MINIMIZE YOUR PRACTICE LIABILITY WITH A LOSS PREVENTION CHECKUP.
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*This interactive guide is not a standard of care. Any guidelines suggested here are not rules, do not constitute legal advice, and do not ensure a successful outcome. The ultimate decision regarding the appropriateness of any action or treatment must be made by each health care practitioner in light of all circumstances prevailing in the individual situation and in accordance with the laws of the jurisdiction in which the care is rendered.*
How to Use This Interactive Guide

This review is not a test. It is an interactive guide designed to help you uncover areas in your practice that could create liability risks.

There is no scoring system. The options for responding to the statements are Always/Yes, Sometimes, Never/No, and N/A. The ideal response to every statement is Always/Yes or N/A. Any other response indicates an area of potential malpractice exposure in your practice that should be addressed and resolved.

Respond to the statements as objectively and honestly as you can. The effectiveness of this interactive guide depends on how candid you are.

The guide is divided into 12 sections. These sections reflect the most frequent patient safety/risk management issues identified in our closed claims.

You can evaluate your practice and systems as a whole or focus only on the sections that are areas of concern.

We understand that you may be one of a large number of anesthesia providers in your group. We also realize that you may be working in more than one facility. Feel free to share this guide with the colleagues in your group since this information could easily be used as part of a performance improvement activity, either within your anesthesia group or in your work sites. Since practice environments and cultures differ, we encourage you to use this guide for each of your work sites.

Knowledge Center

Our extensive online library of articles at www.thedoctors.com/psarticles is considered to be the industry’s definitive resource on today’s most pressing patient safety/risk management and health care policy issues.

Expert Team of Trained Specialists

Our patient safety program is led by an expert team of patient safety specialists, trained medical and patient safety professionals who work tirelessly with member physicians to implement risk management strategies tailored to their specialty and practice.

Our specialists operate regionally and are available to our members for consultation nationwide. E-mail us at patientsafety@thedoctors.com, or call us at (800) 421-2368, extension 1243, and we will connect you with your regional patient safety/risk manager.

If you have an urgent patient safety or claims issue, our specialists are available 24 hours a day, 365 days a year on our nationwide hotline at (800) 421-2368.
Communications

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**ACCESS**

1. There is an effective way for patients and/or family members to reach you with concerns or questions prior to or after the procedure.

2. There is an effective way for the hospital staff to reach you immediately in the event of an emergency.

3. There is an effective backup plan for availability of another anesthesia provider in the event you are occupied with another case and an urgent need arises.

**TIMELINESS**

4. There is a specific time frame for seeing patients who are newly admitted to the pre-op area.

5. There is a specific time frame after being notified by the nurse for seeing patients who are experiencing significant changes in their postoperative status.

6. There is a specific time frame for reporting to the operating room (OR) when called to an emergency case.

**PHYSICIAN-PATIENT COMMUNICATION**

7. You sit at eye level when communicating with a patient.

8. You use active listening techniques when the patient is speaking to you.

9. You ask patients to repeat back to you what you said when giving important instructions or information.

10. You are careful to treat patients' health concerns and anesthesia fears seriously.

11. Family involvement is encouraged both preoperatively and postoperatively.

12. You introduce yourself to the patient and family members and outline what your participation in the patient's care will be.

13. When lateral handoffs occur, you inform the patient of who will be taking over his or her care.
# Communications

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## PHYSICIAN-NURSE COMMUNICATION

14. There are established protocols of communication, such as SBAR (Situation, Background, Assessment, Recommendation), between the anesthesia provider and the nursing staff.

15. You encourage nursing staff to contact you whenever they are in doubt about therapy, orders, legibility, or concerns about the patient.

16. You require read-back or repeat-back for verification of all verbal and telephone orders that you give.

17. You know which abbreviations are on the facility’s list of unapproved abbreviations.

18. Your standing orders have been approved by the medical staff per facility rules and regulations.

19. When using standing orders, you use only approved standing orders for your anesthesia group.

20. You individualize standing orders or order sets for each patient.

21. You solicit input, listen to, and respond to suggestions from nursing or other clinical staff.

22. You praise good work and success in fellow team members.

23. You use a checklist, such as the WHO Surgical Safety Checklist, to review patient-specific and team-specific issues prior to induction, during the time out, and before the patient leaves the operating room.

