

**Beth Israel Deaconess Medical Center  
Department of Anesthesia and Critical Care  
SOP**

***Title: Medication Direction Compliance***

***SOP #: ANES ADM***

**Introduction**

Anesthesiology is the practice of medicine including, but not limited to, preoperative patient evaluation, anesthetic planning, intraoperative and postoperative care and the management of systems and personnel that support these activities. Anesthesiology also includes perioperative consultation, the management of coexisting disease, the prevention and management of untoward perioperative patient conditions, the treatment of acute and chronic pain, and the practice of critical care medicine. The administration of anesthesia to all patients at BIDMC will be provided by a board certified or board eligible anesthesiologist (BC/BE) who is privileged by the Medical Staff Office. An anesthesiologist will personally perform, medically direct, or medically supervise every anesthetic. The Department of Anesthesiology, Critical Care and Pain Medicine of Beth Israel Deaconess Medical Center (BIDMC) is a group practice, including physician anesthesiologists, certified registered nurse anesthetists, and physician residents and fellows.

Certified registered nurse anesthetist (CRNA) - An advanced practice nurse with training in anesthesia and credentialing by the [Advanced Practice Nursing committee at BIDMC].

Resident – An individual who participates in the approved graduate medical education (GME) program at BIDMC, or a physician who is not in an approved GME program but who is authorized to practice only in a hospital setting. The term includes interns and fellows in GME programs. Receiving a staff or faculty appointment or participating in a fellowship does not by itself alter the status of "resident".<sup>1</sup>

## **1. Definition of Care**

### **1. Personally perform:**

The anesthesiologist will be continuously and personally present throughout the entire procedure with the patient. The physician may personally perform the entire anesthesia service alone, or may perform the anesthesia case with a resident or CRNA. The only exception to presence in the operating room is for personal privileges (e.g. visiting the restroom). The anesthesiologist may receive a break (per Break Statement) but will remain personally responsible for the anesthetic. The anesthesiologist may not provide services for other patients during a break.

### **2. Medical direction:**

The anesthesia care team model is that situation wherein the anesthesiologist directs a team of resident physicians and/or certified nurse anesthetists (CRNA) in the provision of anesthesia care. The physician may delegate monitoring and appropriate tasks while retaining overall responsibility for the patient. The anesthesiologist will direct the team in the care of two to four patients. Although the resident or CRNA may contribute to the care of the patient, the anesthesiologist is responsible for all elements of care of each patient, defined below:

- Performs a pre-anesthetic examination and evaluation;<sup>2</sup>
- Prescribes the anesthesia plan;<sup>3</sup>
- Personally participates in the most demanding procedures in the anesthesia plan, including, if applicable, induction and emergence (See Induction and Emergence Statement);
- Ensures that any procedures in the anesthesia plan that he or she does not perform are performed by a qualified anesthetist;<sup>4</sup>
- Monitors the course of the anesthesia administration at frequent intervals;<sup>5</sup>
- Remains physically present and available for immediate diagnosis and treatment of emergencies (see statement);
- Provides indicated post-anesthesia care.<sup>6</sup>

---

<sup>2</sup> A pre-anesthetic evaluation allows for the development of an anesthetic plan that considers all conditions and diseases of the patient that may influence the safe outcome of the anesthetic.

<sup>3</sup> The anesthesiologist is responsible for prescribing an anesthesia plan aimed at the greatest safety and highest quality for each patient. The anesthesiologist discusses with the patient or guardian, as appropriate, the anesthetic risks, benefits and alternatives, and obtains informed consent. When part of the anesthetic care will be performed by another qualified anesthesia practitioner, the anesthesiologist should inform the patient that delegation of anesthetic duties is included in care provided by the Anesthesia Care Team.

<sup>4</sup> The management of an anesthetic is dependent on many factors including the unique medical conditions of individual patients and the procedures being performed. Anesthesiologists will determine which perioperative tasks, if any, may be delegated. The anesthesiologist may delegate specific tasks to qualified non-anesthesiologist members of the Anesthesia Care Team providing that quality of care and patient safety are not compromised.

