# TABLE CONTENTS

<table>
<thead>
<tr>
<th>Medication Policies &amp; Practices</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preparation &amp; Labeling</td>
<td>5</td>
</tr>
<tr>
<td>Transportation</td>
<td>6</td>
</tr>
<tr>
<td>Emergency resuscitation Medication</td>
<td>6</td>
</tr>
<tr>
<td>Off-Site Anesthesia Services</td>
<td>6</td>
</tr>
<tr>
<td>Charging Medications</td>
<td>6</td>
</tr>
<tr>
<td>Used Medications</td>
<td>7</td>
</tr>
<tr>
<td>Infection Control</td>
<td></td>
</tr>
<tr>
<td>Surgical Antibiotics</td>
<td>8</td>
</tr>
<tr>
<td>Peri-operative Attire</td>
<td>8</td>
</tr>
<tr>
<td>Hand Hygiene</td>
<td>8</td>
</tr>
<tr>
<td>Central Line Placement</td>
<td>9</td>
</tr>
<tr>
<td>Room/Equipment Prep</td>
<td>9</td>
</tr>
<tr>
<td>Waste Disposal</td>
<td></td>
</tr>
<tr>
<td>Used Medications</td>
<td>10</td>
</tr>
<tr>
<td>Summary</td>
<td>10</td>
</tr>
<tr>
<td>Additional Compliance Issues</td>
<td></td>
</tr>
<tr>
<td>Time-Outs</td>
<td>11</td>
</tr>
<tr>
<td>Consenting</td>
<td>11</td>
</tr>
<tr>
<td>Transferring Patient Care</td>
<td>11</td>
</tr>
<tr>
<td>Other RCRMC Policies</td>
<td></td>
</tr>
<tr>
<td>Must Attending Call List</td>
<td>12</td>
</tr>
<tr>
<td>Trauma Phone/Pager Duties</td>
<td>12</td>
</tr>
<tr>
<td>Medical, RT &amp; Paramedic Students</td>
<td>12</td>
</tr>
<tr>
<td>Room Turn-Over</td>
<td>13</td>
</tr>
<tr>
<td>Obstetrics</td>
<td>13</td>
</tr>
<tr>
<td>Carts – Peds, Code &amp; MH</td>
<td>13</td>
</tr>
<tr>
<td>Room Temperature</td>
<td>13</td>
</tr>
<tr>
<td>Confidentiality, Adverse Events</td>
<td>13</td>
</tr>
</tbody>
</table>
Welcome
Welcome to Riverside County Regional Medical Center Anesthesia Program. The anesthesia program is designed, innovatively, to foster good patient care and growth of the resident physician and numerous other trainees as providers and wholesome members of the anesthesia community.

Our residency program offers 5 categorical positions per year. In addition, we provide training for Nurse Anesthetist Students, interns and rotating residents from other medical disciplines. Because RCRMC is a state of the art facility servicing the greater Riverside area, we are a very busy facility which allows for an inordinate amount of learning and teaching opportunities. Our diverse population enables our providers to experience obstetrical anesthesia, including high risk obstetrics, general surgery, including thoracic and vascular anesthesia, orthopedic surgery, including spine, pediatric anesthesia, plastic surgery, neurosurgery, and urology as well as managing the trauma patient.

Because of the opportunities offered at RCRMC, our program has gained immense popularity. The clinical experience has been merged with a consummate didactic program that allows for comprehensive education in anesthesia. Also, because of our commitment to providing the best care, we have adopted a model of teaching that incorporates tools that assess progressive learning through specific core competencies. This ensures trainees establish a well rounded, caring, compassionate physician with an objective to provide good quality care and to learn effective physician-patient interaction.

We at RCRMC pride ourselves for our commitment to achieving excellence in clinical care and education. Our program is constantly evolving with a goal of continued enhancement of our education program. Our dedicated staff encourage, participate, and learn alongside the trainees and are an integral part of the experience here.

We look forward to having you as part of our team.
As Joint Commission continues to update and clarify their recommendations, so does the Hospital and the Anesthesia Department’s interpretations. We are continuously modifying our policies and practices and will make every attempt to keep you, the rotator, informed. It is important to appreciate that every institution has its own means by which to comply with all local and national regulations, and therefore as you visit and practice at different locations, you may find yourself learning an entirely new way to practice.

