TORRANCE MEMORIAL MEDICAL CENTER
DEPARTMENT OF ANESTHESIOLOGY
RULES AND REGULATIONS

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PRIVILEGE CARDS

Anesthesia

Pain Management

ARTICLE I – Composition

The Department of Anesthesiology of Torrance Memorial Medical Center shall be composed of those physicians who specialize in the administration of anesthesia as their principal medical specialty. These physician professionals shall adhere to the philosophy that the administration of anesthesia is a distinct medical specialty requiring specialized education, unique requirements of judgment and professionalism, continuing education in anesthesia and the proper character, ethics and integrity.

The staff of the Department of Anesthesiology will be on the Medical Staff consistent with the Bylaws, Rules and Regulations of the Medical Staff of TMMC. Membership and privileges in this Department shall be dependent upon performing sufficient anesthesia procedures on a continuing basis to maintain professional proficiency.

The Department of Anesthesiology at TMMC is dedicated to marinating and demonstrating acceptable ethical and medical standards in its patients' treatment, and under the direction of the Chief of the Department of Anesthesiology, it shall be free to develop internal procedures, regulations and standards which render the department best able to meet patients' needs.

The Department of Anesthesiology shall hold regularly scheduled meetings.

ARTICLE II – Definition of Anesthesiology

Anesthesiology is the practice of medicine dealing with, but not limited to:

1. The management of procedures for rendering a patient insensible to pain and emotional stress during surgical, obstetrical and certain medical procedures;
2. The support of life functions under the stress of anesthetic and surgical manipulations;
3. The clinical management of the patient unconscious from whatever cause;
4. The management of problems with pain relief;
5. The management of problems in cardiac and respiratory resuscitation;
6. The application of specific methods of respiratory therapy;
7. The clinical management of various fluid, electrolyte and metabolic disturbances.

ARTICLE III – Purpose

The purpose of the Department of Anesthesiology shall be:

1. To ensure that all patients admitted to the hospital or treated in the outpatient department receive a quality of care consistent with acceptable ethical and professional standards in anesthesiology.
2. To encourage and further the existence of anesthesiology as a distinct medical specialty.
3. To initiate and maintain policies for the government of the Department of Anesthesiology consistent with the rendering of quality patient care.
4. To maintain quality educational standards and technical proficiency among department members.
5. To properly organize, structure, manage, administer and supervise the provision of anesthesia services at this hospital in the interest of quality of patient safety.

ARTICLE IV – Responsibilities of Departmental Chief

The Department of Anesthesiology will be headed by an Anesthesiology Department Chief elected by the Active member of the Anesthesiology Department. The Department chief must be a member of the Active Medical Staff and participate in the Daily Call Schedule. He/She shall serve one year and until a successor is duly elected by the members of the Anesthesiology Department. The majority of his/her practice shall be at TMMC.

The responsibilities of Chief of the Department of Anesthesiology shall be:

1. Those duties delineated from all Medical Staff Department Chief's in the Bylaws, Rules and Regulations of the Medical Staff of TMMC.
2. Recommending of privileges for all the individuals with primary anesthesia responsibility.
3. The monitoring of the quality of anesthesia care rendered by anesthesiologists anywhere in the facility, including surgical, emergency, outpatient and special procedure areas. The Department Chief shall be free to implement all changes which are necessary to ensure continuing high quality patient care.
4. Development of regulations for anesthesia safety, electrical hazards and infection control. He/She shall maintain and periodically review appropriate procedure manuals.
5. Insuring the retrospective evaluation of the quality of anesthesia care rendered throughout the facility. He/She shall review services rendered and offered and make appropriate recommendations to the medical staff.