24. You debrief the health care team after significant patient events that affect the care and treatment of the patient.

## PHYSICIAN-PHYSICIAN COMMUNICATION

25. When coming on shift, you review all active anesthesia orders for inpatients to assure patient care coordination.

26. You use a standardized physician-to-physician communication process during handoffs, such as SBAR or a checklist.

27. The handoff takes place face-to-face.
Communications

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<td>28. The handoff provides the opportunity for questions to be asked and answered.</td>
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<td>29. There is a sign-out process used when going off shift or off service.</td>
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<td>30. You brief covering physicians about any anticipated patient care problems, pending significant laboratory results, or other relevant procedures or consultations.</td>
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**TIPS**

- Remember to actively listen to your patients' concerns and acknowledge that they have been heard.
- Treat your patients the way you would want to be treated.
- Be aware of body language and verbal congruence.
- Ask the patient to repeat back to you what he or she heard you say.
Coordination of Care: Diagnostic Results, Surgeon, Primary Care Physician

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**LABORATORY TESTS**

1. You document your review of lab and test result reports by time, date, and initials or electronic signature.

2. There is a process for communicating urgent test results to another anesthesia team member when the ordering practitioner is absent.

3. When there are abnormal lab findings (even if not anesthesia related), a follow-up plan is established with the patient and documented in the record, or, when appropriate, the patient’s refusal to cooperate with the plan is documented.

4. There is a system in place to reconcile laboratory tests ordered with results received so that someone will follow up if results are not received while the patient is still under the anesthesia provider’s care.

5. You clarify responsibility for specific patient diagnostic or treatment follow up with the surgeon/primary care physician (PCP). Assignment of follow-up care is documented (e.g., the PCP will manage postoperative anticoagulant therapy).

**HOSPITAL/FACILITY SYSTEMS**

6. The anesthesia group provides information to the primary surgeon/PCP regarding the roles and responsibilities of the anesthesia provider in patient care.

7. At the time of preoperative admission, you are routinely provided with access to necessary records from the surgeon/PCP to allow understanding of the patient and his or her medical status.

**DURING HOSPITALIZATION**

8. You notify the surgeon/PCP when there are significant patient events, such as transfer to the ICU, resuscitation, clarification of code status, or deterioration in postoperative status.

9. If there is a disagreement between the anesthesia provider and surgeon/PCP regarding some aspect of treatment, you work together cooperatively to find approaches that will address each practitioner’s concerns.

10. There is a process (such as chain of command) that will assist you in the event there is a disagreement within the team about the patient’s treatment.
Coordination of Care: Diagnostic Results, Surgeon, Primary Care Physician

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**CONSULTS**

11. You provide advice and consultation to other physicians or providers only after seeing the patient.

12. If another provider asks for a “curbside” consult and refers to a specific patient and specific history, you ask to see the patient and provide a full formal, documented consult.

13. You document any informal or “curbside” consults that you provide or receive.

**CO-MANAGEMENT BETWEEN SURGEON AND ANESTHESIA PROVIDER**

14. There is an agreement between the surgeon and anesthesia provider as to who will manage:

   a. the pre-surgical period in the hospital,
   b. laboratory and diagnostic test ordering and result follow up,
   c. pain control,
   d. blood thinners,
   e. medical conditions, and
   f. communication with the family and patient regarding significant issues.

15. There is an agreement on how surgical admissions will be handled, e.g., triage of cases coming through the emergency medicine department.

16. There is a communication process in place so that if the surgeon changes, the anesthesia provider will be aware of the change.

17. Anesthesia providers and surgeon specialties have agreed upon protocols of care, e.g., deep vein thrombosis (DVT) prophylaxis.
Operating Room Safety

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**TRAINING**

1. Anesthesia staff members participate in annual OR fire safety training.

2. Periodic training includes simulations of emergency situations (fires in the OR, hemorrhage, respiratory arrest, malignant hyperthermia, equipment malfunctions, etc.).

3. A debriefing of simulation exercises is conducted to help identify areas for improvement in teamwork, department processes, and individual knowledge and skill.

4. You have attended team training, such as TeamSTEPPS or Crew Resource Management to assist with OR team communication.

**COMMUNICATION**

5. You participate with proper attention to a time out conducted immediately before the start of each OR procedure.

6. There is a policy in place to halt surgery if the surgical verification process fails (except in case of emergency).

7. You foster an atmosphere of open communication among all members of the OR team.

8. You are supportive of staff members who raise concerns related to patient safety in the OR.

**PATIENT SAFETY**

9. Procedures are in place to safely identify and manage high-risk patients. (Reference: American Society of Anesthesiologists Physical Status Classification System.)

