

# REVISED HOSPITAL ANESTHESIA CONDITION OF PARTICIPATION

**Gary Purvines, M.A.**

**NM Department of Health,  
Health Facility Licensing  
& Certification Bureau  
September 28, 2011**

New Mexico  
Department of

**HEALTH**



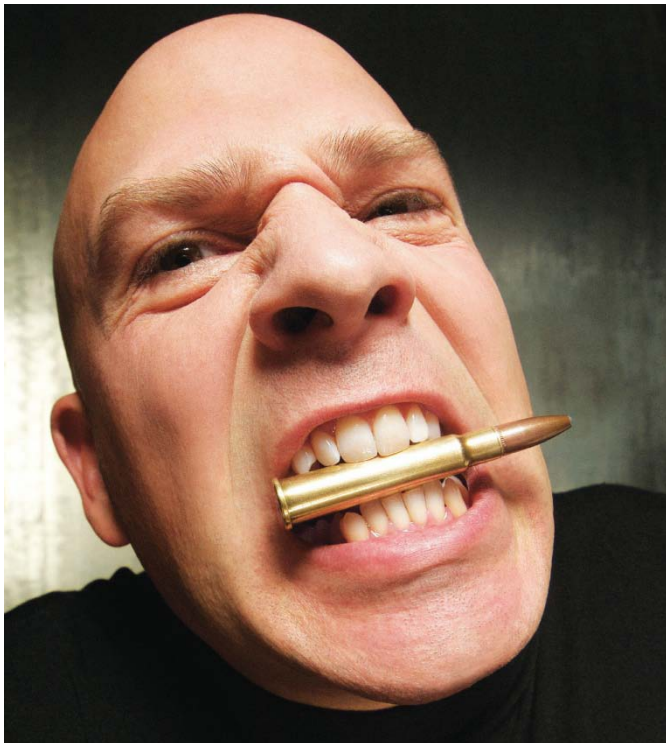
New Mexico  
Hospital Association

# REVISED CONDITION OF PARTICIPATION WENT INTO EFFECT JANUARY 2010



# ANESTHESIA IS AN OPTIONAL HOSPITAL SERVICE

IF HOSPITAL PROVIDES ANY DEGREE OF  
ANESTHESIA SERVICE:



MUST COMPLY WITH  
**ALL** REQUIREMENTS  
OF THIS CONDITION  
OF PARTICIPATION.

# THE ANESTHESIA CONTINUUM

- REVISED REGULATIONS INCORPORATE DEFINITIONS FROM MOST RECENT SET OF PRACTICE GUIDELINES FROM ***AMERICAN SOCIETY OF ANESTHESIOLOGISTS.***
- CONTINUUM GOES FROM ANESTHESIA THROUGH ANALGESIA.

# DEFINING THE TERMS-

- REVISED COP FOR ANESTHESIA HAS VERY DETAILED DEFINITIONS OF THIS ANESTHESIA CONTINUUM AS PART OF CONDITION REGULATORY LANGUAGE.
- AS IN MOST THINGS IN MEDICINE, DEFINITIONS ARE IMPORTANT, SO WE WILL BRIEFLY GO THROUGH THESE DEFINITIONS.



# HOSPITAL ANESTHESIA SERVICES

## ANESTHESIA SERVICES

- General
- Regional
- MAC
- Deep Sedation

To be given by anesthesiologist, CRNA or anesthesia assistant within scope of practice

## ANALGESIA/ SEDATION

- Topical
- Local
- Minimal
- Moderate

To be given by appropriately trained medical professional within scope of practice

RESCUE CAPACITY

“Opt Out” state?

