Anesthesia Compliance Guide 2020

Anesthesia observes <u>four</u> types of time-out:

1. Surgery time-out

    - It must include patient identification (name and DOB), procedure, and laterality. Nothing else is required, but a facility can elect to include extra information (as is the case at TSC)
    - It must be initiated by a designated person at a designated time as determined by the facility. For SWG, it is the circulator or the surgeon, immediately before incision
    - Activity in the room must be suspended so that everyone's focus is on the person reciting the time out. Everyone must verbally concur

2. Procedure time-out

    - This is the same as the surgery time out. It applies to anesthesia procedures performed outside of the OR, or before induction: blocks, epidurals, art lines, etc.

3. Pre-induction identification

    - The anesthesia provider must confirm the patient's identity prior to the induction of GA or MAC
    - It must include name and birthdate
    - Use the patient wristband. Check this against one other ID source (e.g. the permit, chart, schedule, EMR screen, etc.)
    - Does not have to include verification by a second person, however such verbal verification is helpful
    - "Pt. ID'd in OR" is on the SWG EMR
    - "Pt. ID'd in OR" check box is on TSC anes record

4. Evaluation immediately before induction

    - This is a clinical assessment of the patient before proceeding with induction
    - This would include verification that all of the monitors are working and noting the vital signs
    - "Eval before induct" is on the SWG EMR
    - "Eval before induct" is a check box on the TSC anes record

Documentation:

1. The Pre-anesthesia Evaluation
    - The evaluation must be completed before anesthesia start time, but if the note is entered after induction, we back-time the note to the time the patient was seen in the PAA – this is per hospital QI committee protocol
2. The Anesthesia Permit
    - It is not valid without a checkbox filled
    - It can be read by the patient, but not signed by the patient until they speak with an anesthesiologist or anesthetist. (Note - the anesthesiologist must sign the permit before induction
    - Only one time & date is needed
    - Per hospital protocol, only one anesthesia permit is required for an identical procedure over a two-month period (e.g. ECT or Endo)
3. The PACU orders
    - Must be completed by arrival to PACU in order to prevent delays in treating pain and PONV
    - Can be completed in pre-op if orders are left in a planned state (not initiated), thereby the orders can changed as needed
    - May be omitted at TSC for minor cases
4. The Immediate Post-anesthesia Note
    - In the SW EMR, it is the Report to Nursing (green icon)
    - On the TSC anes record, it would be the top portion of the blue sheet, and it does not require a physician signature
5. The Post-anesthesia Assessment
    - This note can be completed as soon as the patient is able to coherently answer questions. However, avoid entering the note immediately upon arrival to PACU
    - You have up to 48 hrs to enter a note for inpatients
    - Outpatients ideally should have their note completed before discharge. However, it is acceptable to do the note after their discharge if:
        - The time that the patient was seen in recovery is included in the note. There is a place to enter that time in the body of the note, so there is no need to back-time the note
        - The note is completed on the day of discharge
    - The note must address pain, NV, respiration, hemodynamics, volume status, and mental status. These are built into the SW EMR template. At TSC, you must check all six boxes
    - The note must include a set of vitals
6. Finalization of the record must be done in a timely fashion. The time is not defined by CMS, but finalization the next day is not acceptable

Capnography:

1. Capnography is utilized for all patients undergoing moderate or deep sedation, whether administered by anesthesia (MAC) or by non-anesthesia physicians
2. Capnography is not necessary for light sedation (also called anxiolysis).
3. Capnography is used for patients receiving IV-PCA narcotics or epidurals on a regular nursing floor.
4. For IV narcotic administration not given by a PCA pump on a regular nursing floor, capnography is used for OSA and elderly patients, and if higher doses of narcotics are given (e.g. over 0.5mg Dilaudid)
5. Note – capnography is not yet available for TSC endo cases; this exception is noted in the ASA Standards

Infection prevention (pre-COVID):

1. The five opportunities for hand hygiene:
   - Before touching a patient
   - Before a sterile procedure
   - After touching a patient
   - After touching a patient's surroundings
   - After exposure to blood or body fluids
2. Scrub IV hub or medication top for 15 seconds before use
3. Hand sanitizer should be on the anesthesia cart
4. Never re-fill syringes, get a new one
5. Personal:
   - Hat has to completely cover hair
   - No exposed long sleeved shirts
   - No rings or watches during sterile procedures
   - Completely remove mask when exiting O.R.
6. Active warming instituted on all cases over 1 hour duration
7. Glucose control guidelines used on all cases
8. Antibiotic given within 1 hr (2hrs for Vanco & Cipro) of incision. Re-dose per the schedule posted in O.R.s
9. Do not pre-open ETTs (except for immediate case preparation)
10. The laryngoscope handle is disinfected between cases
11. Monitor cables, the anesthesia machine, and the anesthesia cart to be wiped down between cases

OPPE and FPPE:

1. OPPE = ongoing professional practice evaluation
2. FPPE = focused professional practice evaluation
3. OPPE is done by the department chairman every 6 months to determine competency. It is used for re-credentialing
4. FPPE is for new staff and for existing staff exhibiting adverse trends
5. Six components of evaluation:
    - Patient care
    - Medical knowledge
    - Practice-based learning (the main example for SWA is regional block technique)
    - Communication skills
    - Professionalism
    - System based practice, i.e. following protocols (located at swa10.com)

What does anesthesia do during a case if there is a fire somewhere in the department?

1. Anticipate someone else closing the wall gas valves; be ready to switch to a O_2 tank
2. Stabilize the patient; inform team of the patient's status
3. Prepare for patient transport unless otherwise directed by the fire chief
4. Work with the surgeon and the circulator to expedite the procedure (consider temporary closure)
5. Keep the doors closed

Anticoagulants Perioperatively

1. Emergency reversal. Besides blood products, we also have four-factor Prothrombin Complex Concentrate (PCC; trade name Kcentra) for the reversal of Factor X and II inhibitors
2. Patients on anticoagulants preoperatively must have a consult from the prescribing physician regarding the perioperative management of those medications

Other anesthesia considerations:

1. All meds require a label with the concentration. Notes from JC:
    - Include expiration date when not used within 24 hours
    - The date and time are not necessary for short procedures, as defined by the hospital.
    - Verification is done by two individuals qualified to participate in the procedure whenever the person preparing the medication or solution is not the person who will be administering it.
    - Label each medication or solution as soon as it is prepared, unless it is immediately administered

2. Lines must be labeled if there is more than just one line
3. The State of Ohio requires all unattended meds to be locked up with no exceptions. (Despite the fact that the JC allows for non-scheduled meds to be left unattended in a secure area such as an O.R.)
4. The state disallows syringes to be in scrub pockets
5. The state requires eye protection during patient care. If you wear glasses, they must have side shields if you are not using any other eye protection
6. SW Anes Dept Manual exists in real-time as www.swa10.com
7. The anesthesia techs follow a full machine checkout list before its first use each day
8. Trash
    - Black-out the patient's name on med bags
    - Non-scheduled meds (bottles, needleless syringes, bags) go in the purple containers
    - Empty bags, bottles, needleless syringes and tubing go into the regular trash
    - Scheduled meds must be wasted into a charcoal bottle