**Medication Policies & Practices**

**Preparation and Labeling**

**Labeling**

Medication that is immediately prepared and administered does not need to be labeled. “Immediately” administration is defined as the provider prepares or obtains, takes directly to the patient and administers to that patient without any break in the process. An example of this might be Versed that you draw at the patient’s bedside in the Pre-Op holding area and immediately administer.

All prepared medications must be labeled with the following:

- Medication’s Name, Strength, Amount
- Date and Time if medication expires within 24 hours (Propofol)

Pre-Labeled syringes already have this information pre-printed on the syringe. Syringes which are prepared by you must have a label attached which states the medication’s Name and Strength. The Amount is demonstrated by the syringe’s graduated markings. All medications are reconciled at the conclusion of the case.

**Specific Examples:**

**Propofol** – must be labeled with “use by” the moment it is removed from refrigerator

**Epidurals/spinals:** please refer to anesthesia residents and/or attending to review our current policy regarding the labeling of medications during these procedures. These policy procedures apply to epidural steroid injections placed in the Pain Clinic as well.

**IV bag** – IV bags hung at patient’s bedside need to be labeled with patient’s name and MRN or DOB throughout the perioperative period. The easiest and most reliable way to accomplish this is to apply a stamped patient sticker to the hung bag which you can obtain from the circulating nurse. If any medication is added to the IV solution, the bag must be labeled with the additional information list above.

**Preparation**

Medications should not be prepared (drawn, ampule or vial opened, plastic removed) until the patient is in the OR; unless the medication is to be administered pre-operatively (ie pre-op sedation, steroids, antisialogue, etc). To reiterate, do not remove or pull back the plastic seal on syringes, prepare empty syringes or remove the tops from medication vials before the patient is in the OR.

Syringes should **NOT** be prepared ahead. Labeling of medications or solutions must occur at the time it is prepared.

Only retrieve medications you anticipate using. For example, two 200mg syringes of Propofol should not be necessary to induce your 65kg 75y/o patient. The same goes for supplies and equipment.
There should never be opened or empty medication containers in an OR in between cases, or medications that have not been pulled and charged to the patient in the OR. In other words, all pulled and prepared medications are patient specific for the patient currently in the operating room. Any medication container that is found without a label should be immediately discarded.

Exceptions: anytime patient safety is a concern. An example of this might be weight based emergency medications for a pediatric patient prepared ahead of time with IM needles. Another example may include setting up infusion drips for a septic patient or that necessary for a difficult case such as a CEA. Be sure to discuss the necessity of these medications with your Attending prior to preparation. In these cases, proper labeling still applies.

**Emergency Resuscitation Medications**
Emergency resuscitation medications are located in the locked Epidural Cart, Sedation Tray (for anesthesia services outside the OR) and all OR Pyxis.

**Transportation of Medications**
Peri-Operative Units are considered to include the following:
- OR - Operating Rooms, Pre-Operative Holding and Post-Anesthesia Care Unit
- Labor & Delivery - Operating Rooms, Laboring Patient Rooms and Recovery Room
- Radiology – CT, X-Ray, MRI and Angiography Rooms

Medications should never be transported outside of these units without a Medication Transport Box. For example, if a patient is to be transported from the OR to an ICU and it is necessary to take specific medications with the patient, these medications must be contained inside a Medication Transport Box. These Boxes are stored in the Anesthesia Store Room along with the transport monitor.

*To reiterate,* medications should never be transported outside of a “Unit” in pockets, fanny pack, etc.

**Off-Site Anesthesia Services (this site is still under construction)**
On occasion the Anesthesia Department will be asked to provide services outside the Operating room Unit. A “Sedation Tray” containing medications most frequently used should be retrieved from the Pyxis located in the OR’s central core. Controlled medications (Midazolam, Fentanyl, Ketamine, Ephedrine, etc.) are available at this pyxis and need to be retrieved individually. Note that these medications are not available in the Radiology Unit and you need to anticipate your need for the entire case. In addition, pediatric and adult crash carts are located throughout the hospital in case of emergency. At the conclusion of the case, the “Sedation Tray” should be returned to the OR Central Core Pyxis and all controlled medications reconciled individually. No medications should be transported between Units (OR to Radiology) unless in a Medication Transport Box or Sedation Tray.

**Charging Medications**
It is critical that all medications removed from the Pyxis be charged to a patient. Otherwise the hospital fails to be reimbursed and the pharmacy is unaware of the limited Pyxis inventory. This will result in failure to stock needed medications.

