PROVIDENCE LITTLE COMPANY OF MARYMEDICAL CENTER-SAN PEDRO
DEPARTMENT OF ANESTHESIOLOGY
RULES AND REGULATIONS

ARTICLE I. ORGANIZATION OF THE DEPARTMENT

Section A. Name

The name shall be the Department of Anesthesiology of the Medical Staff of Providence Little Company of Mary Medical Center-San Pedro. The department is established as provided in the Medical Staff Bylaws, Rules and Regulations of the Medical Staff of Little Company of Mary-San Pedro Hospital. On March 22, 2005, the Hospital Board of Directors approved the provision of anesthesia services under exclusive arrangements with a provider designated by the Hospital ("Exclusive Provider"). All services along the continuum of anesthesia services provided in the hospital are organized under the Department of Anesthesia which is directed by a qualified physician and consistently implemented in every hospital department and setting that provides any type of anesthesia services.

Section B. Membership of the Department

Membership in the department shall be limited to those practitioners who are either certified by the American Board of Anesthesiology or those who are qualified for certification by the American Board of Anesthesiology and for pain management specialists, those who are certified in Pain Management by the American Board of Anesthesia or those who are qualified for certification in Pain Management by the American Board of Anesthesia.

Fulfillment of qualifications for initial appointment and reappoint as outlined in the Medical Staff Bylaws. Ongoing membership criteria will be assessed at the time of reappointment.

The professional conduct of members under the jurisdiction of the department shall be governed by the Medical Staff Bylaws and, if necessary, referred to the Medical Executive Committee.

ARTICLE II. FUNCTIONING OF THE DEPARTMENT

Section A. Department Responsibilities and Functions

SEE MEDICAL STAFF BYLAWS FOR DETAILS and the following:

APPLICATIONS AND PRIVILEGES: Any practitioner seeking to apply for privileges in any area of anesthesia covered by the Exclusive Provider's contract with the Hospital must first have a contractual arrangement with the Exclusive Provider. Any dispute concerning eligibility to apply for anesthesia privileges shall be resolved by the Hospital Administration in consultation with the Chief of Staff and the Exclusive Provider.

Applications for membership and privileges in the Department shall otherwise be processed in accordance with the Medical Staff Bylaws.

Practitioners holding anesthesia privileges must maintain a contractual arrangement with the exclusive provider in order to continue to be eligible to exercise such privileges. The Exclusive Provider is responsible for notifying the Medical Staff Services Department, Chief of Staff and Hospital Administration of the termination or expiration of its contract with any practitioner holding anesthesia privileges.

Fair hearing rights under the Medical Staff Bylaws do not apply to a practitioner whose application for anesthesia privileges is denied or not processed on the basis that the practitioner does not have a contract with the Exclusive Provider. In addition, the termination or expiration of a practitioner's contract with the Exclusive Provider shall result in the automatic termination of the practitioner's clinical privileges to provide all services covered by the Exclusive Provider's exclusive arrangement with the Hospital, without the right to a hearing under the Medical Staff Bylaws unless hearing rights are otherwise expressly afforded by the Bylaws.

Section B. Department Chair and Vice Chair Responsibilities and Election Process

In addition to responsibilities as outlined in the Medical Staff Bylaws (Article X, Section 10.3), the Department Chair (and Vice Chair if necessary) shall be responsible for:

- Planning, directing, and supervising all activities of the anesthesia service;
- Establishing staff schedules;
- Evaluating the quality and appropriateness of the anesthesia patient care.
- Election Process and Qualifications of Department Chair: See Bylaws Article X, Section 10.3.

Section C. Meeting Frequency and Attendance Requirements

SEE MEDICAL STAFF BYLAWS FOR DETAILS

Section D. Quorum

Two (2) Active Staff members of the Department shall constitute a quorum for the conduct of business at any meeting of the Department.

Section E. Voting Privileges

Active members of the Department may vote on all department matters.

Section F. Department Representation

As provided in the Medical Staff Bylaws, a member of the Department may be appointed to other standing Medical Staff departments and committees.