YES

No Physician supervision required for CRNA

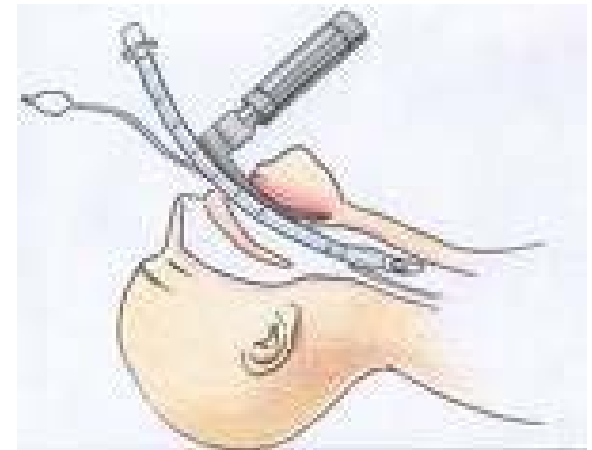
NO

Physician supervision required for CRNA

**NOTE: Analgesia via epidural/spinals for labor and delivery is permitted to be administered by CRNAs without physician supervision**

# “ANESTHESIA”

- INVOLVES ADMINISTRATION OF A MEDICATION TO PRODUCE A BLUNTING OR LOSS OF:
- PAIN PERCEPTION (ANALGESIA)
- VOLUNTARY AND INVOLUNTARY MOVEMENTS
- AUTONOMIC FUNCTION
- MEMORY AND/OR CONSCIOUSNESS
- DEPENDING ON WHERE ALONG CENTRAL NEURAXIL (BRAIN & SPINAL CORD) MEDICATION IS DELIVERED.



# “ANALGESIA”

- INVOLVES USE OF MEDICATION TO PROVIDE RELIEF OF PAIN THROUGH BLOCKING OF PAIN RECEPTOR IN PERIPHERAL AND/OR CENTRAL NERVOUS SYSTEM.
- PATIENT DOES NOT LOSE CONSCIOUSNESS
- BUT DOES NOT PERCEIVE PAIN TO EXTENT THAT MAY OTHERWISE PREVAIL.



# TYPES OF ANESTHESIA

**MUST BE SUPERVISED BY AN  
ANESTHESIA PROFESSIONAL:**

- GENERAL ANESTHESIA
- REGIONAL ANESTHESIA
- MONITORED ANESTHESIA CARE (MAC)
- TOPICAL OR LOCAL ANESTHESIA



# “GENERAL ANESTHESIA”

- DRUG INDUCED LOSS OF CONSCIOUSNESS
- PATIENT CANNOT BE AROUSED EVEN BY PAINFUL STIMULATION
- ABILITY TO INDEPENDENTLY MAINTAIN VENTILATORY SUPPORT IS OFTEN IMPAIRED



- PATIENTS OFTEN REQUIRE ASSISTANCE IN MAINTAINING PATENT AIRWAY

# “GENERAL ANESTHESIA” – cont.

- POSITIVE PRESSURE VENTILATION MAY BE REQUIRED BECAUSE OF DEPRESSED SPONTANEOUS VENTILATION OR DRUG INDUCED DEPRESSION OF NEUROMUSCLAR FUNCTION.
- CARDIOVASCULAR FUNCTION MAY BE IMPAIRED.
- USED FOR THOSE PROCEDURES WHERE LOSS OF CONSCIOUSNESS IS REQUIRED FOR SAFE AND EFFECTIVE DELIVERY OF SURGICAL SERVICES.

# “REGIONAL ANESTHESIA”

- DELIVERY OF ANESTHETIC MEDICATION AT SPECIFIC LEVEL OF THE SPINAL CORD AND/OR TO PERIPHERAL NERVES.
- INCLUDES EPIDURALS/SPINALS AND OTHER CENTRAL NEURAXIAL NERVE BLOCKS
- IS USED WHEN LOSS OF CONSCIOUSNESS IS NOT DESIRED BUT SUFFICIENT ANALGESIA AND LOSS OF VOLUNTARY AND INVOLUNTARY MOVEMENT IS REQUIRED.

