Department Policies and Procedures

Overview

Clinical Service Lines. This document describes the organization and philosophy of the clinical services provided by the department, and contains policies related to certain elements of clinical practice. The clinical service lines are organized into divisions serving the Vanderbilt University Hospital (VUH), the Monroe Carell Jr Children's Hospital at Vanderbilt (MCJCH), the Vanderbilt Psychiatric Hospital (VPH) and several community facilities and surgery centers (Cools Springs Surgery Center, Vanderbilt Bone and Joint Surgery Center). These divisions comprise Ambulatory Anesthesiology, Anesthesiology Critical Care Medicine, Cardiothoracic Anesthesiology, Multispecialty Adult Anesthesiology (including the section of Regional Anesthesiology and Acute Pain Medicine, and the Perioperative Consult Service), Neurosurgical Anesthesiology, Obstetric Anesthesiology, Pain Medicine (Including the Inpatient Chronic Pain Service), Pediatric Anesthesiology, and Pediatric Cardiac Anesthesiology. Organizationally, each division has a Division Chief who reports to the appropriate Vice Chair (VC) for matters related to that VC's specific portfolio, and to the Executive Vice Chair (EVC) and Chair for other matters, as depicted in the departmental organization chart. For the clinical services described here, the immediate first report for the division chiefs is the Associate Vice Chair for Clinical Affairs.

Preamble. Anesthesiology is the practice of perioperative medicine. The care of each patient demands critical analysis and careful professional judgment. Where specific elements of practice are prescribed by institutional or departmental policy, such policies apply. In all other instances, the clinical practice by health care professionals in the Department of Anesthesiology:

1. Must exceed the applicable minimum standard of care,
2. Must be bound by applicable state and federal laws, regulations, or conditions of participation, and
3. Should be informed by the principles of evidence-based medicine and the practice guidelines and advisories promulgated by the American Society of Anesthesiologists and other subspecialty professional societies.

Institutional and departmental clinical policies are linked to this document or incorporated by reference in this section. II-A contains significant institutional policies that govern clinical care throughout the institution and therefore apply to Department of Anesthesiology clinical practice. II-B presents departmental clinical policies that relate to operational clinical matters within the department.

General and Specific Operational Policies and Procedures. These are organized into specific areas of relevance and may be accessed via clicking on the link provided.

They cover the organizational and operational aspects of the clinical services provided by the department to Vanderbilt patients. They are subject to periodic review and update, and are amended as needed as the appropriate standards and expectations evolve and change. General VUMC policies and specific VUMC Anesthesiology policies and procedures are listed in the table below.

Anesthesiologist in Charge ("AIC"). Anesthesia care for procedures and surgery at VUH is coordinated on a day-by-day basis by the Anesthesiologist in Charge ("AIC") for the day at VUH, by the Ambulatory AIC for MCE, CSSC, VBJ and FEL and by the Pediatric AIC at MCJCH. In addition, some specialty areas maintain a separate "board" of work for the day.

The duties of the AIC include:

1. In collaboration with the AIC from the previous weekday, preparation of the faculty assignments for the day;
2. Being present in or immediately available to the OR environment from 0700 to 1500 on the assigned day unless relief or covering arrangements have been made;
3. Collaborating with OR nursing management in assigning added cases, moving scheduled cases, medically evaluating and approving urgent cases, and representing the Department in consultation with the OR nursing and surgical services;
4. Reviewing any case that the in-room attending wishes to postpone or cancel ("two attendings needed to cancel" rule)
5. Evaluating needs and implementing changes in the OR anesthesiology workforce on an as-needed basis as the day progresses;
6. Coordinating bed availability with the holding room and PACU charge nurses;
7. Serving as a resource to resolve conflicts or assist with clinical care challenges in the ORs and PACUs (in general, in order to be able to serve as the attending assigned to the PACU and in order to be available to assist or substitute for another anesthesiologist as requested or needed, the AIC should be assigned no more than 1 OR location at the start of the day);
8. Providing a report and hand-off to his/her relief (incoming anesthesiologist in-house, also known as "first call") and remaining available until all conflicts and significant operational matters are resolved.

The AICs at VUH are responsible for making or delegating clinical assignments in the MSA and Ambulatory Anesthesiology Divisions and for coordinating with the on-call attendings in OB and CT and on the various sub-specialty teams at VUH. The Pediatric AIC serves a similar role with respect to the operating rooms and procedure areas at MCJCH and the Divisions of Pediatric Anesthesiology and Pediatric Cardiac Anesthesiology.

At night and on weekends or holidays, there are three attending anesthesiologists assigned to in-house duty at all times: one each for the VUH ORs, Labor & Delivery, and the MCJCH ORs. These anesthesiologists serve as the AIC for their areas, fulfilling the above duties (for the assigned hours of the shift).

