### PURPOSE:
To develop a safe, consistent and appropriate plan for anesthesia patient care and to ensure that appropriate documentation is reflected pre-anesthesia, peri-anesthesia and post-anesthesia.

### POLICY STATEMENT:
Every patient will be evaluated by the anesthesiologist prior to the administration of anesthetics for moderate or deep sedation and general anesthesia. The visit should include a review of all pertinent information relative to the choice of anesthesia and the surgical, obstetrical, or other procedure anticipated. An anesthesiologist will be responsible for determining the medical status of the patient, developing a plan of anesthesia care, and acquainting the patient or the responsible adult with the proposed plan that will include options and risks. A certified registered nurse anesthetist (CRNA) may administer anesthetics under the supervision of the anesthesiologist who is immediately available if needed. The plan, options, and risks will be discussed with each patient and also documented in the patient’s record. A safe environment will be maintained for each patient.

The standards for basic intraoperative monitoring will apply to all anesthesia care, although, in emergency circumstances, appropriate life support measures take precedence. These standards may be exceeded at any time based on the judgment of the responsible anesthesiologist. They are intended to encourage high quality patient care, but observing them cannot guarantee any specific patient outcome.

### EXCEPTIONS:
Under extenuating circumstances, the responsible anesthesiologist may waive the requirements marked with an asterisk (*); it is recommended that when this is done, it should be so stated (including the reasons) in a note in the patient’s medical record.

### DEFINITION(S):
- **Continual** is defined as “repeated regularly and frequently in steady rapid succession.”
- **Continuous** means, “prolonged without any interruption at any time.”
PROCEDURE: Pre-Anesthesia

These standards apply to all patients who receive anesthesia or monitored anesthesia care. Under unusual circumstances, e.g., extreme emergencies, these standards may be modified. When this is the case, the circumstances shall be documented in the patient’s record.

1. An anesthesiologist shall be responsible for determining the medical status of the patient, developing a plan of anesthesia care and acquainting the patient or the responsible adult with the proposed plan. Development of an appropriate plan of anesthesia care is based upon:
   a) Reviewing the medical record
   b) Interviewing and examining the patient to:
      1) Discuss medical history, previous anesthetic experiences and medical history.
      2) Assess those aspects of the physical condition that might affect decisions regarding perioperative risk and management.
   c) Assignment of ASA physical status.
   d) Obtaining and/or reviewing objective diagnostic data (e.g., laboratory, ECG, X-ray) tests and consultations necessary to the conduct of anesthesia.
   e) Determining the appropriate prescription of preoperative medications as necessary to the conduct of anesthesia. The responsible anesthesiologist shall verify that the above has been properly performed and documented in the patient’s record.
   f) The anesthesia provider assesses and documents the patient’s condition immediately prior to the induction of anesthesia.
   g) Medications must be prepared for each individual patient; preparing multiple patients’ medications (“batching”) is not permitted according to Pharmacy policy. Always prepare medication immediately prior to use and label non-pharmacy prepared medication with the following information: drug name, concentration (e.g., 1%, 10 mg/ml) and amount if not readily apparent from container. Controlled substances will be securely stored to prevent diversion in accordance with hospital policy and State and Federal laws and regulations.
   h) Induction of anesthesia shall only begin after confirmation that the surgeon is available in-house (defined as on the medical campus: SMH campus, Cape Surgery Center, Waldemere Medical Plaza, Doctor’s Gardens, Medical Arts Building, and Heart and Vascular Center). EXCEPTION: For procedural areas the proceduralist should be present before induction.

2. The anesthesia provider will perform the First Use Check, which includes checking the function of the anesthesia machine prior to its first use during any workday, will be performed. At a minimum, the following shall be determined:
a) There is no external damage that compromises function.
b) Adequate main and reserve oxygen supplies are available.
c) The following components, if present, have no visible damage and function correctly:
   1) Flow sensitive fresh gas ratio protection or warning system.
   2) Inspired gas oxygen analyzer and its audible lower-limit alarm.
   3) Breathing system.
   4) Mechanical ventilator and the monitor for breathing system disconnect.
   5) Waste anesthesia gas (WAG) scavenging system.
   6) There are no clinically significant leaks in the anesthesia machine or the breathing system.