ARTICLE IV – Responsibilities of Departmental Chief (Continued)

6. Recommending to the administration and medical staff the type and amount of equipment necessary for administering anesthesia and for related resuscitative efforts, ensuring that ongoing review will be made of the available equipment.
7. Participation in the development of any policies or standards which relate to the functioning of anesthesiologists and administration of anesthesia in various departments or services of the hospital.
8. Where pertinent, the Chief will provide for consultation in the management of problems of acute and chronic respiratory insufficiency as well as a variety of other diagnostic and therapeutic measures related to hospital patient care.
9. The Chief shall be responsible for the scheduling of all elective anesthesia procedures performed by all anesthesiology personnel and for scheduling participation in the Surgery Call Schedule by members of the department. In the absence of the Chief, the Chief shall delegate such duties to another member of the Anesthesia Department to make such decisions.
10. To ensure that patients of this hospital receive quality care in the rendering of anesthesia, the Chief of the Department of Anesthesiology, shall develop appropriate proctoring procedures to ensure that any new applicants to the department undergo appropriate evaluation prior to their participation in the Daily Call Schedule. These proctoring requirements shall be periodically reviewed and updated, consistent with this objective. It shall be the responsibility of the Chief of the Department of Anesthesiology and the Anesthesia Department to review, alter, change and revise such procedures whenever, in their judgment, such alterations, changes or revisions are consistent with the continued rendering quality patient care.
11. The Chief of the Department of Anesthesiology with the assistance and occurrence of the Anesthesiology Department shall make appropriate recommendations to the hospital to encourage and ensure the:
    a. Proper supervision of department operation and activities;
    b. Proper and consistent administration;
    c. Simplification and facilitation of interdepartmental relationships;
    d. Improved training and support staff supervision;
    e. Morale within the department;
    f. Enhanced rapport between support staff and the Anesthesia Department's physicians;
    g. Promotion of professional and proper use of department equipment;
    h. Facilitation of control and standardization of procedures;
    i. Encouragement of specialization in anesthesia techniques;
    j. Proper scheduling to ensure adequate coordination and patient coverage;
    k. Identification of equipment needs;
    l. Ongoing evaluation of the department's effectiveness;
    m. Proper maintenance of staff privileges and related requirements within the department;

ARTICLE IV – Responsibilities of Departmental Chief (Continued)

n. The implementation and maintenance of an effective performance improvement program;
o. Proper review and credentialing of new members.

ARTICLE V – Responsibilities of Department

Along with rights and responsibilities delineated in other sections and provisions of these Rules and Regulations, the Anesthesiology Department shall have the following responsibilities:

1. It shall review and evaluate all applicants for anesthesia privileges, and shall make recommendations to the appropriate hospital committees concerning each applicant consistent with the Bylaws, Rules and Regulations of the Medical Staff of TMMC.
2. It shall conduct ongoing review and evaluation of all members of the Department of Anesthesiology and shall render departmental decisions in accord therewith in order to assure the provision of quality patient care.
3. It shall participate in programs of continuing education based in part on the results of retrospective evaluation.

ARTICLE VI – Privileges

1. Qualifications: See clinical privilege application card for Anesthesia and Pain Management.
2. Proctor Program: The new member of the Department of Anesthesiology will be proctored by direct observation. *(Please see privilege card for specific proctoring requirements.)*

   Once the minimum requirements have been met, the proctoring reports will be reviewed and evaluated by the Chief of the Anesthesiology Department. The department chief may determine that additional proctoring is required.

   The department chief will determine, based upon these reports, whether the physician's proctoring requirement is complete and satisfactory.

   In the case where on-going proctoring is negative, the Chief may remove an anesthesiologist from the regular schedule until such time as the negative proctoring reports may be reviewed and evaluated by the Anesthesiology Performance Improvement Committee. Failure to complete the proctoring program in a satisfactory manner could result in the termination of privileges in the Anesthesia Department.

3. Dentists and Nurse Anesthetists: At no time will dentist anesthetists or nurse anesthetists perform general anesthesia. In those instances where dentists have hospital privileges to perform operative dental procedures under local anesthetic, physical examination and history must be recorded prior to the procedure. The dentist must engage a member of the Medical Staff to manage any medical problem that arises after the procedure or during the hospitalization, in accordance with the Medical Staff Bylaws. The dentist shall be capable of recognizing any untoward reactions and taking appropriate action, should any occur, including knowledge and understanding of the closed chest cardiac/pulmonary resuscitation techniques. The anesthesiologist shall be notified in the event of any untoward reactions of the anesthetic.