The anesthesia care team model. Anesthetic care provided by members of the Department of Anesthesiology at Vanderbilt is medically supervised or medically directed by an Attending Anesthesiologist who is a member of the medical staff. Anesthesia care at VUMC is delivered according to the anesthesia care team ("ACT") model. An ACT consists of an attending anesthesiologist and at least one "in-room provider" who is medically directed or medically supervised by the attending anesthesiologist. The "in-room provider" is someone qualified to provide anesthesia care: a nurse anesthetist, a resident, a fellow, or a student nurse anesthetist. Attending anesthesiologists may concurrently be responsible for more than one anesthetizing location, in line with ASA standards and guidelines. Maximum allowable ratios in the Department are set by applicable regulations and educational quality mandates. Residents, SRNAs, and CRNAs do not practice independently, except in vary rare "life-and-death" emergency situations if the attending is unable to arrive with sufficient promptness to prevent death or irreversible major harm to a patient. This will almost always occur if the attending is dealing with a similar emergency in another location (for example, dealing with an airway issue in a critical care unit), and the AIC is available to minimze this risk during the day.

Anesthesia Times. Anesthesia care begins when the anesthesia provider accepts responsibility for the patient (**Anesthesia Start**) and it continues until handoff in the post-anesthesia care area (a PACU, a Holding Area, or an inpatient floor such as an ICU) (**Anesthesia Stop**). For the duration of the period of anesthesia care, an in-room provider or an attending is continuously in the presence of the patient and is responsible for the patient's anesthetic management. A single in-room provider might provide a patient's anesthetic care for the full duration of that patient's anesthetic care, or might give report to and be relieved by another provider. Such case relief usually occurs when a provider goes off duty. It is **required** that the attending anesthesiologist be notified and approve of such relief, or initiate reconsideration of any plan for case relief should they feel this is not in the patient's best interests. For longer procedures, more than one sequential case relief might occur. At each point of case relief, the previous in-room provider is shown on the medical record to have concluded his or her responsibility to the patient and the new in-room provider may, in collaboration with the attending anesthesiologist, change aspects of the anesthetic plan. A single attending anesthesiologist might medically direct a patient's anesthetic care for the full duration of that patient's anesthetic care, or might give report to and be relieved by another attending. Such case relief usually occurs when an attending goes off duty. At such times, as a matter of courtesy, the surgeon should be informed of the transition of responsibility.

Breaks. In addition, over the course of longer cases, in-room providers are generally given brief periods of relief ("breaks"). Such breaks are generally provided approximately every 3 hours and are considered an important means to maintain alertness and vigilance, and thus promote patient safety. They are generally no longer than 15 minutes in duration (30 minutes for meals) and may be provided by any qualified in-room provider. For the duration of the break, the original in-room provider remains the provider of record and remains readily available to be called back to the room if needed. In contrast to a case relief situation (above), during a break, the original in-room provider does not conclude his or responsibility to the patient, but continues it. The original in-room provider and the attending of record continue to control the anesthetic plan and the duty of the break provider is to continue to execute that plan for the brief period of the break. During a break, the break provider signs into the "breaks" section of the anesthesia record and is shown on the medical record as an additional provider for the period of the break.

On any case where an attending anesthesiologist provides medical direction, (s)he is expected to satisfy the seven CMS-mandated requirements for medical direction. Documentation in the medical record should be concurrent or retrospective and not prospective, and must be dated and timed. The required elements of medical direction are:

1. To perform a pre-anesthetic examination and evaluation;
2. To prescribe the specific anesthesia plan;
3. To **personally participate** in the most demanding aspects of the anesthesia plan, including, if applicable, **induction and emergence**;
4. To ensure that any procedures in the anesthesia plan that (s)he does not perform are performed by a qualified individual;
5. To monitor the course of anesthesia administration at frequent intervals;
6. To remain physically present and available for immediate diagnosis and treatment of emergencies; and
7. To provide indicated post-anesthesia care.

It is required that the anesthesiologist will be readily available to personally intervene in a timely fashion on any case where (s)he provides medical direction. (S)he is required to **personally participate** in the most demanding aspects of the anesthesia plan.

Once the care of the patient has been handed off to the nursing staff in a post-anesthesia care unit, the responsibility for management of clinical issues is shared between the primary service and the Department of Anesthesiology. On call availability to meet this responsibility is the duty of the attending who provided the patient's anesthesia care, or the AIC if the attending who provided the patient's anesthesia care is not able to respond for any reason.

Request cases. A request by a patient or surgeon regarding the composition of a patient's anesthesia care team may be considered by the AIC if the request is

referenced to the patient's medical condition. Patient or surgeon requests to exclude CRNAs, SRNAs or residents from patient care or to exclude individuals based on race, gender, sexual orientation or national origin are not acceptable and will be reported to VUMC EAD. On occasion, specific faculty, residents, and CRNAs may be requested by patients or surgeons to provide care for specific cases. The assignment of the appropriate provider for a particular case is made by the AIC, who will try and honor such a request if the staff accept it, if the request is consistent with the care standards of the Department of Anesthesiology, and if the clinical schedule provides the flexibility to honor it.