10. You evaluate all surgical patients to determine if low flow and less than 30 percent supplemental oxygen or air (not 100 percent oxygen) could be used for facial, mouth, and throat surgery to reduce the risk of fire.

11. Your anesthesia group’s policy prohibits you from disabling clinical alarms in the OR or postanesthesia care unit (PACU).
Medical Records

A complete and accurate medical record promotes quality patient care by providing a comprehensive patient history and by facilitating continuity of care among all members of the health care team. One out of four malpractice cases is based on the medical record. A good record should reflect the care provided and the rationale behind the medical decisions when indicated. It should also be free of any alteration that gives the impression that the record is incomplete or lacks credibility.

Medical records should fulfill many purposes. Medical records:

- describe the patient’s health history,
- document the diagnosis and treatment plan,
- serve as a basis for communication among health care team members,
- serve as the means for obtaining proper reimbursement if content substantiates billing codes,
- promote quality assurance by documenting the standards and patterns of care of the practitioner and providing data for administrative and medical decisions,
- prove compliance with licensure and accreditation standards,
- facilitate successful peer review to promote quality of care,
- provide the best evidence of care, and
- facilitate research and education.

Above all, the medical record is a legal, historical document.

If the facilities where you practice use an electronic health record, see our supplemental Interactive Guide for Electronic Medical Records to help you uncover areas of potential risk.

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1. The assessments are supported by documentation of objective and subjective observations.
2. An expert reviewer would be able to follow and support your medical judgment from review of your records.
3. There is a field in the anesthesia record for the patient’s allergy status to be prominently noted.
4. Your handwritten notes are legible.
5. All notes are signed, dated, and timed.
6. The patient’s name and date of service appear on each page of the medical record.
7. You have been oriented to and follow IT security requirements when using the facility’s electronic health record.
Medical Records

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8. You adhere to the facility's rules and regulations (per medical staff bylaws or Medicare/Medicaid Conditions of Participation) pertaining to documentation, including authenticating, signing, and dating entries and completing timelines for assessments, progress notes, and discharge notes.

9. Your verbal and telephone orders are authenticated, dated, and timed in accordance with the facility's policies (but within 48 hours).

**PREANESTHESIA CARE**

10. A current patient history and physical examination report is reviewed prior to initiating anesthesia care.

11. A comprehensive preanesthesia care evaluation is documented prior to anesthesia induction for all nonemergency patients and includes, at a minimum:

   a. current medical condition and reason for anesthesia,
   b. review of medical and surgical history,
   c. review of anesthesia history,
   d. review of family history, including family's anesthesia history and history of adverse reactions,
   e. review of diagnostic data, including pregnancy test results for women of childbearing age, as indicated,
   f. review of referrals and/or medical clearances,
   g. review of medication history and current medications, including over-the-counter (OTC) and herbal preparations,
   h. allergies and drug reactions, including latex allergy,
   i. airway evaluation,
   j. fasting status,
   k. status of advance directives,
   l. preexisting peripheral nerve injury,
   m. dental health history and assessment, and
   n. assigned ASA classification.
Medical Records

Always/Yes Sometimes Never/No N/A

12. The anesthesia plan discussion and patient acceptance of the plan are documented.

13. Written consent specific to the anesthesia modality selected and specific to the patient’s current medical and surgical condition is obtained.

14. A preanesthesia equipment checklist is completed and documented.

15. Documentation includes verification of:
   a. the patient’s identification,
   b. the procedure to be performed,
   c. the site or side of the procedure,
   d. patient allergies,
   e. consent documents,
   f. surgery schedule posting, and
   g. preoperative orders.

16. An immediate preanesthesia/pre-induction reassessment is documented.

17. The management of an automated implantable cardioverter-defibrillator (AICD) is documented and includes the name of the person suspending function and the method used.

INTRAOPERATIVE CARE

18. Documentation reflects the following:
   a. The anesthesiologist’s presence at the time of induction.
   b. The implementation of protective measures: eye protection and padding/positioning aids.
   c. Intubation details: type, size, absence or presence of cuff, any problems encountered, time of intubation and extubation.
   d. The following parameters, with time and results noted according to policy: oxygenation using pulse oximetry, ventilation using end-tidal carbon dioxide (CO₂) and circulation using a continuous electrocardiogram (ECG).
   e. Correct positioning of the endotracheal tube or laryngeal mask (i.e., by clinical assessment and measurement of the amount of CO₂ in the expired gas).
Medical Records

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- f. Drug administration (medication, dose, route, and time).
- g. The patient's response to drugs, interventions, and care provided.
- h. Administration of blood/blood products and IV fluids.
- i. Urine output and estimated blood loss.
- j. Transfer of care to another anesthesia provider.
- k. The signature of the licensed anesthesia provider.