ARTICLE VII – Amendments

Amendments, changes, additions or deletions to these Rules and Regulations may be made after appropriate vote by the Anesthesiology Department. After approval they shall be submitted to the appropriate bodies for approval consistent with the Medical Staff Bylaws.

ARTICLE VIII – Pre-Anesthesia Visit

1. The preoperative visit shall be conducted personally by the anesthesiologist prior to surgery except on unavoidable and occasional circumstances.
2. At the time of the pre-operative visit there shall be a disclosure of the plan for anesthesia and an acceptance thereof, which shall be set forth in the patient's medical record.

   The documented pre-anesthesia evaluation will include at least:

   a. Evidence of an interview with the patient to verify past and present medical and drug history and previous anesthesia experiences;
   b. Evidence of an evaluation of the patient's physical status. It is accepted practice to document the American Society of Anesthesiologists Physical Status;
   c. Results of relevant diagnostic studies (for example, electrocardiograph pulmonary function tests, laboratory, imaging);
   d. Plan (choice) of anesthesia.
   e. Patients will be assessed immediately prior to induction of anesthesia. This assessment will be documented on the anesthesia record under the comment section.
3. Whenever a serious question is raised regarding the readiness of a patient for elective or emergency surgery, consultation shall be obtained with the operating surgeon as soon as possible.

ARTICLE VIII – Pre-Anesthesia Visit (Continued)

4. The surgeon and/or attending physician shall be responsible for communicating to the anesthesiologist, in such manner as to be clearly understood, any unusual problems known to them which may affect the administration of anesthesia.
5. The anesthesiologist, in consultation with the physician in charge, shall avail him/herself of any consultation, laboratory determination, or diagnostic examination, necessary or desirable, consistent with the current anesthesiological standard of good medical practice.

ARTICLE IX – Conduct of Anesthesia

1. All anesthesia machines shall be equipped with fail-safety systems; pin-dex; scavenger valve, or O_2 analysis and disconnect alarms; must be regularly maintained and the anesthesiologist shall be proficient in its use for anesthesia and resuscitation.
2. Prior to commencing surgery, the anesthesiologist will review the patient’s condition immediately prior to induction of anesthesia. The anesthesiologist shall be in constant attendance and monitoring the patient during anesthesia. The methods of monitoring employed shall be recorded in the chart.
3. During anesthesia, vital signs (e.g., blood pressure, heart or pulse rate and respiration) shall be monitored and contemporaneously charted.
4. On admission to surgery, blood pressure, drugs and doses, and time of administration thereof, in surgery shall be recorded.
5. The use of explosive anesthetic agents is FORBIDDEN.
6. It shall be the responsibility of the anesthesiologist to communicate to the surgeon any untoward event to adverse drug reaction known to him that occurs while the patient is under his care.
7. The anesthesiologist will take every possible precaution to assure the safety of the patient during the anesthetic period.
8. Anesthetic apparatus must be inspected by the anesthesiologist before use.

ARTICLE X – Post-Operative Visits

An anesthesiologist shall make a post-anesthetic visit and record his/her findings in the chart. Complications of anesthesia, when recognized, shall be properly recorded in the chart.

ARTICLE XI – Local Anesthesia

1. If no anesthesiologist is physically present in the operating room, the operating surgeon shall be responsible for the administration of anesthesia.
2. The surgeon shall be knowledgeable and proficient in the use of local anesthesia, and shall be capable of treating any untoward reaction that should occur.
3. During anesthesia, in the absence of any anesthesiologist, vital signs shall be monitored and recorded by a person designation by the operating room surgeon.
4. All drugs, their dosage, route of administration and time of administration shall be recorded on approved forms.