<sup>5</sup> CMS 100.1.4 The teaching physician's physical presence during only the preoperative or postoperative visits with the beneficiary is not sufficient to receive Medicare payment.

Another member of the team or the anesthesia department may provide the pre-anesthesia examination and evaluation or provide post-anesthesia care as part of the completion of the component parts of the anesthesia services.<sup>7</sup>

The anesthesiologist will remain within the peri-anesthetic area and not be occupied in a way that prevents him/her from immediately conducting hands-on intervention, if needed (see Peri-anesthetic Area). Being occupied is defined as engaging in an activity that would produce the potential for harm or would be dangerous if immediately abandoned, or would require substantial time away from the peri-anesthetic area. There are activities that do not diminish the anesthesiologist's ability to medically direct; the activity should be interruptible and allow the anesthesiologist to re-establish direct contact to address urgent or emergent clinical situations. Identified activities which do not substantially diminish the scope of control exercised by the physician in directing the administration of anesthesia include:

- Addressing an emergency of short duration in the immediate area;
- Administering a nerve injection for a surgical pain or to ease labor pain, such as epidural or caudal anesthetic;
- Periodic, rather than continuous, monitoring of an obstetrical patient;
- Receive and prepare patients entering the operating suite for the next surgery;
- Check or discharge patients in the recovery room;
- Handle scheduling matters.

There are other activities that are not appropriate for the medically directing anesthesiologist. Examples of such activities include, but are not limited to:

- Personally performing another anesthetic;
- Performing other elective procedures on patients not undergoing a surgical procedure (such as chronic pain blocks);
- Engaging in any other activity that would prevent a timely return to establish direct contact with the patient to meet medical needs or treat emergencies.

---

<sup>6</sup> Routine post-anesthesia care is performed by nurses who are credentialed by the Department of Nursing of BIDMC with skills and competencies defined as a PACU nurse. The evaluation and treatment of post-anesthetic complications are the responsibility of the anesthesiologist.

<sup>7</sup> CMS 100.1.4: To qualify for payment, the teaching anesthesiologist, or different anesthesiologists in the same anesthesia group, must be present during all critical or key portions of the anesthesia service or procedure involved. The teaching anesthesiologist (or another anesthesiologist with whom the teaching physician has entered into an arrangement) must be immediately available to furnish anesthesia services during the entire procedure. The documentation in the patient's medical records must indicate the teaching physician's presence during all critical or key portions of the anesthesia procedure and the immediate availability of another teaching anesthesiologist as necessary.

Furthermore, if the anesthesiologist leaves the immediate area of the operating suite for other than short durations or devotes extensive time to an emergency case or is otherwise not available to respond they may not provide medical direction.<sup>8</sup>

### **3. Medical Supervision**

Medical supervision is defined as providing anesthesia services to more than four simultaneous cases, when the anesthesiologist cannot provide the seven provisions of anesthesia, or when the anesthesiologist is not available and backup cannot be arranged.

## **2. Break Statement**

All breaks will be provided by a qualified anesthetist (staff, resident or CRNA). Breaks are defined as those of short and long duration.

Short duration breaks are given for personal privileges and must be of brief duration.

- The provider being given the break remains responsible for their portion of the anesthetic.
- They must provide a means of rapid communication (e.g. beeper, cell phone) and must be available to return immediately.
- They must not be occupied in a way that prevents immediate return.

Long duration breaks include relief for other reasons (e.g. to purchase of food for lunch), or for times when the break may be of a short period of time but the provider being given the break is not available, or has left the peri-anesthetic area (e.g. leaving the unit for a meeting).