**POSTANESTHESIA CARE**

- 19. Anesthesia and procedure start and end times are documented.
- 20. Reestablishment of AICD functioning is documented and includes the name of the person reestablishing function and the results of any testing conducted.
- 21. Documentation includes the following:
  - a. The patient's neurological status, vital signs, and condition prior to transfer from recovery.
  - b. A postanesthesia evaluation (completed after the procedure and before discharge from recovery).
  - c. Details of the report to recovery room staff, including the time the report is given and the name of the staff member receiving the report, as well as the patient's:
    - i. mental status,
    - ii. body temperature,
    - iii. pain,
    - iv. nausea and vomiting,
    - v. hydration,
    - vi. urine output,
    - vii. drainage and bleeding, and
    - viii. airway patency.
  - d. Anesthesia care orders (monitors, ventilator, medications) and patient disposition (intensive care unit [ICU], critical care unit [CCU], etc.).
### Medical Records

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**e.** Recovery room discharge order.

**f.** Outpatient discharge instructions (with copy given to a responsible adult), if the patient is being discharged.

**22.** A postanesthesia progress note is documented and includes the procedure, anesthesia modality performed, outcome, anesthesia complications, and appropriate details for continuity of care.

**23.** Each patient is discharged from the recovery room by the anesthesia provider in person or by established criteria coupled with a written order for discharge by criteria.

**24.** The criteria for transition from recovery to discharge are documented.

### TIPS

- If it is not documented, it did not happen.
- Do not write “error” when making a correction. Line through the entry, then date it and initial it. The corrected entry should be added as the next entry and should have the current date.
Medication Management

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<td>The patient’s identity is verified prior to medication administration.</td>
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<td>The patient’s allergy status is checked prior to medication administration.</td>
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<td>All syringes and IV bags containing medications are clearly and completely labeled.</td>
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<td>Labels are standardized with font size, color, and information.</td>
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<td>Medication vials and labels are double checked when medications are drawn up.</td>
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<td>Medication vials and labels are double checked prior to administration to a patient.</td>
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<td>Medication vials, syringes, vaporizers, and administration equipment and supplies are checked prior to the start of the procedure.</td>
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<td>Syringes and vials of narcotics are kept securely locked when not in use.</td>
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<td>Anesthesia carts are standardized with respect to the location, types, concentrations, doses, etc., of medications.</td>
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<td>Anesthesia carts and workspace are kept tidy so that medications can be accessed quickly in emergencies.</td>
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<td>Medication inventory is minimized as much as possible and concentrations standardized.</td>
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<td>Different medications with look-alike packaging and labels are not used.</td>
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<td>Medication entries on the anesthetic record are accurate, timely, and legible.</td>
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<td>Blood and blood products are administered according to facility policy.</td>
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<td>Medication errors and near misses are reported and analyzed for patient safety improvements.</td>
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<td>Before administering anesthetics and other medications, you have reviewed the patient’s most recent prescribed medications, herbal products, and over-the-counter drugs.</td>
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Medication Management

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17. If there is a hospital requirement that you reorder medications when the patient is admitted or transferred, you do not use the order “continue home meds” or “resume previous meds.”

18. You use the computerized physician order entry per facility policy.

19. You require read back of verbal and telephone medication orders to assure that the orders are complete and accurate.

20. You have access to Epocrates or a current edition of the Physicians’ Desk Reference.

21. You were oriented to the facility’s medication management system.

22. You ensure that medication reconciliation takes place prior to discharge or transfer.

23. You use a written protocol for pain management.

24. You use a written protocol for narcotic use.

25. You have registered with the PDR Alert Network (formerly the Health Care Notification Network) to receive electronic drug alerts, and you review alerts as they are received.

26. Prophylactic antibiotics are administered and documented according to facility policy and/or per preoperative orders prior to the start of the procedure.

**TIPS**

- Review a patient’s medication history during the preanesthetic evaluation. Include prescription medications, over-the-counter medications, vitamins, herbal products, dietary supplements, alternative medicines, and homeopathic medications.

- Ensure that the patient receives an up-to-date list of medications at discharge.

- Involve the patient as an active participant in his or her own medication management when possible.