Peri-Anesthesia

1. Qualified anesthesia personnel shall be present in the room throughout the conduct of all general anesthetics, regional anesthetics, and monitored anesthesia care.
   a. Because of the rapid changes in patient status during anesthesia, qualified anesthesia personnel shall be continuously present to monitor the patient and provide anesthesia care.
   b. In the event there is a direct known hazard, e.g., radiation, to the anesthesia personnel which require intermittent remote observation of the patient, some provision for monitoring the patient must be made. In the event that an emergency requires the temporary absence of the person primarily responsible for the anesthetic, the best judgment of the anesthesiologist will be exercised in comparing the emergency with the anesthetized patient’s condition and in the selection of the person left responsible for the anesthetic during the temporary absence.

2. During all anesthetics, the patient’s oxygenation, ventilation, circulation and temperature shall be continually evaluated.
   a. Oxygenation: To ensure adequate oxygen concentration in the inspired gas and the blood during all anesthetics.
      1) Methods
         a) Inspired gas: During every administration of general anesthesia using an anesthesia machine, the concentration of oxygen in the patient breathing system shall be measured by an oxygen analyzer with low oxygen concentration limit alarm in use.*
         b) Blood oxygenation: during all anesthetics, a quantitative method of assessing oxygenation, such as pulse oximetry, shall be employed.* Adequate illumination and exposure of the patient is necessary to assess color.* The
variable pitch pulse tone and the low threshold alarm shall be audible to the anesthesiologist or the anesthesia care team personnel.

b. Ventilation: To ensure adequate ventilation of the patient during all anesthetics.
   1) Methods
   a) Every patient receiving general anesthesia shall have the adequacy of ventilation continually evaluated. Qualitative clinical signs such as chest excursion, observation of the reservoir breathing bag and auscultation of breath sounds are useful. Continual monitoring for the presence of expired carbon dioxide shall be performed unless invalidated by the nature of the patient, procedure or equipment.
   b) When the endotracheal tube or laryngeal mask is inserted, its correct positioning must be verified by clinical assessment and by identification of CO2 analysis in the expired gas. Continual end-tidal CO2 analysis, in use from the time of endotracheal tube/laryngeal mask placement, until extubation/removal or initiating transfer to a postoperative care location, shall be performed using a quantitative method such as capnography, capnometry or mass spectroscopy.* When capnography or capnometry is utilized, the end tidal CO2 alarm shall be audible to the anesthesiologist or the anesthesia care team personnel.
   c) When a mechanical ventilator controls ventilation, there shall be in continuous use a device that is capable of detecting disconnection of components of the breathing system. The device must give an audible signal when its alarm threshold is exceeded.
   d) During regional anesthesia and monitored anesthesia care, the adequacy of ventilation shall be evaluated, at least by continual observation of qualitative clinical signs. During moderate or deep sedation the adequacy of ventilation shall be evaluated by continual observation of qualitative clinical signs and monitoring for the presence of exhaled carbon dioxide unless precluded or invalidated by the nature of the patient, procedure, or equipment.

c. Circulation: To ensure the adequacy of the patient’s circulatory function during all anesthetics.
   1) Methods
a) Every patient-receiving anesthesia shall have the electrocardiogram continuously displayed from the beginning of anesthesia until preparing to leave the anesthetizing location.*
b) Every patient receiving anesthesia shall have arterial blood pressure and heart rate determined and evaluated at least every five minutes.*
c) Every patient receiving anesthesia shall have, in addition to the above, circulatory function continually evaluated by at least one of the following: palpitation of a pulse, auscultation of heart sounds, monitoring of a tracing of intra-arterial pressure, ultrasound peripheral pulse monitoring, or pulse plethysmography or oximetry.
d) During regional anesthesia and monitored anesthesia care, the adequacy of ventilation shall be evaluated, at least by continual observation of qualitative clinical signs.

d. Body Temperature: To aid in the maintenance of appropriate body temperature during all anesthetics.
   1) Methods
      a) Every patient-receiving anesthesia shall have temperature monitored when clinically significant changes in body temperature are intended, anticipated or suspected.