*Note:* Be sure to hit “Accept” on the Pyxis machine to place charge when removing medication directly from drawers 2.1, 2.2 and/or 3.

It is our Pharmacy’s policies that all medications are to be used on a single patient. Once medication has been administered any remaining must be discarded. Do not use the same
medication container for more than one patient in an attempt to conserve. Again, all medications should be disposed at the conclusion of a case.

**Used Medications**
All medications used during an anesthetic must be accessible until the conclusion of the case for review if necessary. In order to accomplish this, all used/partially used vials and syringes need to be kept in an emesis basin until the conclusion of the case. Just prior to exiting the OR, the emesis basin should be emptied, discarding the vials and syringes in the proper containers (see Appendix D).
Infection Control

Surgical Antibiotics

- Appropriate choice and timing of surgical antibiotics are of paramount importance. Documentation is recorded on two separate locations on our Anesthesia Record.
- Note that Surgical Care Improvement Project (SCIP) measures (60 & 120 min before incision) do not apply to patients who are already receiving antibiotic therapy.
- Care must be taken not to start the antibiotics too soon, especially for those which need to be administered within one hour. Intubation, lines, patient positioning, surgical site prep can often take more than one hour. If the antibiotic can be administered rapidly, it is advisable not to start it until the site is being prepped.
- If no antibiotics are ordered by the surgical team you must document this on the Anesthesia Assessment (H&P) under “Time-Out Specific Requests” and the Surgeon who the request and Time-Out was completed with.
- In the case of antibiotics which can have harmful effects at higher concentrations (ie Vancomycin) be sure to check for previous administration and check with your Attending before redosing early.

Peri-Operative Attire

- RCRMC Operating Room scrubs are Navy Blue. Only these scrubs are to be worn inside the Peri-operative Unit.
- RCRMC scrubs are never to be worn outside of the hospital.
- If you would like to wear your own scrubs in and out of the facility, please wear those of a different color.
- When you leave the OR suites (cafeteria, pre/post-op rounds) you must wear a cover gown or lab coat and remove shoe and head covers. Cover gowns must be worn with the opening in the back.

Eye Protection:

- Is to be worn during any procedure and in the operating rooms at all times.

Procedural Attire

- Surgical hats and masks must be worn when involved with the placement of Spinals, Epidurals, Central-Lines and Peripheral Nerve Blocks whether in the OR or not.

Hand Hygiene

- Shall be performed using warm water and hospital provided liquid soap and rubbed together vigorously enough to create a large amount of lather for 15 to 30 seconds.
- Hand sanitizing gels and foams can be used up to five times in between using soap and water and only if hands are not visibly soiled. Sanitizer should cover both sides of hands, fingers and wrists and rubbed until dry.
- Hand sanitation must occur –
  - At the beginning and end of every shift.
  - Before and after providing care and/or performing any procedure, including handling medical records.
  - Before and after eating, using the restroom or any time hands are visibly soiled.
**Central Lines**

- RCRMC has a strict policy regarding the insertion of central lines. Confer with your Attending and/or Resident if presented with the opportunity to place a central line in order to ensure all current procedures are followed.
- Chest X-Rays must be obtained immediately following placement and Orders stating correct placement in the patient’s chart. Exception can be made at the discretion of the Attending in cases of trauma/emergency, etc.
- A “Central Line Check-List” is completed by the nursing staff.

**Room/Equipment Prep**

**OR Preparation:**

Any equipment (OPAs, ET tubes, laryngeal scopes) that is taken out of their packaging and/or drawers is considered dirty and must be wasted or processed at the end of the case. For this reason, only take out the items you anticipate using. We have organized the anesthesia area so that backup airway equipment is readily accessible in case of emergency.

For example:

- If the plan includes a LMA, get one and do not open ET tubes or take a DL blade out of the drawer.
- If the plan does include intubation, do not bring a LMA into the OR and only open and stylet the ET tube you plan on using. There are disposable LMAs in the “Emergency Airway Kit” in every room in case of emergency.

**IV Ports & multi-dose vials:**

- Prior to administering medications through an IV, all ports must first be wiped off with an alcohol swap. The RCRMC Pharmacy discourages the use of multi-dose vials.