ARTICLE XII – Post-Anesthesia Room (PAR or Recovery Room)

1. Patients shall not be removed from the operating room until the person administering anesthesia is satisfied with the patient's stability and has so recorded this information on the chart.
2. All patients undergoing operative, manipulative or diagnostic procedures under any form of anesthesia (regional or general) shall be taken to the PAR before being returned to their rooms, ICU-CCU, etc., except:
    a. Newborn infants requiring special care;
    b. Other patients when, in the judgment of the surgeon and/or anesthesiologist, it is in the best interest of the patient to be taken to a facility other than the PAR;
    c. Cases requiring isolation.
3. Patients entering the recovery room shall be accompanied by the anesthesiologist.
4. The care of the post-anesthesia patient shall not be delegated by the anesthesiologist or surgeon to the post-anesthetic care facility nurse until the anesthesiologist or surgeon has ascertained that the patient's condition is such that the patient may safely be transferred from the immediate supervision of a physician to that of a post-anesthesia care facility.
5. The status of the patient at the time supervision is transferred to the post-anesthetic care facility shall be recorded.
6. Whenever the anesthesiologist feels the patient's condition warrants it, he/she should discuss the care of the patient with the recovery room nurse at the time the general care if the patient is passes to the nurse. Such discussion may include anesthetic technique used, surgery performed, untoward reactions or any unusual incidents, special orders or precautions, if indicated, and oxygen therapy.
7. Postoperative orders are to be written when the patient's care is transferred to the recovery room nurse except when extreme emergency requires the responsible physician's presence in another area.

ARTICLE XII – Post-Anesthesia Room (PAR or Recovery Room) (Continued)

8. Discharge from the PAR is to be accomplished:
    a. By direct order of the surgeon or anesthesiologist. The actual release of a post-anesthetic patient by a physician and documentation thereof does not necessarily require the presence of a signature of a specific physician at the time of release.
    b. Patients who have received spinal, caudal or epidural anesthesia shall remain in PAR until there has been a return of motor function or at the discretion of the anesthesiologist.
9. The PAR is not to be used as a substitute for routine post-operative floor care (e.g., outpatients undergoing prolonged surgical procedures and requiring prolonged observation and care postoperatively are to be admitted).
10. The responsibility for patients in the PAR is a joint one shared by the surgeon and the anesthesiologist. Requests for assistance by PAR personnel shall evoke immediate and appropriate response of the part of the physicians involved.
11. If no anesthesiologist is involved in the care of the patient, the surgeon shall perform those duties in the recovery room for which an anesthesiologist would normally have been responsible.

ARTICLE XIII – Equipment and Safety Regulations

1. Anesthetic devices shall be inspected regularly by a qualified service technician, and a log maintained of the dates of inspection.
2. Prior to administering anesthesia, the anesthetist shall check the readiness, availability, cleanliness, sterility, where required, and the working condition of all equipment used in the administration of anesthetic agents.

    Laryngoscopes, airways, breathing bags, masks, endotracheal tubes, and all reusable equipment in direct contact with the patient shall be cleaned after each use.

ARTICLE XIV – Criteria for Consultation

Consultations may be sought under the following circumstances:

1. The patient's condition warrants specialist consultation (e.g., Cardiology, Neurology and Pulmonary)
2. With another anesthesiologist when anesthesia management may be questionable.

APPENDIX I

SUBJECT/TITLE: **ANESTHESIA CARE IN BARIATRIC SURGERY**
REVIEWED AND APPROVED BY: Anesthesiology Department
Medical Executive Committee

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1. Pre-op before Surgery Date
   a. Surgeon sends patient work-up package to Anesthesia office and contacts anesthesia for anticipated difficult patients (ASA > 3) and other issues that require anesthesia attention
   b. Anesthesia evaluates patient work-up and contacts patient if necessary

2. Pre-op on Day of Surgery
   a. Review of preoperative work-up package that includes: H & P, labs, EKG, X-ray, appropriate cardiac, pulmonary workups, consults, consent, type and cross or screen for blood, etc.
   b. Meet the patient
   c. Take a history and physical examination
   d. Airway evaluation in anticipation of potential difficult airway include: sleep apnea history, range of motion of head, neck and jaw, length of neck, size of circumference of neck and Mallampati score
   e. Order additional workup if necessary
   f. Preoperative sedation is minimal or avoided
   g. Antibiotics, gastric emptying agent, non-particulate antacid and subcutaneous heparin prophylaxis administration as needed
   h. Transdermal scopolamine patch for PONV prophylaxis in appropriate patients.
   i. Discuss PONV and techniques to minimize its risk, e.g. Total Intravenous Anesthesia (TIVA), minimization of volatile anesthetic gases, minimization of narcotic – type analgesics, use of regional anesthesia e.g. TAP blocks