Scheduling and Call. The Department has wide-ranging clinical commitments in support of the missions of every clinical department in the medical center. In order to fulfill those commitments, it is essential that individuals assigned to clinical duty or pager call be aware of and fulfill those assignments. When unavoidable events supervene, individuals must notify their Division Chief or the AIC of their unavailability, and an attempt to find appropriately skilled coverage will be made.

In order to facilitate the dissemination of daily clinical duty assignments and daily patient case assignment information to clinical faculty and staff, the Department maintains an electronic scheduling calendar system. All faculty, CRNAs, and residents are expected to maintain an active calendar subscription from this system to whatever electronic email and calendar clients they use on their computers and smartphones.

It is an expectation that all clinicians in the department will facilitate communication by providing the department their telecommunication information (landline, messaging, and cellular numbers) and by being reasonably accessible when not out of town. Individuals in leadership positions have a progressively higher obligation to be reachable by phone, text message, and email. An attending on pager call is expected to be present in the hospital within 45 minutes of receiving a request to come in.

General and Specific Clinical Operational Policies. This subsection contains internal departmental policies that govern clinical practice in one or more specialty areas.
Follow the link to access the full list of clinical policies (you will need to sign in with your VUnet ID and password to access): https://ww2.mc.vanderbilt.edu/anesfaculty/1637

1. ***The VUH Airway Response Team.*** A resident and an attending constitute the VUH Airway Response Team, as outlined in the VUH Airway Response Team Policy. Click here to access policy.

2. ***Dental injury during anesthesia.*** Teeth may be broken during anesthesia, especially during airway management, despite excellent, prudent care. The department has a policy that describes what to say and to whom to report the issue. Click here to access policy.

3. ***Pre-Anesthesia Fasting ("NPO") Policy.*** The Department has a policy that delineates the required period of fasting prior to elective procedures. The policy is standardized across all VUMC anesthetizing locations. Click here to access policy.

***Standards and Guidelines for Patient Care in Anesthesiology*.** Departmental Clinical Evidence Based Anesthesiology (CEBA) guidelines are developed and revised by departmental faculty under the supervision of the CEBA Director. These clinical guidelines are consensus documents based on literature searches and are intended to achieve consistency, minimize unnecessary variation and provide reliable service to our patients and surgeons. As a general rule, it is expected that these guidelines will be followed by all members of the department unless there is good reason not to do so. When a CEBA guideline is not followed it is expected that the clinician will indicate in the patient's medical record the overarching concerns that led the clinician to do something different from what the guideline would recommend.

ASA Standards, Guidelines, Statements, and Practice Parameters are important resources because they inform the practice of anesthesiology. They are published on the members' section of the American Society of Anesthesiologists website http://www.asahq.org/quality-and-practice-management/standards-and-guidelines with the following explanatory text (accessed April 6, 2016):

> "ASA Standards, Guidelines and Statements provide guidance to improve decision-making and promote beneficial outcomes for the practice of anesthesiology. They are not intended as unique or exclusive indicators of appropriate care. The interpretation and application of Standards, Guidelines and Statements takes place within the context of local institutions, organizations and practice conditions. A departure from one or more recommendations may be appropriate if the facts and circumstances demonstrate that the rendered care met the physician's duty to the patient.
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> "Standards provide rules or minimum requirements for clinical practice. They are regarded as generally accepted principles of patient management. Standards may be modified only under unusual circumstances, e.g., extreme emergencies or unavailability of equipment.
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> "Guidelines are systematically developed recommendations that assist the practitioner and patient in making decisions about health care. These recommendations may be adopted, modified, or rejected according to clinical needs and constraints and are not intended to replace local institutional policies. In addition, practice guidelines are not intended as standards or absolute requirements, and their use cannot guarantee any specific outcome. Practice guidelines are subject to revision as warranted by the evolution of medical knowledge, technology, and practice. They provide basic recommendations that are supported by a synthesis and

analysis of the current literature, expert opinion, open forum commentary, and clinical feasibility data.

"Statements represent the opinions, beliefs, and best medical judgments of the House of Delegates. As such, they are not necessarily subjected to the same level of formal scientific review as ASA Standards or Guidelines. Each ASA member, institution or practice should decide individually whether to implement some, none, or all of the principles in ASA statements based on the sound medical judgment of anesthesiologists participating in that institution or practice."

"ASA practice parameters provide guidance in the form of requirements, recommendations, or other information intended to improve decision-making and promote beneficial outcomes for the practice of anesthesiology. The use of practice parameters cannot guarantee any specific outcome. Practice parameters are subject to periodic revision as warranted by the evolution of medical knowledge, technology and practice. Variance from practice parameters may be acceptable, based upon the judgment of the responsible anesthesiologist."