- When the anesthesiologist is providing a long duration break, the anesthesiologist is temporarily personally performing, and is responsible for identifying and communicating to an available staff anesthesiologist (see Backup Provider) to care for any other anesthetizing locations they are associated with.
- When the break is being provided by someone other than the anesthesiologist, the resident or CRNA who is receiving a break is responsible for communicating to the anesthesiologist that they are being relieved.
- The resident or CRNA who is receiving a break is responsible for providing appropriate sign out to the person providing the break for temporary transfer of care; the person providing the break is responsible for providing appropriate sign out to the resident or CRNA to return care.

---

<sup>8</sup> CMS 50.C quotation: This allows the anesthesiologist to leave the immediate area of the operating suite for short duration!

### **3. Backup Statement**

As a group practice, the Department of Anesthesiology, Critical Care and Pain Medicine at BIDMC has providers who act as a backup for when the primary anesthesiologist is not immediately available. The backup anesthesiologist will be physically present and available for immediate diagnosis and treatment of emergencies and be responsible for the provision of anesthesia services. The backup anesthesiologist does not become the primary anesthesiologist (transfer of responsibility for care) but acts in the capacity of surrogate for the primary anesthesiologist. These providers are BC/BE anesthesiologists who may be assigned on the schedule, and are identified as (but not limited to): Floor manager, Regional attending, Available East/West. Providers may also be brought from the non-clinical pool of clinicians to provide coverage and, therefore, may not be listed on the daily OR coverage (i.e. brought in for a specific purpose for a limited duration). The floor manager on each campus is the coordinating anesthesiologist to ensure that adequate backup physicians are available for coverage. The backup anesthesiologist must remain in the immediate peri-anesthetic area and must always carry a pager and answer promptly any pages to an anesthetized location.

### **4. Induction and Emergence Statement**

The anesthesiologists must be physically present and available for induction of anesthesia. Induction of anesthesia occurs as a discrete event during general anesthesia and regional anesthesia, but does not occur as a discrete event during monitored anesthesia care, anxiolysis or analgesia. Documentation of the presence of the anesthesiologist must be made in the chart.

Emergence of anesthesia is a continuum of care provided at the end of an anesthetic. Emergence from general anesthesia is neither a discrete point in time nor not limited to extubation. Emergence from general anesthesia begins with the decision to decrease the level of anesthesia and continues through extubation, when applicable, and ends when the patient is awake, oriented in the recovery room. The anesthesiologist must be physically present and available for immediate diagnosis and treatment of emergencies during emergence. He/She will medically direct the emergence; i.e., the anesthesiologist is involved in how emergence will be handled and will be “face-to-face” with the patient at some time during the emergence period.

Emergence cannot be defined during regional anesthesia (both neuraxial and peripheral), as patients may have blockade that is purposefully prolonged to provide postoperative pain relief (e.g. 24 hours after surgery). Emergence of anesthesia from monitored anesthesia care, anxiolysis and analgesia are not applicable.

## 5. Physically Present Statement

The anesthesiologist must be physically present and available for immediate diagnosis and treatment of emergencies during a medically directed anesthetic. The medically directing anesthesiologist is immediately available when in physical proximity that allows the anesthesiologist to return to reestablish direct contact with the patient to meet medical needs and address any urgent or emergent clinical problems. Physical proximity is defined as being in the peri-anesthetic area (see below). This responsibility may also be met through coordination among anesthesiologists. The demands of particular surgical and other diagnostic or therapeutic procedures and the clinical needs of patients may further restrict what constitutes immediate availability under specific circumstances.

### 1. Peri-anesthetic Area

The peri-anesthetic area at BIDMC is defined as:

EAST CAMPUS	Shapiro OR suite	Feldberg OR Suite	GI 3 <sup>rd</sup> floor	GI 4 <sup>th</sup> floor	Radiology L3
Shapiro OR suite	X	X			
Feldberg OR Suite	X	X	X	X	X
GI 3 <sup>rd</sup> floor		X	X	X	X
GI 4 <sup>th</sup> floor		X	X	X	
Radiology L3		X	X		X

