



**Department of Surgery  
Division of Anesthesiology  
Rules and Regulations**

**SECTION 1. ORGANIZATION**

- A. The Division of Anesthesiology shall be organized, directed, and integrated with the Department of Surgery at Ventura County Medical Center/Santa Paula Hospital. The Division shall be composed of those members who practice anesthesiology as a specialty. New members shall be board certified as outlined in the Surgery Department Rules and Regulations, Section 7. The members of the Anesthesia Division shall meet regularly as a group to:
  - 1. Review clinical work, and establish and maintain criteria for quality patient care.
  - 2. Formulate rules and regulations appropriate for anesthesia care consistent with Medical Staff Bylaws, Rules and Regulations.
  - 3. Function as a source for medical education.
- B. The Anesthesia Division shall be directed by a physician member of the medical staff. The Director shall be board certified in Anesthesiology. The Director shall have a minimum of five years of clinical experience, and shall demonstrate leadership qualities. The Director shall be responsible for ensuring compliance with these Rules and Regulations, the General Rules and Regulations of the Medical Staff, Medical Staff Bylaws, and the policies and procedures of the Hospital and the Medical Staff.

**SECTION 2. ANESTHESIA SERVICES**

- A. Standards of anesthetic care provided in this hospital shall be in conformity with the standards of patient care of the American Society of Anesthesiologists.
- B. Anesthesia care provided at VCMC/SPH, with the exception of "procedural sedation," shall be provided only by those members privileged in Anesthesiology, as outlined in Section 5, below. "Procedural sedation" may be administered by non-anesthesiologists privileged to do so. The Anesthesia Division will have direct participation in the development of policies and procedures for those areas in which these anesthesia services are provided.
- C. The administration of anesthesia in areas outside the Operating Room (O.R.) shall be conducted in the same manner as in the O.R.
- D. New surgical procedures and/or anesthesia techniques shall be reviewed, and the Director shall be responsible for advancing new procedures and for determining if proctoring is required.

**SECTION 3. DIRECTOR'S RESPONSIBILITY**

The Director of the Division of Anesthesiology shall be responsible for:

- A. Supervising the quality and appropriateness of anesthesia care provided by those approved individuals anywhere in the hospital including surgery, obstetrics, and special procedures area.
- B. Representing the Anesthesia Division's findings as they pertain to the recommendation of primary anesthesia responsibility, which shall be processed through established Medical Staff committees.

- C. Recommending to the Executive Committee and Hospital Administration the requirements for equipment, personnel and medications, assuring through annual review that such equipment is available.
- D. Developing regulations concerning anesthesia safety.
- E. Assuring regular meetings to evaluate quality and appropriateness of anesthesia care rendered throughout the hospital and make appropriate recommendations to the Surgery Committee and Medical Executive Committee.
- F. Assuring on-going continuing education for all individuals having anesthesia privileges, including inservice training where the results of the evaluation of anesthesia care necessitates.
- G. Participating in the development of policies to approved individuals administering anesthesia in various departments or services of the hospital for recommendation to Surgery Committee and the Medical Executive Committee.
- H. Assuring quality and appropriateness of post-anesthetic services.

#### **SECTION 4. ADMINISTRATION OF ANESTHETIC AGENTS**

- A. Selection of the anesthetic agent shall be made by the attending anesthesiologist according to the anesthesiologist's evaluation of the patient's physical and mental status and in conjunction with the patient's consent. Procedures will be reviewed through Quality Assurance as well as by interaction with the Surgery Department.
- B. Proper precautions will be taken in the administration of anesthetic agents. Proper precautions are provided in a manner consistent with The Joint Commission (T.J.C.), California State Law, and the National Fire Protection Association (NFPA). These shall include:
  - 1. Anesthetic apparatus must be inspected and tested by the anesthesiologist before use. If a leak or any other defect is observed, the equipment must not be used until the fault is repaired.
  - 2. Only non-combustible agents shall be used for anesthesia or for the pre-operative preparation of the surgical field.

