the form of a broad review or specific attention to a clinical problem.

   Follow-up on the above might include:
   
a) Inservice (or departmental education/training). (Example: A follow-up on the review of epidural narcotics or lecture to the nursing staff on these modalities and means to decrease side effects.)

b) Revision of policy or procedures

c) Potential staff changes/proctoring, dismissal, etc.

d) Purchase of equipment. (Example: The O.R. monitoring equipment has expanded dramatically in recent years and exceeds the American Society of Anesthesiology standards).

C. REPORTING

Performance Improvement/Patient Safety (PIPS) and Utilization Management activity records will be maintained by the department. Further, minutes will be sent to the Medical Staff Office and will include PIPS and Utilization Management information/follow-up, etc.

D. CLINICAL INDICATORS
The Department of Anesthesia and Perioperative Care believes in the consistent delivery of quality patient care, as defined by the Institute of Medicine, i.e. that it is safe, timely, effective, efficient, equitable and patient-centered. The Anesthesia and Perioperative Care Clinical Service reviews and evaluates the quality and appropriateness of the care delivered on a continuous basis. This is a multi-faceted program with data collection from numerous sources. These include:

1. Direct supervision of the performance of residents and CRNA’s by members of the attending staff. Monthly evaluation of each resident includes direct comment on patient care issues. Performance evaluations of CRNA’s are done on an annual basis.

2. All anesthesia-related deaths and complications are reviewed at monthly Morbidity and Mortality meetings. Cases are reviewed for deaths, myocardial infarction, neurologic injury, aspiration, and other adverse events occurring within 48 hours of anesthesia care. These indicators are reviewed at the monthly M&M conference and are included as part of OPPE. All members of the Anesthesia Service, including faculty, CRNA’s, residents, and students are expected to attend these meetings. They are accredited for Continuing Medical Education. An attempt is made to determine ways to improve patient outcomes and avoid future problems. This is an open forum for frank discussion. Records are kept in the departmental office.

Cases are also reviewed at routine SFGH departmental faculty meetings with an emphasis on specific problems on possible changes in practice. Some cases are also presented and discussed at UCSF departmental Grand Rounds.

3. STARS conferences (SFGH Tuesday Afternoon Resident Seminars) are for primarily residents and are directed to topics relevant to the care of patients at SFGH. These meetings are to discuss cases, recent and topical journal articles, special techniques and ideas to improve anesthesia management, especially as pertains to trauma and indigent care, and avoidance of future problems.

E. CLINICAL SERVICE PRACTITIONERS PERFORMANCE PROFILES

Refer to Section IX.D.

F. MONITORING & EVALUATION OF APPROPRIATENESS OF PATIENT CARE

It is understood that regular review by the Performance Improvement/Patient Safety Committee will occur as reports and problems arise from our department or others within SFGH. Further, there shall be an annual review of our program and Performance Improvement and Patient Safety Issues from the previous year. Refer to Section IX.D.

G. MONITORING & EVALUATION OF PROFESSIONAL PERFORMANCE

See Attending, Resident, and CRNA staff. Refer to Section IX.D.

H. CLINICAL INDICATORS

Refer to Section IX.D, Clinical Indicators
X. MEETING REQUIREMENTS

In accordance with SFGH Medical Staff Bylaws 7.2.1, All Active Members are expected to show good faith participation in the governance and quality evaluation process of the Medical Staff by attending a minimum of 50% of all committee meetings assigned, clinical service meetings and the annual Medical Staff Meeting.

The Anesthesia and Perioperative Care Clinical Service shall meet as frequently as necessary, but at least quarterly to consider findings from ongoing monitoring and evaluation of the quality and appropriateness of the care and treatment provided to patients.

As defined in the SFGH Medical Staff Bylaws, Article VII, 7.2.G., a quorum is constituted by at least three (3)-voting members of the Active Staff for the purpose of conducting business.

XI. ADDITIONAL CLINICAL SERVICE SPECIFIC INFORMATION

A. Monthly orientation sessions are held to inform house staff of SFGH specific rules and regulations, patient care issues, schedules, etc.
B. Ongoing educational sessions are held for faculty and CRNAs regarding hospital and department policies and procedures, equipment, performance improvement and patient safety, etc.
C. Scheduling of house staff is done in accordance with the UCSF resident work hour improvement project.
D. Risk Management: the department adheres to all hospital policies. Any untoward events are reported promptly to risk management
E. Well Being: The Department of Anesthesia has an active Physician Well Being Committee. Any evidence of impairment is referred to the committee and a prompt and thorough investigation is carried out. If impairment is found it is promptly treated appropriately.

XII. ADOPTION AND AMENDMENT

The Anesthesia and Perioperative Care Clinical Service Rules and Regulations will be adopted and revised by a majority vote of all Active members of the Anesthesia and Perioperative Care Clinical Service every two years at an Anesthesia and Perioperative Care Clinical Service meeting.