WEST CAMPUS	West OR suite	Radiology IR/CT/INR	Cardiology	WPC	MRI	ECT
West OR suite	X	X	X			
Radiology IR/INR	X	X				
Cardiology	X		X			
WPC				X		
MRI					X	
ECT						X

## 6. Specific Cases

### 1. Monitored Anesthesia Care (MAC):

Monitored anesthesia care involves the intra-operative monitoring by the anesthesiologist, or a resident or CRNA under the medical direction of an anesthesiologist, of the patient's vital physiological signs in anticipation of the need for administration of general anesthesia or of the

development of adverse physiological patient reaction to the surgical procedure. For MAC cases, all seven requirements of medical direction must also be met, with the exception that MAC cases do not require that the anesthesiologist be present for induction and emergence, as these may not exist, per se. The anesthesiologist must be physically present for some portion of the case, and must remain available to diagnosis and treatment of emergencies.

## **2. Regional Anesthesia:**

Regional anesthesia includes neuraxial anesthesia (spinal, combined spinal epidural, epidural, caudal) and peripheral nerve blocks (as the primary anesthetic or a postoperative pain management block). Regional anesthesia is not an analgesic procedure but an anesthetic intended to allow for a surgical procedure. The anesthesiologist must fulfill all seven requirements of medical direction with the exception that emergence may not exist, per se. The anesthesiologist must be present for injection of the anesthetic medications, and be physically present for some portion of the case, and must remain available to diagnosis and treatment of emergencies.

Regional anesthesia for postoperative pain management can be performed preoperatively, intraoperatively, or postoperatively. When the patient receives a block preoperatively and it is performed as a primary anesthetic (even if they receive sedation, but not general anesthesia, intraoperatively) then this is considered the anesthesia of record. When the block was performed solely for postoperative pain management, and is not the primary anesthetic, then this is considered a separate anesthetic procedure. The anesthesiologist must identify if the block was performed as part of the intraoperative anesthetic or was used for postoperative pain, alone.

## **3. Neuraxial and Peripheral Nerve Analgesia:**

Neuraxial analgesia includes obstetric, intraoperative, and postoperative pain control modalities (spinal, combined spinal epidural, epidural, caudal). Peripheral nerve analgesia includes peripheral nerve catheters placed for pain control via a continuous, low-dose infusion of local anesthetic. Similar to MAC and intravenous analgesia, induction and emergence cannot be defined. The anesthesiologist must fulfill all seven requirements of medical direction with the exception that emergence may not exist, per se. The anesthesiologist must be physically present for some portion of the case, and must remain available to diagnosis and treatment of emergencies.<sup>9</sup>

## **4. Supervision for Labor Analgesia**

Labor analgesia includes spinal, combined spinal epidural, epidural, caudal techniques. Although labor analgesia is an exception to medical direction, the anesthesiologist must provide personal direction provided by these criteria:

---

<sup>9</sup>This way we don't need to be there when the resident starts the APS infusion in the OR or PACU.

1. Reviewing the patient's history and physical examination and personally examining the patient within a reasonable period after the patient's admission and before the patient's discharge.
2. Confirming or revising the patient's diagnosis.
3. Determining the course of treatment to be followed.
4. Ensuring that appropriate supervision of residents is provided.
5. Ensuring that the analgesic regimen is intermittently monitored and directing changes, as needed.
6. Ensuring the patient is visited during the postpartum period, when indicated.

For complex cases, including but not limited to: severe preeclampsia, super morbid obesity, obstetric hemorrhage, sepsis, or significant maternal comorbidities, the anesthesiologist should be aware of changes in the patient's condition either by personally monitoring the patient or through communication by the supervised resident.

For invasive procedures, including surgery, cesarean section, D&C, the medical direction documentation rules apply.

### **5. Intensive Care**

See HMFP compliance rules

### **6. Acute and Chronic Pain**

See HMFP compliance rules

### **7. Pain Medicine**

See HMFP compliance rules

**Policy Owner:** Dr. Philip Hess

**Review Date:** Dec. 2018

**Next Review Date:** Dec. 2021