Chapter 1. The Department of Anesthesiology

◊ The Organization of an Anesthesia Department (2008)	o An anesthesiologist must be personally responsible to each patient for the provision of anesthesia care.
◊ Guidelines for the Ethical Practice of Anesthesiology (2008)	o The anesthesia record must contain certain pre-, intra- and post-operative information. For compliance purposes, it must fully substantiate the services provided.
◊ Documentation of Anesthesia Care (2008)	o The discussion of the Medicare Hospital Conditions of Participation Interpretive Guidelines and the documentation these require is out of date. Consult instead the 2011 version of the Anesthesia Interpretive Guidelines and ASA's corresponding policy templates (e.g. Director of Anesthesia Services Policy, Post-Anesthesia Evaluation Form)
◊ Sample informed consent forms and discussion	
◊ American Association of Clinical Directors Glossary of Procedural Times	

Chapter 2. Delineation of Clinical Privileges in Anesthesiology

◊ Guidelines for the Delineation of Clinical Privileges in Anesthesiology (2008)	o Reviews criteria recommended for consideration relating to clinical privileges in the domains of education, licensure, performance improvement, personal qualifications and practice patterns.
◊ Guidelines for the Delineation of Clinical Privileges in Anesthesiology (2008 American Society of Echocardiography and Society of Cardiovascular Anesthesiologists Task Force Guidelines for Training in Perioperative Echocardiography (2002)	o Subspecialty or procedure credentialing can draw from various hyperlinked statements on OB, critical care, pediatric and regional anesthesia, etc.
◊ Anesthesia Care Team (2009)	o Department chairs are often asked to help determine sedation privileges for non-physician health professionals and non-anesthesiologists
◊ Statement on Safe use of Propofol (2009)	o Joint Commission credential verification and privileging concepts of general competencies, focused and continuous evaluation.

Chapter 3. Standards, Guidelines and Statements for Patient Care in Anesthesiology

◊ Basic Anesthetic Monitoring, Standards for (Effective July 1, 2011)	o NB: Standards for Basic Anesthetic Monitoring have been updated since this chapter was prepared. The latest version is available through the hyperlink in the left-hand column.
◊ Basic Standards For Preanesthesia Care (2010)	o The Joint Commission (TJC) and CMS views still differ on which medications must be locked vs. "kept in a secured area."
◊ Standards For Postanesthesia Care (2009)	o TJC "Sentinel Events" database is the source of Alerts and also National Patient Safety Goals.
◊ Continuum Of Depth Of Sedation: Definition Of General Anesthesia And Levels Of Sedation / Analgesia (2009)	o TJC recommends formal policy, timely anesthesia equipment maintenance and appropriate post-op follow-up for helping to prevent and managing anesthesia awareness
◊ Links /summaries of all Practice Guidelines and Advisories	
◊ CMS Regulations on "locked carts"	
◊ Sample policy on unintended Intraoperative awareness	
◊ CMS Conditions of Participation for Anesthesia Services / Services of CRNA or AA	
◊ CMS rules for paying teaching anesthesiologists	

Chapter 4. Quality Improvement and Peer Review in Anesthesiology

	o Regulatory requirements for "quality:" both TJC and Det Norske Veritas (DNV) survey hospitals for Medicare. Ambulatory accreditation bodies and states also require QI.
	o CMS "never events" include hospital-acquired infections for 10 categories of conditions.
	o OIG, in its work to prevent fraud, also requires that patient care meet certain standards.

	o Discussion of QI in an Anesthesiology department and data collection methods o Anesthesia Quality Institute (AQI) and National Anesthesia Clinical Outcomes Registry (NACOR) o Maintenance of Certification in Anesthesiology (MOCA) includes Practice Performance Assessment and Improvement, with case evaluation. o Legal protection of Peer Review o ASA Anesthesia Consultation Program
Chapter 5. Ambulatory Anesthesiology	
◊ American Association for Accreditation of Ambulatory Surgery Facilities [AAAASF] Standards ◊ Office Based Anesthesia: Considerations for Anesthesiologists in Setting Up and Maintaining a Safe Office Anesthesia Environment (ASA Manual) ◊ ASA Guidelines for Ambulatory Anesthesia And Surgery (2008) ◊ ASA Guidelines for Office-Based Anesthesia (2009) ◊ ASA Statement on Distinguishing Monitored Anesthesia Care ("MAC") From Moderate Sedation/Analgesia (Conscious Sedation) (2009) ◊ Outcome Indicators for Office-Based and Ambulatory Surgery ◊ Sample Forms: •Patient Pre-Anesthesia Questionnaire •Preoperative Instructions •Statement of Patient Acknowledgment and Compliance •Home Care Instructions •Postoperative Follow Up	o TJC and Accreditation Association for Ambulatory Health Care (AAAHC) are the major players in accrediting ambulatory facilities, but their standards must be obtained from them directly.
Chapter 6. The Joint Commission: What You Need to Know and What You Need to Show	
◊ Comprehensive Accreditation Manual for Hospitals (CAMH): The Official Handbook (Your hospital will have a copy)	o TJC's accreditation process evaluates healthcare organizations' compliance with CMS requirements and its own standards o Survey process has a 3-year cycle o "Health care organizations should use their Periodic Performance Review (PPR) as a self-assessment tool to make Joint Commission standards part of everyday operations and ongoing quality improvement efforts." o ORYX, standardized core measures, PPR, Priority Focus Process, Strategic Surveillance System o Description of steps in survey process o "So, what else can we learn from the Sentinel Event Database? Well, your chances of committing suicide in a health care organization are nearly as high as your chances of wrong-site surgery; and your chances of being assaulted, raped, or murdered are twice as high as …. an anesthesia- event!"
Chapter 7. Emergency Preparedness	

◊ Elements of a disaster plan ◊ 3 Ss: Supplies, Staff, Space ◊ Operating Room Chief Priority Task list ◊ Emergency Physicians (ACEP) have published a “Policy on Unsolicited Medical Volunteers ◊ Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) Medical Reserve Corps	o Each anesthesiologist and each Department Chairperson should be aware of his or her role in the practice/hospitals’ unique local disaster plan. o The Anesthesiology Chair, in conjunction with departmental leadership and the Hospital Emergency Preparedness Committee, is responsible for ensuring continuity of care during a crisis. o Hazard Vulnerability Analyses for both hospital and Anesthesia department o ACEP advises: “medical personnel should not respond to an emergency unless officially requested by the jurisdiction’s emergency medical services agency. o Methods for civilian physicians to volunteer o Self-protection