OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

GUIDELINES FOR OFFICE-BASED SURGERY AND OTHER INVASIVE PROCEDURES

These Guidelines are intended to assist Oklahoma medical doctors who are considering or currently practice ambulatory surgery or other invasive procedures which require anesthesia analgesia or sedation in an office setting. These recommendations focus on quality care and patient safety in the office. These are minimal guidelines and may be exceeded at any time based on the judgment of the physicians involved. Minor procedures in which unsupplemented local anesthesia is used in quantities equal to or less than the manufacturer's recommended dose adjusted for weight, are excluded from these guidelines. Nevertheless, it is expected that any practice performing office-based surgery regardless of anesthesia will have the necessary equipment and personnel to be able to handle emergencies resulting from the procedure and/or anesthesia.

The OSMBLS wants physicians to be aware that compared with acute care hospitals and licensed ambulatory surgical facilities, office operatories currently have little or no regulation, oversight or control by federal, state or local laws. Therefore, physicians must satisfactorily investigate areas taken for granted in the hospital or ambulatory surgical facility such as governance, organization, construction and equipment, as well as policies and procedures, including fire, safety, drugs, emergencies, staffing, training and unanticipated patient transfers.

The following issues should be addressed in an office setting to provide a high standard of patient safety and to reduce risk and liability.

1. *Quality of Care*

A. All health care practitioners and nurses should hold a valid license or certificate to perform their assigned duties.

B. All personnel who provide clinical care in an office-based surgical setting should be qualified to perform services commensurate with appropriate levels of education, training and experience.

C. Policies and procedures should be written for the orderly conduct of the facility and reviewed on an annual basis.

D. The facility should be under the supervision and control of a qualified physician.

E. All surgical personnel must wear suitable operative attire.

2. *Facility and Safety*

A. Facilities should comply with all applicable federal, state and local laws, codes and regulations pertaining to fire prevention, building construction and occupancy, accommodations for the disabled, occupational safety and health, and disposal of medical waste and hazardous waste.

B. Policies and procedures should comply with laws and regulations pertaining to controlled drug supply, storage and administration.

C. All premises must be kept neat and clean. Sterilization of operating materials must be adequate.

3. *Clinical Care*

Patient and Procedure Selection

A. Procedures to be undertaken should be within the scope of practice of the health care practitioners and the capabilities of the facility.

B. The procedure should be of a duration and degree of complexity that will permit the patient to recover and be discharged from the facility.

C. Patients who by reason of pre-existing medical or other conditions may be at undue risk for complications should be referred to an appropriate facility for performance of the procedure and the administration of anesthesia.

4. *Preoperative Care*

A. The anesthesia provider should adhere to the listed Anesthesia: Desiderata.

B. The anesthesia provider should be physically present during the intraoperative period and be available until the patient has been discharged from anesthesia care.

C. Discharge of a patient should be documented in the medical record and effected by a licensed independent practitioner.

D. Personnel with training in advanced resuscitative techniques (e.g., ACLS, PALS) should be immediately available until all patients are discharged home.

5. Monitoring *and Equipment*

A. At a minimum, all facilities should have a reliable source of oxygen, suction, resuscitation equipment and emergency drugs.

B. There should be sufficient space to accommodate all necessary equipment and personnel and to allow for expeditious access to the patient, anesthesia machine (when present) and all monitoring equipment.

C. All equipment should be maintained, tested and inspected according to the manufacturer's specifications.

D. Back-up battery power sufficient to ensure patient protection in the event of an emergency should be available.

E. In any location in which anesthesia is administered, there should be appropriate anesthesia apparatus and equipment which allow monitoring consistent with the Anesthesia: Desiderata and documentation of regular preventive maintenance as recommended by the manufacturer.

F. In an office where anesthesia services are to be provided to infants and children, the required equipment, medication and resuscitative capabilities should be appropriately sized for a pediatric population.

6. Emergencies *and Transfers*

A. All facility personnel should be appropriately trained in and regularly review the facility's written emergency protocols.

B. There should be written protocols for cardiopulmonary emergencies and other internal and external disasters such as fire.

C. The facility should have medications, equipment and written protocols available to treat malignant hyperthermia when triggering agents are used.

D. The facility should have a written protocol in place for the safe and timely transfer of patients to a prespecified alternate care facility when extended or emergency services are needed to protect the health or well-being of the patient. Pre-existing arrangements for definite care of the patient shall be established.

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DESIDERATA: ANESTHESIA

In order to promote optimum patient care in the practice of anesthesia, the Oklahoma State Board of Medical Licensure and Supervision recommends these desiderata:

1. An orderly preoperative anesthetic risk evaluation is to be done by the responsible physician and recorded on the chart in all elective cases, and in urgent emergency cases, the anesthetic evaluations will be recorded as soon as feasible.

2. Every patient receiving general anesthesia, spinal anesthesia, or managed intravenous anesthesia (i.e., local standby, monitored anesthesia or conscious sedation), shall have arterial blood pressure and heart rate measured and recorded at least every five minutes where not clinically impractical, in which case the responsible physician may waive this requirement stating the clinical circumstances and reasons in writing in the patient's chart.

3. Every patient shall have the electrocardiogram continuously displayed from the induction and during maintenance of general anesthesia. In patients receiving managed intravenous anesthesia, electrocardiographic monitoring should be used in patients with significant cardiovascular disease as well as during procedures where dysrhythmias are anticipated.

4. During all anesthetics, patient oxygenation will be continuously monitored with a pulse oximeter, and whenever an endotracheal tube or Laryngeal Mask Airway (LMA) is inserted, correct positioning in the trachea and function will be monitored by end-tidal CO2 analysis (capnography) throughout the time of placement.

A. Additional monitoring for ventilation will include palpation or observation of the reservoir breathing bag, and auscultation of breath sounds.

B. Additional monitoring for circulation will include at least one of the following: Palpation of the pulse, auscultation of heart sounds, monitoring of a tracing of intra-arterial pressure, pulse plethsymography, or ultrasound peripheral pulse monitoring.

5. When ventilation is controlled by an automatic mechanical ventilator, there shall be in continuous use a device that is capable of detecting disconnection of any component of the breathing system. The device must give an audible signal when its alarm threshold is exceeded.

6. During every administration of general anesthesia using an anesthesia machine, the concentration of oxygen in the patient's breathing system will be measured by a functioning oxygen analyzer with low concentration audible limit alarm in use.

7. During every administration of general anesthesia, there shall be readily available a means to measure the patient's temperature.

8. Availability of qualified trained personnel dedicated solely to patient monitoring.

These desiderata apply for any administration of anesthesia, including general, spinal, and managed intravenous anesthetics (i.e., local standby, monitored anesthesia or conscious

sedation), administered in designated anesthetizing locations and any location where conscious sedation is performed.

“Conscious sedation” means a minimally depressed level of consciousness that retains the patient’s ability to independently and continuously maintain an airway and respond appropriately to physical stimulation or verbal command, produced by a pharmacologic or non-pharmacologic method, or a combination thereof.

In emergency circumstances in any situation, immediate life support measures can be started with attention returning to these monitoring criteria as soon as possible and practical.