Ex officio members of the Department (non-voting) shall consist of, but not be limited to representatives from Hospital Administration, Performance Improvement, and Patient Care Services (Nursing). Other members shall be at the discretion of the chair.

Section G. Divisions

The department chair may appoint division chairs to conduct business at his/her discretion.

ARTICLE III. CLINICAL PRIVILEGES

Section A. Assignment of and Granting of Clinical Privileges

At the time of initial appointment and reappointment, a privilege delineation form shall be completed by eligible applicants and members outlining those privileges being requested. During the reappointment cycle, members requesting privilege modifications shall provide supporting written documentation of training (certificate of course completion or letter from program director attesting to training) and experience (number of procedures done in the prior 2 years).

Privileges in the Department are granted by the Board of Directors of the Hospital, upon the recommendation of the Medical Executive Committee. The Department is responsible for the evaluation of each member of the Department, and of each eligible applicant for membership in the Department, with regard to privileges, and makes recommendations in this regard to the Medical Executive Committee, consistent with the Medical Staff Bylaws.

Once approved, an approved privilege listing will be sent to the member and to the appropriate hospital departments. The original privilege request form shall be maintained in the member's credential file in the Medical Staff Services Department.

Section B. Special Privileges

SEE MEDICAL STAFF BYLAWS FOR DETAILS

Section C. Focused Professional Practice Evaluation (Proctoring)

Policy: All Provisional Staff members initially granted privileges shall complete a period of focused review (proctoring period minimum 6 months and maximum 24 months). All practitioners granted special/interim privileges during the time final action is pending concerning their application, during a probationary period, shall be proctored. Practitioners granted special privileges may be required to be supervised as required by the department chair or Chief of Staff. Reference: Focused Professional Practice Evaluation Policy/Procedure.

Additional proctoring may be required for Provisional members to adequately evaluate their practice. This additional proctoring shall not constitute grounds for a hearing.

Additional proctoring may be required for members requesting new privileges. This shall not constitute grounds for hearing.

Proctoring may be required for members whose clinical department determines that additional or continued proctoring is necessary or desirable.

Number of Required Proctored Cases: See Privilege Delineation Form.

Assignment of Proctor: The proctor assignments shall be coordinated through the department chair. At least two (2) proctors shall be involved in proctoring Provisional members.

The proctors shall provide written documentation of the analysis of proctoring review of the Provisional member and forward it to the Medical Staff Services Department as soon as is practicably possible.

Proctoring Duration: Each Provisional member granted clinical privileges must be proctored on the minimum number of cases/hours identified on the privilege delineation form. The proctoring period shall be for a minimum of 6 months and a maximum of 24 months.

Non-Provisional members granted clinical privileges must be proctored on the minimum number of cases identified on the privilege delineation form.

Extension of Proctoring: If the Provisional member has reached the 24 month time period and has not satisfied the proctoring requirements of the department, there is nothing derogatory related to his or her clinical practice, and the member continues to make good faith attempts to complete proctoring, the Medical Executive Committee has discretion to extend the proctoring period for a period not to exceed one (1) year.

Proctoring Review: The proctored member shall be notified initially of the proctoring requirements and, if proctoring is not already completed, shall be updated at 18 months via Certified Mail with regard to the number of proctored cases/hours necessary to complete the requirements (failure to receive such notice shall not excuse the member from meeting such requirements or entitle the member to an extension of the proctoring period).

When the department is considering whether to terminate proctoring requirements, and grant the member unsupervised privileges, it shall have the department chair or his/her designee review the proctored member's file to assure that the necessary completed proctoring forms/documentation are in order and the member is in good standing. The department chair may recommend release from proctoring or additional proctoring for reasons as outlined by the chair.

Provisional Staff members may be allowed to advance from the Provisional Staff if upon successful completion of proctoring.