3. Operating Room Preparation
   a. Anesthesia machine check, monitors suitable for bariatric patients
   b. Operating table capable for bariatric patients
   c. Invasive monitors needed for bariatric patients
   d. Medication appropriate for bariatric patients
   e. Difficult airway cart present with various equipment for difficult intubation (see attached)

4. Pre-induction in Operating Room
   a. Thoracic epidural catheter is placed in appropriate patients
   b. All pressure points carefully checked and padded and patient's head and neck in neutral position, upper extremities abduction less than 90 degrees, foot board in place
   c. Reverse trendelenburg position in most bariatric patients

APPENDIX I – ANESTHESIA CARE IN BARIATRIC SURGERY (CONTINUED)

d. Standard monitors includes BP, EKG and Pulse Oximeter
e. Special monitors may include BIS monitor, Arterial line, Central Venous line, Pulmonary wedge catheter placement

5. Induction and intubation
   a. Short acting and rapid onset induction agents such as propofol are usually selected
   b. Depolarizing muscle relaxant and in certain cases non-depolarizing relaxants are selected
   c. An anesthesia technician, nurse or second anesthesiologist may present to assist with induction and intubation, or anticipated difficult airway cases.
   d. Awake intubation, rapid sequence induction or modified rapid sequence induction are used depending on the degree of anticipated difficulty of intubation

6. Intra-operative management
   a. Short acting inhalational agents vs TIVA for maintenance of anesthesia
   b. Fluid management: NPO status duration, bowel prep fluid loss, blood loss, urine output, and third space loss fluid replacement is given
   c. Epidural or IV narcotic or other appropriate analgesic medications to control intraoperative nociceptive stimuli
   d. Temperature monitor and control such as fluid warmer, operating room temperature and use of force air warming device are used
   e. Hemodynamic monitoring with non-invasive or invasive techniques
   f. Hemodynamic control with fluid (crystalloid or colloid) or vasoactive medications if necessary
   g. Ventilation control: N2O is often avoided, low PEEP may be considered if cardiac function is not compromised

7. Awakening and Extubation
   a. Inhalation agent dissipation
   b. Reversal of muscle paralysis
   c. Patient is able to follow oral commands
   d. On a patient with difficult intubation a trial of breathing with endotracheal tube with cuff down, or extubation with airway stylet in place may be performed
   e. Patient with difficulty with extubation right away is transported to PACU with endotracheal tube in place

8. Recovery Room PACU
   a. Transferring to PACU with oxygen and pulse ox
   b. Anesthesiologist present in PACU until vital signs are stable and patient is safely extubated or placed on ventilator if extubation is not imminent
   c. Patient remains under the supervision of the anesthesiologist until all PACU criteria are met and then is transferred to floor or ICU

APPENDIX I – ANESTHESIA CARE IN BARIATRIC SURGERY (CONTINUED)

9. Post-Operative care on the floor or ICU
   a. Patient is followed up if necessary and checked for anesthetic complications if present
   b. If used: Pain management post op with PCA is supervised by the anesthesiologist
   c. PCEA patient is followed by the anesthesiologist daily

APPENDIX II

SUBJECT/TITLE: **ANESTHETIC PROBLEMS IN BARIATRIC SURGERY**
REVIEWED AND APPROVED BY: Anesthesiology Department
Medical Executive Committee

1. Intubation difficulty- follow the **ASA Difficult Airway Algorithm Guideline**
   a. Anticipated- Awake fiberoptic intubation
   b. Unanticipated- call for additional help immediately
      i. Able to ventilate-asleep fiberoptic, video laryngoscopy, intubation with LMA device, retrograde intubation, wake up patient for awake fiberoptic intubation
      ii. Unable to ventilate- non surgical airways such as LMA, combitube, etc., if fail perform emergency surgical airways immediately

2. Extubation difficulty
   a. Check for adequate reversal of all anesthetic medications
   b. Ensure patient with adequate temperature, metabolic and hemodynamic status and confirm with laboratory studies if necessary
   c. Extra time to allow awakening in OR or PACU prior to extubation
   d. If patient unable to awake consider CT of the head or EEG studies
   e. If patient unable to be extubated then chest X-ray, ABG for evaluation and place patient on ventilator and transfer to ICU for further care