#### **SECTION 5. PRIVILEGES**

- A. All new members must show competence and document successful outcomes during proctorship of the following type of cases: craniotomy, Cesarean section, major vascular procedure, thoracotomy and general endotracheal for infant under one year.
- B. The Anesthesia Director will evaluate, during proctorship, and upon completion appraise and recommend the physician's status through Surgery Committee.
- C. At the time of reappointment, members shall document in writing all continuing medical education courses attended during the immediate past two years.
- D. In order to maintain departmental privileges it is necessary to demonstrate competency of the electronic health record (EHR). Failure to do so will result in administrative suspension per the Medical Staff Bylaws, Section 13.3-6.

## SECTION 6. PROFESSIONAL CONDUCT

### A. Pre-Anesthetic Review

1. An anesthesiologist shall, prior to initiation of anesthesia, meet the patient formally and do a final review of all information in order to complete the anesthesia history portion of the anesthesia record. This shall include a review of all appropriate screening tests, the history and physical, and the informed consent.
2. Whenever a serious question is raised regarding the condition of a patient for anesthesia for elective or emergency surgery, consultation shall be obtained with the operating surgeon as soon as possible. Such surgical procedure shall be postponed until such time as there has been an adequate reevaluation. Whenever the anesthesiologist finds it necessary to withdraw from a case, the anesthesiologist shall state his/her reasons. It is the prerogative of the anesthesiologist to withdraw with cause; it is the privilege of the operating room surgeon to obtain another consultant, reschedule, or cancel the case.
3. A completed history and physical examination shall be available on the patient's chart prior to surgery.
4. The anesthesiologist shall avail him/herself of any consultation, laboratory determination or diagnostic exam, necessary or desirable, consistent with current anesthesiology standards of good medical practice.
5. Immediately prior to induction of anesthesia, the anesthesiologist will review patient's condition and document the pre-induction assessment.

### B. Conduct of Anesthesia

1. The anesthesiologist shall have a functioning anesthesia machine in the anesthetizing area during all forms of anesthesia and shall be proficient in its use for anesthesia and resuscitation. The Anesthesiologist shall have available equipment, drugs and parenteral fluids necessary for administering anesthesia and for related resuscitative efforts.
2. The anesthesiologist shall be in constant attendance and shall monitor the patient during anesthesia. The methods of monitoring employed shall be recorded on the chart. Whenever possible, safety warning systems of proven efficiency shall be utilized.
3. Complete documentation will be made of the intraoperative phase of anesthesia care, including the maintenance of and emergence from anesthesia, the amount and duration of all anesthetic agents, other drugs, intravenous fluid, and blood or blood fractions.

### C. Local Anesthesia

1. If no anesthesiologist is physically present in the operation room, the operating surgeon shall be responsible for administration of anesthesia (e.g., local anesthesia).
2. All usual drugs and necessary resuscitation equipment shall be available and the surgeon or physician shall be knowledgeable and proficient in their use.
3. During anesthesia, in the absence of an anesthesiologist, vital signs shall be monitored and recorded by a person designated by the operating surgeon or physician in charge. In addition, a pulse oximeter should be used.
4. All drugs, their dosage, route of administration, and time of administration shall be recorded on approved forms.

### D. Post Anesthesia Care - Recovery Room

The Anesthesia Division (in conjunction with the Surgery Department) will define Recovery Room procedure and supervise patient care in this area.