- Consider technology that can measure the dose of medication administered at the point of care and incorporate that information into an automated anesthetic record.
Informed Consent and Refusal

Informed consent to medical treatment is based on the following beliefs:

- Patients generally have only a basic understanding of the medical sciences.
- Adults of sound mind have the right to determine whether to submit to medical treatment and to decide what will happen to their own bodies.
- A patient’s consent to treatment must be an informed decision.
- The patient trusts and depends on his or her physician for the information needed to make an informed decision.

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- The anesthesia provider’s informed consent discussion is documented in the preanesthesia notes.
- The discussion includes the benefits, risks, complications, expected outcomes, and limitations associated with the recommended anesthesia plan, as well as the alternatives.
- The patient's concerns and questions and acceptance of the anesthesia plan are included in the documentation.
- An anesthesia consent form, separate from the surgical consent, is used to obtain written consent for anesthesia care and services.
- The consent form includes a description of the proposed anesthesia modality and plan in nonmedical terms that the patient can understand.
- There is documentation of the discussion regarding withdrawal of "Do Not Resuscitate" orders during the intraoperative period.
- Written consent to rescind “Do Not Resuscitate” orders during the intraoperative period is obtained.
- You have an informed refusal form for patients who decline the recommended anesthesia plan.
- When the patient requires an interpreter, the name of the interpreter appears on all consent forms and is noted in documentation of the consent process.
- There is a policy to delay or cancel nonemergency surgery if appropriate anesthesia consent cannot be obtained.
Informed Consent and Refusal

TIPS

• The process of obtaining informed consent (not merely signing a form) is the anesthesia provider’s responsibility and cannot be delegated.

• When documenting informed consent or informed refusal, do not use abbreviations.

• When discussing a procedure or treatment with the patient, use words that the patient understands. If there is an issue regarding the patient’s ability to comprehend due to a language barrier or disability, an interpreter should be provided.

• When appropriate, distinguish right from left (using the word, not an abbreviation) on the form and in your documentation.

• When a competent adult patient refuses treatment, document his or her decision in the medical record, including the patient’s acknowledgment of the risks of refusal.

• Date and time all entries in the medical record regarding informed consent and informed refusal.

• Ensure that the patient has enough information to make an informed decision. Explain to the patient how to contact you if he or she has other questions.

• To be effective, the information given to the patient must be appropriate to the literacy level of the patient.

• Follow the facility’s policies and procedures on advance directives.
Confidentiality and Privacy

Health care practitioners have an obligation to protect patient confidentiality under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The purpose of these regulations is to define and limit the circumstances in which “individually identifiable health information” can be used or disclosed by physicians, hospitals, or other covered entities. Individually identifiable health information includes any information created or received by a covered entity relating to the physical or mental health of an individual. Such information includes oral or recorded matter in any form, such as written materials and electronically stored data.

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<td>1. You are mindful of a patient's privacy and are careful not to discuss a patient within earshot of another patient or a visitor.</td>
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<td>2. You alert the patient to your presence and obtain permission before entering the patient’s room or curtained area.</td>
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<td>3. You have been oriented to and adhere to the HIPAA policies and procedures of the facilities in which you practice.</td>
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TIPS

- Do not discuss confidential medical information in elevators, hallways, cafeterias, shuttle buses, or any place where others may overhear.
- Prior to discussing a patient’s condition, make sure you know the identity of the person, and be certain that the patient has authorized the release of information to that person.
- Never release medical information on an answering machine.
- Protect the confidentiality of the electronic record. Use all security features provided. Log off your computer when leaving your desk. Protect your password.
- Psychiatric, psychological, and HIV-related medical information require special consent from the patient for release and may require a court order in some states.
- Be aware of the special laws pertaining to minors regarding disclosure of certain conditions—even to their parents.
- Before faxing or e-mailing health care information to a patient, obtain the patient’s specific consent.
Emergency Procedures

Each facility where anesthesia services are provided should orient you and your anesthesia team to its emergency procedures. There should be measures to identify anesthesia providers who possess current advanced cardiac life support (ACLS), pediatric advanced life support (PALS), and/or neonatal advanced life support (NALS) certifications.

Anesthesia team members should clearly understand their responsibilities in the event of an emergency from a natural or man-made disaster. You may be deployed as a member of a rapid response team to an emergency medicine department or another area in your facility. Familiarize yourself with your role in an emergency and with the facility’s fire, biohazard, and electrical safety programs.