**Safe Injection Practices:**

- Use aseptic technique.
- Do not administer medications to multiple patients using the same syringe, even if the needle is changed.
- Do not administer medications from single-dose vials to multiple patients.
- Do not use bags or bottles of intravenous solution as a common source of supply for multiple patients.
- Do not keep multi-dose vials in the immediate patient treatment area.

**Labeling Lines:**

- All PIVs, Central Lines, A-Lines, NG/OG Tubes must be labeled following insertion if to be continued outside the OR. Adhesive labels are provided by the Circulating Nurse. The label must include: **Date** placed and **Initials** of the proceduralist.

So if you place a line/tube which is going to be left in place at the conclusion of the case – Label it with Date & Initials.
Waste Disposal

Used Medications
All medications used during an anesthetic must be maintained until the patient leaves the OR. Many providers find it useful to place all used/partially used vials and syringes in an emesis basin until the conclusion of the case. Just prior to exiting the OR, the emesis basin should be emptied, discarding the vials and syringes in the proper containers.

Summary
You must review and be familiar with RCRMC’s waste disposal policy. A copy of the policy is included as a separate download.
High Yield –
· The red sharps container is for empty syringes, needles, razors, guide wires, etc.
· The blue & white container is for unused medications, medication vials, IV fluid bags (including crystalloids, colloids, abx).

Blue & White Container → Anything that held a medication or fluid except syringes
Red Sharps Container → Needles and syringes
Additional Compliance Issues

Time-outs

**Marking of Procedural Site with Initials:**
- Marking the surgical or procedure site not necessary when the proceduralist doesn’t leave the patient from completion of the consent to the actual procedure, when a single organ is involved (ie appendix), or when the site is not specific (ie central line).
- The procedural site can be marked by a licensed independent practitioner who is ultimately accountable for the procedure or a supervised individual in a medical postgraduate education program (ie PGY-II). The individual marking the procedure site must be present when the procedure is performed.

**Surgical Procedure:**
- To be completed prior to induction (except at the Anesthesia Attending’s discretion or in cases of emergency).
- Must be completed with a member of the surgical team who will actually be scrubbed, involved with the case and has first hand knowledge of the procedure. In high risk procedures and/or high risk patients it may be desirable to have the time-out completed attending to attending.
- Should include pre-operative abx, beta-blockers, patient positioning and OR table orientation, anticipated risks including extended duration, large EBL, ICU admission, invasive monitoring, etc. Be sure the antibiotic start time is correct and results in administered within one hour of surgical incision.
- When possible the patient should be involved and confirm name, DOB and surgical procedure location.

**Epidurals, Spinals, Central Lines, Peripheral Nerve Blocks:**
- To be completed prior to procedure
- This is an additional and separate time-out from that of the surgical procedure. The surgeon does not need to be present.
- Must be completed with a nurse familiar with the patient and procedure.

**A-Lines:**
- A separate Time-Out needs to be conducted only if the line is to be placed outside of the OR.

Consenting

Must be completed for any procedure requiring a Time-Out which is preformed outside the OR. Procedures preformed inside the OR are covered by surgical consent. The department is currently developing an anesthesia specific consent which is not yet in circulation.

Transferring Patient Care

This is the format RCRMC has adapted and should be used for all patient transfers (provider breaks, PACU and ICU nursing, etc.) of care.

- **S** – situation
- **B** – background
- **A** – assessment
- **R** – recommendations

When transferring a patient to the ICU, report should be given directly to the physician team assuming responsibility for the patient. When possible, the team should meet you in the ICU upon arrival.

When you assume care of a patient, you are also assuming responsibility for medications and equipment. It is always necessary to sign the anesthesia record and include times.
Other RCRMC Policies

Must Call Attending List

If you are ever unable to contact your Attending, or are unsure of whom your Attending is, call x30176. Attending back-up is available 24/7 at this extension.

- Beginning and end of every case
- Prior to any off-site intubations (ICU, etc.)
- All cases must be presented to an attending (this includes OB)
- Multiple doses of any pressor
- Deviation of baseline vitals >30% or MAP <55
- Significant bradycardia (that which effects hemodynamic stability)
- Discussion/thoughts about blood product administration
- Prior to any insulin administration
- Acute blood loss of >300ml or 4ml/kg
- Unexpected additional use of induction agents during an anesthetic
- Any time you are evaluating an airway in the Emergency department which may be difficult and/or you are requested to assist with an intubation.