ARTICLE IV. CLINICAL PRACTICE

Section A. Responsibility of the Anesthesiologist and Documentation Requirements

Anesthesiologists are available to consult with Medical Staff members regarding all forms of patient care rendered in the hospital pertaining to the specialty of Anesthesiology, including Inhalation Therapy, Cardiopulmonary Resuscitation and special problems in pain management.

PRE-ANESTHETIC EVALUATION: There shall be a pre-anesthesia evaluation of the patient by the anesthesiologist. The evaluation shall be documented in the patient's record and include at least the following information:

1. Surgical/obstetrical procedure anticipated.
2. The choice of anesthesia.
3. Previous drug history.
4. Other anesthesia experience.
5. Potential anesthetic problems.

At the time of the pre-operative visit there shall be a disclosure of the plan for anesthesia and an acceptance thereof by the patient or by a proper representative. A pre-anesthetic note of the findings relating to the plan of anesthetic and acceptance thereof, shall be set forth in the patient's medical record.

In those patients requiring general anesthesia, the patient's physical examination, history and laboratory work should be completed the day prior to surgery and this information should be given to the anesthesiologist prior to premedication orders.

Any conflicts between the operating surgeon and the anesthesiologist with respect to the type of anesthetic to be administered shall be resolved prior to the time a plan of anesthesia is discussed with the patient whenever reasonably possible. The anesthesiologist has the primary responsibility to decide on the type of anesthesia needed.

Since it is physically impossible and impractical for the anesthesiologist to see patients who are admitted to the Emergency Room holding area for an outpatient procedure, all such patients must fill out the anesthetic questionnaire. The questionnaire will then be attached to the front of the chart by the nurses.

PRE-SURGICAL WORKUP: SEE MEDICAL STAFF RULES AND REGULATIONS

PRE-OPERATIVE EVALUATION GUIDELINES:
Cardiology Consultation
The Department of Anesthesia recognizes the current ACC/AHA Guidelines on Perioperative Cardiovascular Evaluation for Noncardiac Surgery. Based on these principles we recommend a cardiology consultation for patients with the following conditions:

- Unstable coronary syndromes
- Congestive heart failure
- History of myocardial infarction or revascularization within the last give years with poor exercise tolerance or inability to exercise (i.e., wheelchair bound, severe peripheral vascular disease).
- Rheumatic heart disease without recent ECHO or with worsening cardiac symptoms
- Significant systolic murmur (>II/VI) or any diastolic murmur
- Pericardial effusion
- Cardiomyopathy
- Anticipated prolonged surgical procedures associated with significant fluid shifts and or blood loss for patients with:
    - Advanced age
    - Ischemic changes on EKG
    - Rhythm other than sinus

    - History of stroke
    - Uncontrollable systemic hypertension
- Patients with packemakers or ICD (implantable cardiac defibrillators)

For patients with poor exercise tolerance suggestive of coronary artery disease, as well as for patients with known coronary artery disease scheduled for a high risk operative procedure, a cardiology consultation may be required on a case by case basis. The need for consultation is at the discretion of the anesthesiologist and operating surgeon.

For patients scheduled for vascular surgery, a cardiology consultation may be required on a case by case basis. The need for consultation is at the discretion of the anesthesiologist and the operating surgeon.

Medicine Consultation

Medicine consultation should be attained to aid the primary surgeon and optimize the patient for surgery (e.g., make recommendations on controlling the blood pressure for a hypertensive patient, make recommendations on controlling the blood glucose for a diabetic patient, etc). A medicine consult should never be attained to “clear” a patient for surgery. Consultation between the anesthesiologist and the surgeon should instead occur to determine whether a patient is appropriately optimized to undergo surgery.

Dialysis Patients

Dialysis should occur on the day before surgery in order to optimize fluid and electrolyte status. Blood determinations of electrolytes should be done post dialysis. Dialysis on the day of surgery is discouraged since it may lead to potential problems with rebound anticoagulation, rapid fluid shifts, hypokalemia, and hypoxemia. Dialysis should be discouraged if the surgery is to be scheduled greater than 48 hours later, since these patients may develop fluid overload, increased potassium levels, and acidosis.