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<tr>
<td>1. Each setting where general or regional anesthesia or sedation/analgesia is delivered has developed a plan for emergencies that addresses availability of emergency equipment and personnel and specifies the type and extent of emergency care that can be rendered.</td>
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<td>2. Qualified personnel and appropriate medications and equipment are available to manage major medical emergencies, including, but not limited to, hypotension, respiratory depression, seizure, myocardial depression, cardiopulmonary arrest, malignant hyperthermia, difficult or obstructive airway, and latex allergy or other anaphylactic event.</td>
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<td>3. Pediatric dosing and equipment are available if the pediatric population is served.</td>
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<td>4. Wherever anesthesia services are provided, functional monitoring and emergency equipment and other resources (e.g., trained staff) are immediately available and are commensurate with the patient population and complexity of services offered, including:</td>
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<td>a. adequate vital signs and cardiac monitoring resources that include pulse oximetry,</td>
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<td>b. advanced airway equipment,</td>
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<td>d. resuscitation medications,</td>
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<td>e. defibrillator, and</td>
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<td>f. at least one individual with advanced life support skills.</td>
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Emergency Procedures

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5. There is a backup plan for anesthesia provisions if the on-call anesthesia provider is involved in care and another emergency arises.

6. Personnel qualified to reintubate are available when needed.

7. Policies and procedures are established for the timely and efficient transport of patients who require transfer to an acute care facility.

8. Each setting where sedation/analgesia is delivered has the capability to manage cardiopulmonary emergencies.
Credentialing and Staffing

Appropriately maintained credentialing data help to ensure that your organization has determined the qualifications of your practitioners and that it continues to provide qualified, experienced, and competent physicians and allied practitioners.

Deficiencies in credentialing may indicate a lack of commitment to the goal of providing quality medical care and may provide direction for decisions regarding granting privileges. Consistently applied credentialing processes help avoid allegations of unfair decisions related to granting privileges.

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1. The provision of anesthesia services adheres to standards established by state and federal agencies and relevant professional organizations, such as the American Society of Anesthesiologists (ASA), the American Association of Nurse Anesthetists (AANA), the American Society of PeriAnesthesia Nurses (ASPA), and the American College of Obstetricians and Gynecologists (ACOG).

2. Only currently licensed and appropriately credentialed anesthesia professionals provide anesthesia.

3. All anesthesia providers who administer general or regional anesthesia or intravenous sedation possess appropriate anesthesia privileges granted by the health care organization.

4. An anesthesiologist, in good standing, is involved in granting anesthesia privileges.

5. All anesthesia providers’ credential files include verification of a current license, a certificate of insurance, a current Drug Enforcement Agency certificate, verification of education, references, malpractice history, and any physician credentialing database query results.

6. Current advanced life support certification is a condition for appointment of privileges.

7. A review of the anesthesia provider’s qualifications, experience, and competency is performed prior to granting appointment and reappointment of privileges.

**PATIENT SAFETY, QUALITY MONITORING, AND PEER REVIEW**

8. There is an ongoing, consistently applied peer review and quality monitoring process that includes patient outcomes, patient satisfaction, recovery times, complications, and length of stay.

9. There is anesthesiology participation in formal perioperative patient safety initiatives.
Credentialing and Staffing

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10. Review of unplanned returns to the operating room and unplanned admissions and hospital transfers are included in the peer review process.

11. A procedure is established regarding chain of command and handling disruptive practitioners.

12. Peer review concerns are effectively included at reappointment.

**ADMINISTRATIVE OVERSIGHT**

13. There is a director of anesthesia at each site where anesthesia services are provided. The director is involved in the approval and oversight of all anesthesia-related staff appointments and in anesthesia-related policies and procedures.

14. The director of anesthesia has a consultative role in the preparation and credentialing of clinicians who may administer local anesthesia or intravenous sedation/analgesia.

15. The director of anesthesia ensures that qualified anesthesia personnel are available for consultation/service 24 hours a day or as outlined in service contracts.

16. The director of anesthesia services oversees anesthesia services throughout the facility, including cardiac catheterization, endoscopy, and diagnostic and care arenas to ensure consistent adherence to anesthesiology policies and procedures.

**SCOPE OF PRACTICE**

17. Appropriate, immediate consultation is available to the licensed anesthesia provider throughout the course of perioperative care, as needed.

18. The licensed anesthesia care provider is present in the room throughout the conduct of all general and regional anesthesia.

19. There is a qualified, licensed anesthesia care provider to medically direct special anesthesia services, such as pediatric and obstetrical anesthesia.

20. An anesthesiologist is involved in developing policies and procedures and training for nursing staff members who provide intravenous sedation and in the care of patients receiving anesthetic services, such as obstetrical epidurals.