Trauma Phone/Pager Duties

- Code Blues – a member of the anesthesia team must be present for all Code Blues. Your role is usually airway management and provide team assistance as necessary. **It is critical that you identify the recorder and be sure you let them known that anesthesia responded.**
- Level A traumas – a member of the anesthesia team must be present for all Level A Traumas in the ER. Your role is usually patient assessment in the event they go to the OR and airway management if assistance is requested by the ER/Trauma Service. **It is critical that you identify the trauma nurse recorder and let them know that you are the anesthesia department representative when you responded (name & time).**

  First responsibility is an airway assessment. If the airway is not yet to be secured and your evaluation raises some concerns, immediately call and give report to your Attending. The same applies if the ED requests your assistance on an airway.

- Intubations – it is important to gather certain information:
  - Who is calling
  - Where is the pt.
  - Is the intubation urgent or emergent (can it wait up to 30min)
  - What are the indications
  - Is there a history of or any reason to anticipate difficulty with the airway

  After obtaining this information call the Senior Resident or the Attending On-Call to develop a plan.

Medical, RT & Paramedic Students

- Here to assist you.
- It is your decision as to whether or not allow them the privilege of conducting procedures (intubations, PIVs, etc.) with patient safety being paramount. It is recommended that if you allow them to intubate, you take a first look.
- Students are NOT to prepare or administer medication.
- If a medical student has assisted with a Pre-Operative H&P; it is still your responsibility to verify the information, explain the anesthetic, and discuss the risks and benefits.
Room Turn-Over

As with any Anesthesia Department and/or Provider, we are often judged by our ability to deliver cases in and out of the operating room in a timely fashion. Here at RCRMC we place a high emphasize on efficiency, second only to patient care.

First case of the day – once the pre-operative check-list has been initialied by 1-Pre-op Nurse; 2-OR Circulating Nurse; and, 3-Member of the Surgery Team the patient can be taken to the OR Suite. It is not necessary to check with the room or the nurse to confirm.

Between cases – To verify your next case, refer to the OR Control Board or call the front desk at x64572. Most of the time a Medical Student will be assigned to every room. It is your responsibility to coordinate your team and have the next patient pre-op’d and presented to the Attending before completing the current case. The patient can be brought to the OR when the circulating Nurse and Surgeon have initialed the Pre-Op Worksheet.

Obstetrics

Obstetrical Anesthesia Reading Assignments and Manual can be found on our web-site. If you anticipate gaining OB privileges these will need to be reviewed.

Carts – Code & MH

Malignant Hyperthermia Cart:
· MH Cart is located in the Anesthesia Storage Room (door code 4523*) and outside the Obstetric ORs.
· The contents of the cart are listed on the exterior of the cart. While the cart’s location will be pointed out during your facility tour, it is your responsibility to familiarize yourself with its contents.
· The MH Hot-line phone number and treatment check-list is laminated and located in most ORs and on the MH Cart.

Pediatric Cart:
· The Pediatric Cart is located in the central core. During off-hours (or anytime an anesthesia tech is not available) the cart should be brought into the OR for any patient under the age of 12 and/or less than 50 kilograms. You should familiarize yourself with the cart’s contents.

Code Carts:
· Adult Crash Carts are located in the central core and PACU. You should be familiar with the cart’s contents.
· Pediatric Crash Cart is located in the PACU. You should be familiar with the cart’s contents.

Room Temperature
· All OR Suites are set at a temperature of 68°F. The acceptable range for OR temperature is 68-73°F. A request to increase the room’s temperature should be made for trauma and pediatric patients, or in the event that a patient’s temperature cannot be maintained intra-op despite other warming devices. Warming an OR because you, the provider, are cold is not an acceptable reason. Warm-up jackets are provided for your use. In the event that increasing the temperature has been deemed necessary, discuss with the circulating nurse who will place the request to Facility Management.
Anesthesia Documentation

Overview

· No blank lines should left, if there is nothing to document: put a line through it.
· Frequently made mistakes:
  - Not timing and/or signing the “Post-Anesthesia Note” on the H&P and the PACU Orders.

NOTE: The Anesthesia Assessment’s (H&P) “proposed procedure” must be verbatim what the surgical consent states, however, abbreviations are acceptable.

During your first few shifts it will be important to learn where to submit each of the anesthesia documents. Copies of the Department’s Anesthesia Paperwork can be found in separate download. Please review before starting orientation.