Baseline EKG should be done for all patients over the age of 40 who are otherwise healthy. In addition, patients with the following conditions should have an EKG:

- Hypertension
- Diabetes
- Significant systolic murmur (>II/VI) or any diastolic murmur
- Angina
- Syncope history
- Arrhythmias or history of palpitations
- Cocaine or other illicit substance abuse
- Renal disease
- Obstructive pulmonary disease

A pregnancy test should be done in all female patients of childbearing age unless there is a history of hysterectomy.

Chest x-rays should be done for all patients over the age of 60. A chest radiograph should also be obtained in the following conditions:

- Symptomatic pulmonary disease (e.g., COPD, asthma, cystic fibrosis)
- Significant smoking history (> 20 pack year history)
- Recent pneumonia or upper respiratory infection
- Cardiac disease (such as CAD, cardiomyopathy, rheumatic heart disease)
- Patients scheduled for thoracic surgery
- Patients with neck mass suggestive of tracheal deviation
- Malignancy with possible metastasis, radiation or chemotherapy

PRE-OP MEDICATION: The floor nurse is responsible for notifying the anesthesiologist if a pre-op patient who is scheduled to have pre-anesthetic pre-medication, has received a tranquilizer, sedative or narcotic within a 4-hour period prior to the scheduled anesthetic pre-medication.

BLOOD TRANSFUSION IN OR: All blood that is to be transfused in the operating room must be checked by an M.D. and an R.N. prior to transfusion.

ASSESSMENT PRIOR TO INDUCTION: There shall be a review of the patient's condition immediately prior to the induction of anesthesia. This review shall include the medical record with regard to completeness, pertinent laboratory data, and time of administration and dosage of pre-anesthesia medications together with an appraisal of any changes in the patient's condition as compared with that noted on previous visits.

Prior to administering anesthesia, the anesthesiologist shall check the readiness, availability, cleanliness, sterility where required, and working condition of all equipment used in the administration of anesthetic agents.

EQUIPMENT MAINTENANCE: Laryngoscopes, airways, breathing bags, masks, endotracheal tubes, and all reusable anesthesia equipment in direct contact with the patient shall be cleaned after each use. All disposable anesthetic equipment must be discarded after each use.

Each anesthetic machine shall have a pin-index safety system, scavenging system and an oxygen pressure interlock system. All must have an oxygen analyzer and pulse oximeter.

DOCUMENTATION/INTRA-OPERATIVE CARE: All pertinent events taking place during the induction of, maintenance of and emergence from anesthesia, including the dosage and duration of all anesthetic agents, other drugs, intravenous fluids, and blood or blood components is required.

All patients shall have a pulse oximeter, an EKG monitor, a BP monitor and a precordial stethoscope during all general, MAC or regional anesthetics. All general anesthesia cases utilizing endotrachael tube (ET) or laryngeal mask airway (LMA), shall also be monitored by an end-tidal CO_2 monitor.

Only non-combustible anesthetic agents are to be used in the operating room.

POST ANESTHESIA: Following any procedure for which anesthesia was administered, the anesthesiologist or his qualified designee(s) shall remain with the patient as long as required by the patient's condition relative to his anesthesia status, and until responsibility for proper patient care has been assumed by other qualified individuals. Personnel responsible for post-anesthetic care shall be advised of specific problems presented by the patient's condition. The same degree of care shall be provided when the patient is returned to the nursing floor to recover.

RECOVERY ROOM: The anesthesiologist shares responsibility with the attending surgeon for post-operative care of the patient while in the recovery room.

The anesthesiologist shall not commence a second case if the preceding case has not recovered sufficiently beyond threat or jeopardy.

Criteria for Discharge from Recovery Room:

1. Direct order by anesthesiologist and/or surgeon in accordance with established discharge criteria.
2. Status of patient not requiring continuous direct supervision unless transferred to intensive care unit.

The number of post-anesthesia visits shall be determined by the status of the patient in relation to the procedure performed.