21. Anesthesia providers have received training and have been deemed competent in intubation using fiberoptic scopes.
### Credentialing and Staffing

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#### PEDIATRIC ANESTHESIA SERVICES

22. A credentialed anesthesia provider with pediatric experience is present to monitor the pediatric patient throughout any procedure performed with sedation/analgesia or anesthesia.

23. Physicians and nurses who administer sedative agents or monitor sedated infants and children during diagnostic procedures are PALS-trained.

24. Clinicians providing anesthesia to infants and children have documented, ongoing training and experience in pediatric anesthesia and an understanding of pediatric physiology and age-specific behavior.

25. Pediatric anesthesia privilege delineation policies and procedures address:

- the criteria used to define the “pediatric” patient,
- minimal exposure requirements for privileges (e.g., volume of experience),
- elective versus emergency anesthesia privileges,
- types of procedures for which privileges are granted, and
- privileges for use of a fiberoptic scope to facilitate intubation.

#### OBSTETRICAL ANESTHESIA SERVICES

26. Anesthesia services are available to accommodate an emergency cesarean section within 30 minutes of the decision to operate.

27. At least one person skilled in basic neonatal resuscitation, other than the anesthesia care provider, is present at every delivery.

28. A licensed anesthesia care provider:

- initiates and maintains, or directly supervises, regional analgesia or anesthesia for the obstetrical patient,
- remains immediately available throughout the conduct of regional analgesia or anesthesia for the obstetrical patient, and
- remains immediately available until the obstetrical patient is stable and adequately recovered from the regional anesthetic.
Credentialing and Staffing

ALIGNED PRACTITIONERS

29. In accordance with applicable state regulations, privileging for allied practitioners (physician assistants, anesthesiology assistants, and certified registered nurse anesthetists) includes a written agreement that defines the following:

   a. Physician supervision (naming specific physicians), including the duration and timing of proctoring procedures.

   b. Delineation of clinical privileges.

   c. Clinical care guidelines or pathways that define the scope of practice or detail-specific protocols that include the following:

      i. The types of cases the allied practitioner can handle or manage without direct anesthesiologist supervision.

      ii. The types of cases or clinical situations/diagnoses that require direct supervision or anesthesiologist consultation.

30. There are appropriate policies in place to ensure adherence with current state licensure requirements and the work site's protocols for allied practitioners.

31. The ratio of student nurse anesthetists, student anesthesiology assistants, or anesthesiology residents to an immediately available anesthesia care provider does not exceed one-to-one.

32. Anesthesia providers use clinical consultation appropriate to the patient's medical condition when indicated.

33. Anesthesia providers participate in patient safety, quality monitoring, and peer review activities.

34. Nursing staff members who are responsible for the care of patients receiving sedation/analgesia have appropriate knowledge and training in pharmacology of agents administered, pharmacologic antagonists, associated complications, response to emergencies, and patient assessment.
Pain Management

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1. Pain management services are supervised and directed by the anesthesia services department, and authority is established in the medical staff bylaws.

2. Pain assessments, pain monitoring, effectiveness of interventions, and a plan for pain management are performed and documented per facility protocol and in adherence with current applicable state regulations.

3. The documented pain assessment includes the following:
   a. The characteristics of pain—its location, level of pain at rest and during activity, medication usage and adverse effects, provoking or precipitating factors, quality of pain, radiation of pain, severity of pain, pain-related symptoms, and timing.
   b. Physical examination findings.
   c. Relevant laboratory and diagnostic tests.
   d. The effect pain has on the patient, including the distress caused by pain, coping responses, affect on daily living, and psychosocial, psychological, and spiritual effects.
   e. The patient's understanding of the current illness, including his or her response to receiving information about the condition and treatment options.
   f. The patient's pain history.

4. Patient exclusion criteria are developed and address patients that:
   a. are not motivated or are unwilling to participate in the program,
   b. are unwilling to comply with program requirements,
   c. present with an active, major mental disorder (e.g., psychotic disorder, clear suicide risk),
   d. are suitable for further medical/surgical treatment or investigations,
   e. have experienced pain for less than three months,
   f. have a primary addiction problem, and
   g. are characterologically disturbed, such as patients with antisocial, borderline, histrionic, and narcissistic personalities.
Pain Management

5. Documentation includes:
   - all patient contacts,
   - treatment rationale,
   - history and physical examination findings,
   - diagnostic results,
   - referral notes,
   - pain interventions and treatment history,
   - informed consent for invasive procedures,
   - controlled substance treatment agreement,
   - evidence that the patient meets treatment criteria, and
   - confirmation that the patient has a responsible adult chaperone prior to initiating pain intervention.