# “REGIONAL ANESTHESIA” – cont.

GIVEN THE POTENTIAL FOR CONVERSION AND EXTENSION OF REGIONAL TO GENERAL ANESTHESIA IN CERTAIN PROCEDURES, IT IS NECESSARY THAT ADMINISTRATION OF REGIONAL AND GENERAL ANESTHESIA BE DELIVERED OR SUPERVISED BY



*A PRACTITIONER AS SPECIFIED IN 42CFR 482.52(a).*

# “PRACTITIONER” DEFINED

- FEDERAL REGULATIONS IN 42 CFR 482.52(a) REQUIRE THAT ANESTHESIA **MUST** BE ADMINISTERED ONLY BY:
- QUALIFIED ANESTHESIOLOGIST (*DOCTOR OF MEDICINE OR OSTEOPATHY*)
- DENTIST, ORAL SURGEON, OR PODIATRIST WHO IS QUALIFIED TO ADMINISTER ANESTHESIA UNDER **STATE LAW**
- CERTIFIED REGISTERED NURSE ANESTHETIST (CRNA)

# “MONITORED ANESTHESIA CARE” (MAC)

ANESTHESIA CARE THAT INCLUDES MONITORING OF THE PATIENT BY AN ANESTHESIA PROFESSIONAL

- INDICATIONS FOR **MAC** DEPEND ON:
  - NATURE OF PROCEDURE
  - PATIENT’S CLINICAL CONDITION AND/OR NEED TO CONVERT TO A GENERAL OR REGIONAL ANESTHETIC
  - DEEP SEDATION/ANALGESIA IS INCLUDED IN MAC



# ANESTHESIA SERVICES NOT SUBJECT TO ANESTHESIA ADMINISTRATION & SUPERVISION REQUIREMENTS

- ✓ TOPICAL OR LOCAL ANESTHESIA
- ✓ MINIMAL SEDATION – DRUG INDUCED STATE DURING WHICH PATIENTS RESPOND NORMALLY TO VERBAL COMMANDS *ALTHOUGH COGNITIVE FUNCTION AND COORDINATION MAY BE IMPAIRED, VENTILATOR AND CARDIOVASCULAR FUNCTIONS ARE UNAFFECTED.*

# ANESTHESIA SERVICES NOT SUBJECT TO ANESTHESIA ADMINISTRATION & SUPERVISION REQUIREMENTS – CONT.

## MODERATE SEDATION/ANALGESIA (CONSCIOUS SEDATION)

- ✓ A DRUG INDUCED DEPRESSION OF CONSCIOUSNESS DURING WHICH PATIENTS RESPOND PURPOSEFULLY TO VERBAL COMMANDS EITHER ALONE OR ACCOMPANIED BY LIGHT TACTILE STIMULATION.

# RESCUE CAPACITY

- ✓ BECAUSE SEDATION IS A CONTINUUM, NOT ALWAYS POSSIBLE TO PREDICT HOW AN INDIVIDUAL PATIENT WILL RESPOND
- ✓ HOSPITAL MUST ENSURE THAT PROCEDURES ARE IN PLACE TO RESCUE PATIENTS WHOSE LEVEL OF SEDATION BECOMES DEEPER THAN INITIALLY INTENDED
- ✓ “RESCUE” FROM A DEEPER LEVEL OF SEDATION THAN INTENDED REQUIRES AN INTERVENTION BY PRACTITIONER WITH EXPERTISE IN AIRWAY MANAGEMENT AND ADVANCED LIFE SUPPORT





# ALL TOGETHER NOW!



ANESTHESIA SERVICES **THROUGHOUT**  
HOSPITAL (*INCLUDING ALL DEPARTMENTS IN ALL  
CAMPUSES AND OFFSITE LOCATIONS WHERE ANESTHESIA  
SERVICES ARE PROVIDED*) **MUST** BE ORGANIZED  
INTO **ONE** ANESTHESIA SERVICE, UNDER  
THE DIRECTION OF A QUALIFIED DOCTOR  
OF MEDICINE OR DOCTOR OF  
OSTEOPATHY.