3. Hemodynamic instability
   a. Check hemodynamic reading again and communication situation with surgeon immediately
   b. Begin fluid resuscitation and vasoactive medication
   c. Identify reason for hemodynamic instability
   d. Treat the cause of hemodynamic instability

APPENDIX III

SUBJECT/TITLE: **PAIN MANAGEMENT IN BARIATRIC SURGERY**
REVIEWED AND APPROVED BY: Anesthesiology Department
Medical Executive Committee

1. Preoperative period
   a. Assessment of patient's pain history including prior surgical pain control, usage of NSAIDs, Opioids, and benzodiazepenes.
   b. Discussion with patient about pain management options which may include PCA, TAP block, ketorolac and oral pain medication(s) that will be appropriate for the patient and the surgery
   c. Formulate a pain management plan for the perioperative period with emphasis on the minimization of narcotic – type analgesics through the use of adjuvant therapies and regional anesthesia

2. Intraoperative period
   a. Initiate intraoperative pain management
      i. For most laparotomies: thoracic epidural placement is initiated prior to induction
      ii. For most laparoscopies: intraoperative opioid such as fentanyl, morphine, and/or hydromorphone is used
   b. Additional intraoperative pain medications may include acetaminophen, ketamine, and ketorolac in selected, appropriate patients
   c. In consultation with the surgeon, a TAP block may be performed to reduce narcotic requirements.

3. Post-operative in PACU period
   a. If an epidural is in situ, continue epidural medications (bupivacaine with either fentanyl or hydromorphone) as ordered by anesthesiologist in the PACU setting.
   b. Consider PCA (with hydromorphone or morphine) for patient without an epidural
   c. Additional pain medication to optimize pain control with opioids such as morphine and hydromorphone
   d. When patient's pain is adequately controlled (pain score of 4 or less), patient may be transferred to the floor

4. Post-operative in patient room period
   a. Continue PCEA or PCA administration
   b. Patient's pain is assessed by the nursing staff q 4 hours
   c. Daily visit from anesthesiologist while epidural is in place
   d. Supplemental pain medication such as other opioid medications may be used when PCEA or PCA is inadequate with the approval of the anesthesiologist
   e. PCEA and PCA is discontinued when patient is taking PO (usually post-op day 1 on laparoscopic patient and post-op day 2-3 on laparotomy patient)
   f. Transition to PO pain medication such as: acetominophen with codeine elixir, Lortab elixir, vicodin, percocet, hydromorphone, etc.
   g. A prescription of above oral medication is given to patient by the surgeon prior to patient's discharge

APPENDIX IV

SUBJECT/TITLE: DIFFICULT INTUBATION CART
REVIEWED AND APPROVED BY: Anesthesiology Department
Medical Executive Committee

1. Top of Cart
    d. Double lumen ET tubes
        i. Size 32 Fr, 35 Fr, 37 Fr, 39 Fr
    e. Central line kit – located on A-line cart

2. First drawer
    d. Clamps x3
    e. Portable light source
    f. Batteries for light sources
    g. Light cord
    h. Nu-Trake emergency airway

3. Second drawer
    e. Fastrach ET tube + tube advancer x3
        i. Size 6 Fr, 6.5 Fr, 7 Fr, 7.5 Fr, 8 Fr
    f. Fastrach LMA
        i. Size 3, 4, 5
    g. LMA reusable
        i. Size 3, 4, 5, 6
    h. LMA single use
        i. Size 1, 1.5, 2, 2.5, 3, 4, 5

4. Third drawer
    h. Neo-Synephrine
        i. Mild, Regular, Extra strength
    i. Albuterol
    j. Exactacain
    k. Lidocaine Hydrochloride 4%
    l. 2% Lidocaine Jelly
    m. Fred
    n. Astroglide
    o. Surgilube
    p. Tongue Blades
    q. Syringes
        i. 5cc, 10cc
    r. Alcohol pads

APPENDIX IV – DIFFICULT INTUBATION CART GUIDELINES (CONTINUED)