1. Patients shall not be removed from the O.R. until the anesthesiologist is satisfied with the patient's stability.

2. All patients undergoing operation, manipulation or diagnostic procedures under anesthesia (regional or general) shall be taken to the Recovery Room before being returned to their rooms, ICU, PEDS, NICU, etc. except when in the judgment of the surgeon or anesthesiologist, it is in the best interest of the patient to be taken to a unit other than the Recovery Room.
3. Patients entering the Recovery Room shall be accompanied by their surgeon or responsible physician and anesthesiologist.
4. The care of the post-anesthetic patient shall not be delegated by the anesthesiologist, surgeon, or responsible physician to the post-anesthetic care facility personnel until the anesthesiologist, surgeon, or responsible physician has ascertained that the patient's condition is such that the patient may be safely transferred from the immediate supervision of a physician to that of the Recovery Room personnel.
5. The status of the patient at the time of transfer to the post-anesthetic care facility shall be recorded on the chart by the physician or the anesthesiologist.
6. The physician responsible for the anesthesia or the care of the patient shall advise post-anesthetic care personnel of specific problems presented by the patient's condition. Such discussion shall include the pre-operative condition of the patient, the anesthetic technique used, surgery or procedure performed, untoward reactions, or any unusual incidents, and special orders or precautions, if indicated, and oxygen therapy.
7. A registered nurse with training and experience in post anesthesia nursing care shall be responsible for the nursing care and nursing management in the recovery room.
8. In the absence of specific orders, routine recovery care shall be given to each patient as described in the Post-Anesthesia Care Unit (PACU) section of the Surgical Services Policy and Procedure Manual.
9. Post-operative orders are to be written when the patient's care is transferred to the Recovery Room personnel, except when extreme emergency requires one responsible physician's presence in another area.
10. Discharge from the Recovery Room shall be accomplished:
  - a. By written order of the surgeon or anesthesiologist or their designees.  
AND
  - b. When a patient meets the Standard Discharge Criteria list on the back of the Recovery Room record.
11. The responsibility for patients in the Recovery Room is a joint one shared by the surgeon and the anesthesiologist; requests for assistance by Recovery Room personnel shall evoke immediate and appropriate response from the physician involved.
12. If no anesthesiologist is involved in the care of the patient, the surgeon or responsible physician shall perform those duties in the Recovery Room for which the anesthesiologist would normally have been responsible.
13. All unusual incidents and untoward reactions shall be recorded in the Recovery Room record.
14. The anesthesiologist shall be notified immediately if there is:
  - a. deterioration of the patient's condition;
  - b. significant abnormality of vital signs (tachycardia, bradycardia, hypertension, etc.);
  - c. excessive post-operative hemorrhage;
  - d. convulsions;
  - e. hyperpyrexia;
  - f. respiratory distress, cyanosis;
  - g. oxygen saturation below 90 percent;
15. Cardiac resuscitation by the closed chest technique is to be effected by any available Recovery Room personnel whenever indicated and without delay.
16. Post- anesthesia follow-up report will be documented within 48 hours after

surgery and will include date and time of follow-up., and (b) the presence or absence of any anesthesia-related problems or complications. The follow-up and documentation shall be made after the patient has recovered sufficiently to participate in the evaluation.

## SECTION 7.

### ON CALL SCHEDULE

- A. The Anesthesia Division shall maintain a first and second on-call schedule readily available for the O.R.
- B. Staff anesthesia members shall be within thirty (30) minutes response time from the hospital when "on call." Members should be available by telephone directly or by pager. New trauma guidelines, when instituted, will require fifteen (15) minute in-house availability.

## SECTION 8.

### PERFORMANCE IMPROVEMENT

- A. Quality Assurance activities will be performed through the regularly scheduled anesthesia meetings and will include, but not be limited to chart review based upon defined clinical criteria and occurrence screens approved by the Medical Staff.

Members of the anesthesia staff will participate in the hospital's Medical Staff quality assurance program as well as cooperate with the Performance Improvement Committee and other clinical areas in the peer review process in a manner consistent with the hospital's Performance Improvement Plan.

In addition to the usual monthly quality assurance reports and related group discussion, the Anesthesia Division will regularly review information from other multi-disciplinary committees concerned with patient care in an effort to maintain and improve high professional standards.

## SECTION 9.

### BYLAWS, RULES AND REGULATIONS, POLICIES AND PROCEDURES

- A. The Rules and Regulations and policy and procedure manual shall be reviewed and approved annually in accordance with TJC Standards. This review shall be documented.
- B. In the event of any inadvertent inconsistency between these Rules and Regulations and those of the Surgery and Medical Staff Bylaws, Rules and Regulations the latter two shall prevail.

**Review / Approval:**

Surgery Committee: 12/02/05; 02/22/08; 10/28/2011; 02/04/2014; 02/2017  
Executive Committee: 12/13/05; 03/11/08; 11/08/2011; 02/11/2014;