# ALL TOGETHER NOW! –CONT.

- AREAS WHERE ANESTHESIA SERVICES ARE FURNISHED MAY INCLUDE:
- OPERATING ROOM SUITES – INPATIENT AND OUTPATIENT
- OBSTETRICAL SUITE(S)
- RADIOLOGY DEPT.
- CLINICS
- EMERGENCY DEPT.
- PSYCHIATRY DEPT.
- OUTPATIENT SURGERY AREAS
- SPECIAL PROCEDURES AREAS (ENDOSCOPY SUITE)



# ORGANIZATION

HOSPITAL'S MEDICAL STAFF ESTABLISHES  
CRITERIA FOR QUALIFICATIONS FOR  
DIRECTOR OF ANESTHESIA *SERVICES*  
*(IN ACCORDANCE WITH STATE LAWS AND*  
*ACCEPTABLE STANDARDS OF PRACTICE)*



# ORGANIZATION - cont.

## **ANESTHESIA SERVICE IS RESPONSIBLE FOR:**

- **DEVELOPING POLICIES & PROCEDURES GOVERNING PROVISION OF ALL CATEGORIES OF ANESTHESIA SERVICES, INCLUDING SPECIFYING MINIMUM QUALIFICATIONS FOR EACH CATEGORY OF PRACTITIONER WHO IS PERMITTED TO PROVIDE ANESTHESIA SERVICES THAT ARE NOT SUBJECT TO ANESTHESIA ADMINISTRATION REQUIREMENTS LISTED IN SLIDE # 14.**

# ORGANIZATION –CONT.

ANESTHESIA SERVICE **MUST** BE  
INTEGRATED INTO HOSPITAL'S  
REQUIRED QUALITY ASSESSMENT &  
PERFORMANCE IMPROVEMENT (QAPI)  
PROGRAM TO ASSURE PROVISION OF  
SAFE CARE TO PATIENTS



# POLICIES & PROCEDURES

ANESTHESIA SERVICES  
MUST BE DELIVERED IN  
A MANNER THAT IS  
CONSISTENT WITH  
NEEDS AND  
RESOURCES OF  
HOSPITAL



# POLICIES & PROCEDURES – CONT.

## ANESTHESIA POLICIES & PROCEDURES AT A MINIMUM MUST ADDRESS:

- HOW HOSPITAL'S ANESTHESIA SERVICES NEEDS WILL BE MET
- DELIVERY OF ANESTHESIA SERVICES CONSISTENT WITH RECOGNIZED STANDARDS FOR ANESTHESIA CARE

# POLICIES & PROCEDURES – CONT.



A WELL DESIGNED ANESTHESIA SERVICES POLICY WOULD ADDRESS ISSUES SUCH AS:

- ✓ *PATIENT CONSENTS;*
- ✓ *INFECTION CONTROL MEASURES;*
- ✓ *SAFETY PRACTICES IN ALL ANESTHESIA AREAS;*
- ✓ *PROTOCOL FOR SUPPORTIVE LIFE FUNCTIONS, e.g. CARDIAC AND RESPIRATORY EMERGENCIES;*

# POLICIES & PROCEDURES – CONT.

- ✓ *REPORTING REQUIREMENT;*
- ✓ *DOCUMENTATION REQUIREMENTS;*
- ✓ *EQUIPMENT REQUIREMENTS;*
  - ✓ *don't forget: MONITORING, INSPECTION, TESTING/MAINTENANCE OF ANESTHESIA EQUIPMENT IN HOSPITAL'S BIOMEDICAL EQUIPMENT PROGRAM*
- ✓ *DELINEATION OF PRE- AND POST – ANESTHESIA STAFF RESPONSIBILITIES*



# PRE-ANESTHESIA EVALUATION

- PRE-ANESTHESIA EVALUATION **MUST** BE PERFORMED FOR EACH PATIENT WHO RECEIVES GENERAL, REGIONAL OR MONITORED ANESTHESIA.
- EVALUATION MUST BE PERFORMED BY SOMEONE QUALIFIED TO ADMINISTER ANESTHESIA AS LISTED ON SLIDE #13.
- MORE STRINGENT REQUIREMENTS OF 482.52 (B)(1) **DO NOT PERMIT** DELEGATION OF PRE-ANESTHESIA EVALUATION TO PRACTITIONERS WHO ARE NOT QUALIFIED TO ADMINISTER ANESTHESIA.

# PRE-ANESTHESIA EVALUATION

-cont.

PRE-ANESTHESIA EVALUATION ***MUST BE PERFORMED WITHIN 48 HOURS*** PRIOR TO ANY INPATIENT OR OUTPATIENT SURGERY OR PROCEDURE REQUIRING ANESTHESIA SERVICES.