5. Fourth drawer
   a. Laryngeal Scope Blades
      i. Assorted sizes
   b. Flexible connector
   c. Dental guard
   d. Bite guard
   e. Oxygen tubing
   f. McGell Forceps
   g. ILA
      i. Size 2, 3.5, 4.5
   h. ILA removal stylet
   i. Atomizer

6. Fifth drawer
   a. Nasal Airway
      i. Size 18, 20, 22, 24, 26, 28, 32, 34, 36
   b. Straight tubing connector
   c. MLT
      i. Size 4Fr, 5Fr, 6Fr
   d. ET tubes
      i. Cuffed 9, 8.5. 8, 7.5, 7, 6.5, 6, 5.5, 4.5, 4
      ii. Uncuffed 6, 5.5, 5, 4.5, 4, 3.5
   e. Oral RAE
      i. Cuffed 8, 7.5, 7, 6.5, 6
      ii. Uncuffed 6, 5.5, 5, 4.5, 4, 3.5
   f. Nasal RAE
      i. Cuffed 6, 6.5, 7, 7.5, 8
      ii. Uncuffed 3.5, 4, 4.5, 5, 5.5, 6

7. Last drawer
   a. Bodai
   b. Intubating airway
      i. 9cm, 10cm
   c. 14Fr suction catheter
   d. Yankauer suction handle
   e. Hand Held Nebulizer
   f. Oxygen mask
      i. Adult & Peds
   g. Nasal Cannula

8. Side Door
   a. Fiber optic scopes
      i. Adult, Small Adult, Peds

APPENDIX V

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SUBJECT/TITLE:	DISCHARGING PATIENTS AFTER ANESTHESIA TO NURSING UNIT	
REVIEWED AND	Anesthesiology Department	18-92; 5-11-94; 3-14-12
APPROVED BY:	Medical Executive Committee	1-14-92; 6-14-94; 5-8-12

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Patient is to be discharged by anesthesiologist or attending physician. The patient is returned to the nursing unit accompanied by a Registered Nurse (RN) who gives patient's condition report to an RN assuming care.

All Surgical patients are kept in PACU except for:

a. Patients that are going to be recovered in the critical care units

b. Patients that have received no sedation for 30 minutes preceding recovery room admission.

APPENDIX VI

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SUBJECT/TITLE:	CRITERIA FOR SEDATION AND ANALGESIA PRIVILEGES	
REVIEWED AND APPROVED BY:	Anesthesia Department	06-09-97, 03/08/00, 11/13/02, 02/12/03, 11/12/03, 04/14/04, 1/11/06, 09/09/09
	Medical Executive Committee	06/10/97, 03/14/00, 12/10/02, 03/11/03, 12/10/03, 05/14/04, 10/12/04, 11/08/05, 02/14/06, 10/13/09

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It is the standard of practice at Torrance Memorial Medical Center that medical staff members will be credentialed for the use of sedation and analgesia. The following indicates the privilege criteria by which physicians will be credentialed.

Granting of Privileges: The Anesthesiology Department is responsible for granting privileges and evaluating the privilege criteria. No revisions to the criteria will be made without approval by the Anesthesiology Department.

Continuous Quality Improvement: Cases will be referred for review to the Anesthesiology Department based upon criteria as established and approved by the Anesthesiology Department and individual Departmental Performance Improvement efforts.

The overall monitoring of sedation and analgesia remains the responsibility of the Anesthesiology Department.

Privileging

MODERATE SEDATION: Members of the Medical Staff who wish to perform Moderate Sedation, other than Anesthesiologists, must hold privileges to administer Moderate Sedation. See specialty clinical privilege application card for qualifications, requirements and proctoring.

The definition of Sedation and Analgesia (Moderate Sedation) will remain consistent with those outlined in the Sedation policy located in the Patient Care Manual. All practices (i.e., policies, monitoring, equipment needs, charting) will also remain consistent of those identified in the Sedation and Analgesia (Moderate Sedation) policy.

DEEP SEDATION: Members of the Medical Staff who wish to perform Deep Sedation, other than to administer Deep Sedation. See specialty clinical privilege application card for qualifications requirements and proctoring.