6. A controlled substance treatment contract is negotiated with patients receiving prescriptions for any controlled substance for chronic pain management.

7. The controlled substance treatment contract includes the patient’s agreement to:
   - use a single pharmacy for prescriptions,
   - inform all prescribing practitioners of all current medications being prescribed,
   - notify the practice of any medication side effects,
   - obtain controlled substance only from your practice unless specific permission for an exception is provided,
   - keep medication in a secure location, out of the reach of children, and not share, sell, or trade medications,
   - bring medications in the original container to each visit,
   - maintain scheduled appointments,
Pain Management

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h. submit to random urine or serum toxicology screens,
i. use caution when driving or operating machinery while taking controlled substances,
j. refrain from using illegal substances,
k. refrain from altering medications in any way (crushing, injection, insufflation),
l. refrain from altering prescriptions, and
m. refrain from requesting early refills or requesting a replacement prescription for lost or stolen medications.

8. Pain management monitoring includes psychosocial screenings and screening for substance abuse and psychological dependency, as well as for suicidal ideations.

9. There is periodic reevaluation of patients prior to providing prescription refills.

10. Current address and contact information is verified periodically.

11. Noncompliance with the treatment contract is documented and managed immediately.

12. Pain management policies and procedures address violent patient behavior.

13. A security plan is in place.

14. There is an appropriate termination procedure for noncompliance, breach in contract, or breakdown of the patient-physician relationship or other indications.
Building Reliable Systems

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<td>1. The patient load is equitably distributed among the anesthesia providers.</td>
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<td>2. The maximum number of critical care patients that can be safely cared for at any given time has been determined by you and/or the group. This number can be qualified by comorbidities or other factors that you and the group have determined.</td>
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<td>3. There are methods in place for the facility to elicit the anesthesia providers' feedback and to respond to concerns and suggestions.</td>
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<td>4. Anesthesia providers are kept informed of changes in the workplace.</td>
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<td>5. The facility has a feedback mechanism in place to give the anesthesia providers information to improve systems and processes, e.g., monthly quality improvement meetings and discussions.</td>
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<td>6. You promote an environment in which all staff can report errors without fear of reprisal.</td>
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<td>7. You are actively involved in quality improvement activities within your anesthesia group.</td>
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<td>8. You are actively involved in quality improvement activities within your facility.</td>
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<td>9. The quality improvement activities are coordinated between the facility and your group.</td>
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<td>10. You have implemented the use of checklists, written reminders, and technology, such as calculators or personal data assistants (PDAs), to reduce the reliance on memory.</td>
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<td>11. Schedules are conducive to a safe work environment, such as limiting the number of consecutive shifts to reduce the chance of fatigue.</td>
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<td>12. Backup coverage is available if you cannot safely practice due to fatigue.</td>
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TIPS

- Build healthy relationships with facility administration, other physicians, and staff so that questions and interactions are encouraged.
- Participate in team communication skills training with operating room staff.
- Use the facility's decision support tools, such as checklists and PDAs.
- Encourage your group to seek your input related to your schedule.
National Patient Safety Goals

The Joint Commission National Patient Safety Goals highlight problematic areas in health care and describe the evidence and expert-based consensus on solutions to these problems. Recognizing that sound system design is intrinsic to the delivery of safe, high-quality health care, these goals generally focus on system-wide solutions, whenever possible.¹

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1. When receiving critical test results, you write the results down and read them back.

2. The patient is identified, and the site of the treatment is verified before the start of the procedure or other treatment.

3. You require the nursing staff to read back your verbal orders.

4. You confirm that the read-back of orders or test results is correct.

5. You eliminate the “Do Not Use” abbreviations from your orders or medication-related documentation.

6. You have been oriented to the critical test results policy of the facilities you serve.

7. There is a mechanism in place for you to provide feedback to the facilities you serve if you have specific requests related to critical test results.

8. You review each patient's medication list before writing new medication orders.

9. Where appropriate, you monitor patients’ anticoagulant therapy while under your care.

10. You consistently wash/disinfect your hands before and after each patient contact.

11. You follow protocols to prevent the transmission of multidrug-resistant organisms.

12. You follow protocols to prevent central line infections.

13. You are involved in the medication reconciliation process, as appropriate, for patients while under your care.

Additional information:
www.jointcommission.org/PatientSafety/NationalPatientSafetyGoals

Reference:
¹2011 Hospital Accreditation Standards. Oakbrook Terrace, IL: Joint Commission Resources; 2011:221.