(DELIVERY OF THE FIRST DOSE OF MEDICATION FOR THE PURPOSE OF INDUCING ANESTHESIA MARKS END OF THE 48 HOUR TIME FRAME.)



# PRE-ANESTHESIA EVALUATION

-cont.

IN ACCORDANCE WITH CURRENT STANDARDS OF ANESTHESIA CARE -

PRE-ANESTHESIA EVALUATION OF THE PATIENT **MUST** INCLUDE [AT A MINIMUM]:

- ✓ REVIEW OF MEDICAL HISTORY, INCLUDING ANESTHESIA, DRUG AND ALLERGY HISTORY
- ✓ INTERVIEW AND EXAMINATION OF PATIENT
- ✓ NOTATION OF ANESTHESIA RISK (ACCORDING TO ESTABLISHED STANDARDS OF PRACTICE [*i.e.* ASA CLASSIFICATION OF RISK])

# PRE-ANESTHESIA EVALUATION

- cont.

- ✓ IDENTIFICATION OF POTENTIAL ANESTHESIA PROBLEMS – PARTICULARLY THOSE THAT MAY SUGGEST POTENTIAL COMPLICATIONS OR CONTRAINDICATIONS TO THE PLANNED PROCEDURE
- ✓ ANY ADDITIONAL PRE-ANESTHESIA EVALUATION, IF APPLICABLE, AND AS REQUIRED IN ACCORDANCE WITH STANDARD PRACTICE PRIOR TO ADMINISTERING ANESTHESIA. (e.g. STRESS TESTS, ADDITIONAL SPECIALIST CONSULTATION)

~~Complications  
in Anesthesia~~

# PRE-ANESTHESIA EVALUATION –

cont.

- ✓ DEVELOPMENT OF PLAN FOR PATIENT'S ANESTHESIA CARE INCLUDING:
  - ❑ TYPE OF MEDICATION FOR INDUCTION
  - ❑ MAINTENANCE AND POST-OPERATIVE CARE
  - ❑ DISCUSSION WITH PATIENT (OR PATIENT'S REPRESENTATIVE) OF RISKS AND BENEFITS OF DELIVERY OF ANESTHESIA



# INTRAOPERATIVE ANESTHESIA RECORD

ANESTHESIA POLICIES **MUST** ENSURE THAT THE  
FOLLOWING CARE IS PROVIDED FOR EACH  
PATIENT:

- ✓ INTRA-OPERATIVE ANESTHESIA RECORD OR REPORT  
FOR EACH PATIENT WHO RECEIVES GENERAL,  
REGIONAL OR MONITORED ANESTHESIA

*NOTE: CURRENT PRACTICE DICTATES THAT PATIENT RECEIVING  
MODERATE SEDATION BE MONITORED AND EVALUATED BEFORE,  
DURING AND AFTER PROCEDURE BY TRAINED PRACTITIONERS,  
AN INTRA-OPERATIVE ANESTHESIA REPORT IS NOT REQUIRED.*

# INTRAOPERATIVE ANESTHESIA RECORD – cont.

CURRENT STANDARD OF CARE STIPULATES THAT  
INTRA-OPERATIVE ANESTHESIA RECORD, AT A  
MINIMUM, INCLUDES:

- ✓ PATIENT NAME & HOSPITAL IDENTIFICATION NUMBER
- ✓ NAME(S) OF PRACTITIONER WHO ADMINISTERED ANESTHESIA
- ✓ NAME, DOSAGE, ROUTE AND TIME OF ADMINISTRATION OF DRUGS AND ANESTHESIA AGENTS



# INTRAOPERATIVE ANESTHESIA

## RECORD – cont.

- ✓ NAME AND AMOUNT OF IV FLUIDS, INCLUDING BLOOD OR BLOOD PRODUCTS IF APPLICABLE
- ✓ TIME-BASED DOCUMENTATION OF:
  - Vital signs
  - Oxygenation and ventilation parameters
- ✓ ANY COMPLICATIONS (ADVERSE REACTION) OR PROBLEMS OCCURRING DURING ANESTHESIA INCLUDING:
  - *time*
  - *description of symptoms*
  - *vital signs*
  - *treatments rendered*
  - *patient's response to treatment*