3. Monitoring and Documentation
   a. Monitoring and documentation of the patient’s status during this phase will include but is not limited to:
      1) Immediate review prior to initiation of anesthetic procedures
      2) Patient reevaluation
      3) Check of equipment, drugs and gas supply
      4) Vital signs recorded immediately prior to induction will be the pre-op vital signs and documented on the Anesthesia Record as follows:
         X = Induction Time
      5) Monitoring of the patient (e.g., recording vital signs)
      6) Ventilation will be noted as follows:
         SV = Spont
         SAV = Assisted
         CV = Controlled
      7) Amounts of all drugs and agents used and times given.
      8) The type and amounts of all intravenous fluids used including blood and blood products and times given. All blood bank products administered during anesthesia and surgery are to be accounted for prior to discharge of the patient from anesthesia care.
Documentation on either the Anesthesia Record or Blood Bank bag tag will include unit numbers, start and stop times, patient vital signs, and volume infused. If required elements of documentation are noted on the Anesthesia Record, the bag tag will be labeled with the sticker: “See Anesthesia Record.” Any reaction or incident involving the administration of blood bank products, as well as patient outcomes, will be recorded and reported per hospital procedure Blo12 Reactions to Blood and Blood Components. In emergencies or other situations requiring massive, rapid transfusions, a scribe will be assigned to assist with tracking and recording transfusions.

9) The technique(s) used.
10) Unusual events during the anesthesia period.
11) Any suspected equipment malfunction will be immediately reported and remedied. Documentation on the Anesthesia Record will include the nature of the malfunction, how it was remedied, and the patient’s condition during and after the event. An Occurrence Reported will be completed per policy 00.RSK.12 Sentinel/Adverse Event/Incident/Occurrence/Medication Variance/Identity Theft: Reporting And Management.

12) The status of the patient at the conclusion of anesthesia.

b. Patients receiving moderate sedation will be managed according to SMHCS Policy # 00.PAT.38, Moderate Sedation.

c. Staff may review clinical reference material during the peri-anesthesia phase.

Post-Anesthesia
These standards apply to post-anesthesia care in all locations. These standards may be exceeded based on the judgment of the responsible anesthesiologist. They are intended to encourage quality patient care, but cannot guarantee any specific patient outcome. They are subject to revision from time to time as warranted by the evolution of technology and practice.

1. All patients who have received general anesthesia, regional anesthesia or monitored anesthesia care shall receive appropriate post-anesthesia management.

a. A Post-Anesthesia Care unit (PACU) or an area that provides equivalent post-anesthesia care (for example, a Surgical Intensive Care Unit) shall be available to receive patients after anesthesia care. All patients who receive anesthesia care shall be admitted to the PACU or its equivalent except by specific order of the anesthesiologist responsible for the patient’s care.

b. The medical aspects of care in the PACU shall be governed by policies and procedures that have been reviewed and approved by the Department of Anesthesiology.

c. The design, equipment and staffing of the PACU shall meet
requirements of the facility’s accrediting and licensing bodies.

2. A member of the anesthesia care team who is knowledgeable about the patient’s condition shall accompany a patient transported to the PACU. The patient shall be continually evaluated and treated during transport with monitoring and support appropriate to the patient’s condition.

3. Upon arrival in the PACU, the patient shall be re-evaluated and a verbal report provided to the responsible PACU nurse by the member of the anesthesia care team who accompanies the patient.
   a. The patient’s status on arrival in PACU shall be documented.
   b. Information concerning the preoperative condition and the surgical/anesthetic course shall be transmitted to the PACU nurse.
   c. The member of the Anesthesia Care Team shall remain in the PACU until the PACU nurse accepts responsibility for the nursing care of the patient.

4. The patient’s condition shall be evaluated continually in the PACU.
   a. The patient shall be observed and monitored by methods appropriate to the patient’s medical condition. Particular attention should be given to monitoring oxygenation, ventilation, circulation, level of consciousness, and temperature. During recovery from all anesthetics, a quantitative method of assessing oxygenation such as pulse oximetry shall be employed in the initial phase of recovery.* This is not intended for application during the recovery of the obstetrical patient in whom regional anesthesia was used for labor and vaginal delivery.
   b. An accurate written report of the PACU period shall be maintained. Use of an appropriate PACU scoring system or discharge standards is encouraged for each patient on admission, at appropriate intervals prior to discharge and at the time of discharge.
   c. General medical supervision and coordination of patient care in the PACU should be the responsibility of an anesthesiologist.
   d. An anesthesiologist will remain available in the facility to manage anesthesia related complications and provide cardiopulmonary resuscitation until patients have met PACU discharge criteria.

5. A physician is responsible for the discharge of the patient from the post-anesthesia care unit.
   a. Patients will be discharged in accordance with department policy 139.1603 Admission/Discharge Criteria: Post Anesthesia Care Units (PACU).
   b. Post-anesthesia documentation should include:
      1) Patient evaluation on admission and discharge from the post anesthesia care unit.
      2) A time-based record of vital signs and level of consciousness.
      3) A time-based record of drugs administered their dosage and route of administration.
4) Type and amounts of intravenous fluids administered, including blood and blood products.