The post-anesthesia evaluation shall be written only when the patient has recovered sufficiently from the anesthesia to appropriately participate in the assessment. The follow-up note should be made after discharge from Recovery Room when appropriate. The post-anesthesia evaluation should be completed within 48 hours after surgery/procedure and must be dated and timed and shall note the presence or absence of complications.

POST-RECOVERY: Patient should be informed by the surgeon of the possibility that outpatient surgical procedure involved could require inpatient post-operative care.

Section B. Infection Control

The anesthesiologist shall follow appropriate scrubbing and gowning techniques:

1. When leaving the department, masks and shoe coves shall be removed; scrub suits shall be covered or changed when re-entering the department.
2. Visitors shall not be permitted in the Operating Room or Recovery Room unless their presence is absolutely necessary for the care or well being of the patient, or they are a student in the medical education program at Little Company of Mary-San Pedro Hospital. When permitted in the department, they must conform to the dress code and rules of the department.

Section C. Equipment and Safety

Anesthetic apparatus must be inspected and tested by the anesthetist before use. If a leak or any other defect is observed, the equipment must not be used until the fault is repaired.

Each anesthetic machine in any and all anesthetizing areas shall have a pin-index safety system and a fail-safe system.

Equipment cover shall not be left on anesthesia apparatus since this would permit the collection of anesthetic gases.

Transportation of patient while an inhalation anesthetic is being administered by means of a mobile anesthesia machine shall be prohibited, unless deemed essential for the benefit of the patient in the combined judgment of the surgeon and anesthesiologist.

Continuous monitoring of the electrical circuits in the surgical suite is provided by use of a round contact indicator.

Section D. Consultations

SEE MEDICAL STAFF RULES/REGULATIONS

Section E. Service to the Emergency Department and Coverage

The Department Chair shall be responsible for preparing the call schedule. Anesthesia coverage will be provided 24 hours a day, seven days a week, for surgical procedures necessitating anesthesia services. The call schedule will be located in at least the following places:

1. Switchboard area
2. Surgery scheduling book
3. Nursing Supervisor receives copy of on-call schedule by 2 p.m.
4. Perinatal Services

Problems which arise involving the performance or availability of an on-call member will be brought to the attention of the Department Chair for timely action and follow-up to ensure that the patient's emergent needs are addressed.

ARTICLE V ADOPTION

Any proposed amendments or additions to these Rules and Regulations shall be presented to the Department Chair in writing. No proposed amendment or addition shall be contrary to applicable law or to the Medical Staff Bylaws. Any proposed amendment or addition shall be presented to the Department for approval. All Rules and Regulations approved by the Department shall be subject to approval by the Medical Executive Committee and the Board of Directors. Approval by the Board of Directors shall not be unreasonably withheld.

REVISED:
CORE COMMITTEE (ANESTHESIA): 02/22/06
MEDICAL EXECUTIVE COMMITTEE: 02/27/06
BOARD OF DIRECTORS: 03/09/06

REVISED:
CORE COMMITTEE (ANESTHESIA): 07/18/07
MEDICAL EXECUTIVE COMMITTEE: 09/17/07
BOARD OF DIRECTORS: 09/25/07

REVISED:
CORE COMMITTEE (ANESTHESIA): 10/15/08
MEDICAL EXECUTIVE COMMITTEE: 11/17/08
BOARD OF DIRECTORS: 11/25/08

REVISED:
CORE COMMITTEE (ANESTHESIA): 11/18/09
MEDICAL EXECUTIVE COMMITTEE: 11/23/09
BOARD OF DIRECTORS: 11/24/09

REVISED:
CORE COMMITTEE (ANESTHESIA): 1/20/10
MEDICAL EXECUTIVE COMMITTEE: 1/25/10
BOARD OF DIRECTORS: 1/26/10

REVISED:
CORE COMMITTEE (ANESTHESIA): 7/21/10
MEDICAL EXECUTIVE COMMITTEE: 9/20/10
BOARD OF DIRECTORS: 9/28/10