# POST-ANESTHESIA EVALUATION

- ✓ A POST-ANESTHESIA EVALUATION COMPLETED AND DOCUMENTED BY AN INDIVIDUAL QUALIFIED TO ADMINISTER ANESTHESIA NO LATER THAN 48 HOURS AFTER SURGERY OR A PROCEDURE REQUIRING ANESTHESIA SERVICES.
- ✓ THE POST-ANESTHESIA EVALUATION FOR ANESTHESIA RECOVERY **MUST** BE COMPLETED IN ACCORDANCE WITH STATE LAW AND WITH HOSPITAL POLICIES AND PROCEDURES THAT HAVE BEEN APPROVED BY THE MEDICAL STAFF AND THAT REFLECT CURRENT STANDARDS OF ANESTHESIA CARE.

# POST-ANESTHESIA EVALUATION – cont.

POST-ANESTHESIA EVALUATION IS REQUIRED ANY  
TIME *GENERAL, REGIONAL OR MONITORED*  
*ANESTHESIA HAS BEEN ADMINISTERED*

*NOTE: While current practice dictates that patient receiving moderate (conscious) sedation be monitored and evaluated before, during and after procedure by trained practitioners, A POST-ANESTHESIA EVALUATION IS NOT REQUIRED.*



# POST-ANESTHESIA EVALUATION – cont.

REQUIREMENTS OF 482.52(B)(3) DO NOT PERMIT DELEGATION OF POST-ANESTHESIA EVALUATION OF PRACTITIONERS WHO ARE NOT QUALIFIED TO ADMINISTER ANESTHESIA.



CALCULATION OF THE 48 HOUR  
TIMEFRAME  
BEGINS AT POINT WHERE PATIENT  
IS MOVED INTO  
DESIGNATED RECOVERY AREA.

# POST-ANESTHESIA EVALUATION –

cont.

EXCEPT IN CASES WHERE POST-OPERATIVE SEDATION IS NECESSARY FOR OPTIMUM MEDICAL CARE OF PATIENT (e.g. ICU), EVALUATION GENERALLY WOULD NOT BE PERFORMED IMMEDIATELY AT POINT OF MOVEMENT FROM OPERATIVE AREA TO DESIGNATED RECOVERY AREA



# POST-ANESTHESIA EVALUATION –

cont.

- ACCEPTED STANDARDS OF ANESTHESIA CARE INDICATE THAT EVALUATION MAY NOT BEGIN UNTIL PATIENT IS SUFFICIENTLY RECOVERED FROM ACUTE ADMINISTRATION OF ANESTHESIA SO AS TO PARTICIPATE IN THE EVALUATION,( e.g. answer questions appropriately, perform simple tasks, etc)
- EVALUATION **CAN** OCCUR IN PACU/ICU OR OTHER DESIGNATED RECOVERY LOCATION.
- FOR OUTPATIENTS, POST-ANESTHESIA EVALUATION **MUST** BE COMPLETED PRIOR TO PATIENT'S DISCHARGE.

# POST-ANESTHESIA EVALUATION –

cont.

ELEMENTS OF AN ADEQUATE POST-ANESTHESIA EVALUATION SHOULD BE CLEARLY DOCUMENTED AND CONFORM TO CURRENT STANDARDS OF ANESTHESIA CARE, INCLUDING:



# POST-ANESTHESIA EVALUATION-

## cont.

- ✓ Respiratory function, including respiratory rate, airway patency and oxygen saturation.
- ✓ Cardiovascular function, including pulse rate and blood pressure.
- ✓ Mental status
- ✓ Temperature
- ✓ Pain
- ✓ Nausea and vomiting
- ✓ Postoperative hydration



# QUESTIONS & COMMENTS?

THANK YOU FOR YOUR ATTENTION



**Gary Purvines**

[gary.purvines@state.nm.us](mailto:gary.purvines@state.nm.us)

505.841.5801