5) Any unusual events including post anesthesia or post procedural complications. Documentation in the Anesthesia Record will include unusual occurrences pertinent to patient outcomes such as equipment malfunctions or adverse drug reactions, actions taken to remedy the malfunction or treat the patient, patient response during and after the incident, and patient outcome. In addition, documentation will include notation of report to the surgeon and/or relief staff. Adverse events will be reported per policy 00.RSK.12 Sentinel/Adverse/Event/Incident/Occurrence/Medication Variance: Reporting and Management.

6) Post anesthesia visits.

RESPONSIBILITY: It is the responsibility of the Medical Director of Anesthesia to assure that this policy is adhered to. It is the responsibility of each independent practitioner to make sure this policy is followed on his or her patients.


State of Florida Agency for Health Care Administration (AHCA), 59A-3.2085, Hospital Licensure H3.06

Aspen Federal Regulation Set, A19.03

Commission, Oakbrook Terrace, Illinois

Sarasota Memorial Health Care System Policy #00.PAT.38, Moderate Sedation

Sarasota Memorial Health Care System Policy (Pharmacy) #129.007/126.203 Medication Storage and Compliance Monitoring

REVIEWING
Dr. Sean Daley, Chief of Anesthesia

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ATTACHMENT(S): Continuum of Depth of Anesthesia
### APPROVALS:

Signatures indicate approval of the new or reviewed/revised department policy

<table>
<thead>
<tr>
<th>Committee/Sections (if applicable):</th>
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<tbody>
<tr>
<td>Clinical Practice Council</td>
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<tr>
<td>Signature:</td>
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<tr>
<td>Title:               Director of Perioperative Services</td>
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<tr>
<td>Title:               Vice President/Administrative Director (if applicable):</td>
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<td>Signature:</td>
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<tr>
<td>Title:               Connie Andersen, Vice President and Chief Nursing Officer</td>
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Definition of General Anesthesia and Levels of Sedation/Analgesia*
(Approved by House of Delegates on October 13, 1999)

<table>
<thead>
<tr>
<th></th>
<th>Minimal Sedation (Anxiolysis)</th>
<th>Moderate Sedation/Analgesia (&quot;Conscious Sedation&quot;)</th>
<th>Deep Sedation/Analgesia</th>
<th>General Anesthesia</th>
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<tbody>
<tr>
<td><strong>Responsiveness</strong></td>
<td>Normal response to verbal stimulation</td>
<td>Purposeful** response to verbal or tactile stimulation</td>
<td>Purposeful** response following repeated or painful stimulation</td>
<td>Unarousable even with painful stimulus</td>
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<td><strong>Airway</strong></td>
<td>Unaffected</td>
<td>no intervention required</td>
<td>Intervention may be required</td>
<td>Intervention often required</td>
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<td><strong>Spontaneous Ventilation</strong></td>
<td>Unaffected</td>
<td>Adequate</td>
<td>May be inadequate</td>
<td>Frequently inadequate</td>
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<td><strong>Cardiovascular Function</strong></td>
<td>Unaffected</td>
<td>Usually maintained</td>
<td>Usually maintained</td>
<td>May be impaired</td>
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Minimal Sedation (Anxiolysis) is a drug-induced state during which patients respond normally to verbal commands. Although cognitive function and coordination may be impaired, ventilatory and cardiovascular functions are unaffected.

Moderate Sedation/Analgesia ("Conscious Sedation") is a drug-induced depression of consciousness during which patients respond purposefully** to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

Deep Sedation/Analgesia is a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully** following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.

General Anesthesia is a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

Because sedation is a continuum, it is not always possible to predict how an individual patient will respond. Hence, practitioners intending to produce a given level of sedation should be able to rescue patients whose level of sedation becomes deeper than initially intended. Individuals administering Moderate Sedation/Analgesia ("Conscious Sedation") should be able to rescue patients who enter a state of Deep Sedation/Analgesia, while those administering Deep Sedation/Analgesia should be able to rescue patients who enter a state of general anesthesia.

- Monitored Anesthesia Care does not describe the continuum of depth of sedation; rather it describes "a specific anesthesia service in which an anesthesiologist has been requested to participate in the care of a patient undergoing a diagnostic or therapeutic procedure."

**Reflex withdrawal from a painful stimulus is NOT considered a purposeful response.