APA-1
6/93

TRANSMITTAL SHEET FOR NOTICE OF INTENDED ACTION

Control 540 Department or Agency Alabama State Board of Medical Examiners
Rule No. 540-X-10, Appendix B
Rule Title: Standards of the American Society of Anesthesiologists
X New ___ Amend X Repeal ___ Adopt by Reference

Would the absence of the proposed rule significantly harm or endanger the public health, welfare, or safety?	YES
Is there a reasonable relationship between the state's police power and the protection of the public health, safety, or welfare?	YES
Is there another, less restrictive method of regulation available that could adequately protect the public?	NO
Does the proposed rule have the effect of directly or indirectly increasing the costs of any goods or services involved and, if so, to what degree?	NO
Is the increase in cost, if any, more harmful to the public than the harm that might result from the absence of the proposed rule?	NO
Are all facets of the rulemaking process designed solely for the purpose of, and so they have, as their primary effect, the protection of the public?	YES

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Does the proposed rule have an economic impact? NO

If the proposed rule has an economic impact, the proposed rule is required to be accompanied by a fiscal note prepared in accordance with subsection (f) of Section 41-22-23, Code of Alabama 1975.

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Certification of Authorized Official

I certify that the attached proposed rule has been proposed in full compliance with the requirements of Chapter 22, Title 41, Code of Alabama 1975, and that it conforms to all applicable filing requirements of the Administrative Procedure Division of the Legislative Reference Service.

Signature of certifying officer [signature]

Date: March 16, 2017

APA-2
6/93

**ALABAMA STATE BOARD
OF MEDICAL EXAMINERS**

NOTICE OF INTENDED ACTION

AGENCY NAME: Alabama State Board of Medical Examiners

RULE NO. & TITLE: 540-X-10, Appendix B, Standards of the American Society of Anesthesiologists

INTENDED ACTION: To repeal and replace the Appendix

SUBSTANCE OF PROPOSED ACTION: To repeal and replace the Appendix with an updated version.

TIME, PLACE, MANNER OF PRESENTING VIEWS: All interested persons may submit data, views, or arguments, orally or in writing, concerning the proposed new rules. For written submissions, submit to: Patricia E. Shaner, Office of General Counsel, Alabama State Board of Medical Examiners, Post Office Box 946, 848 Washington Avenue (36104), Montgomery, Alabama 36101-0946, by mail or in person between the hours of 8:30 a.m. and 4:30 p.m., Monday through Friday, until and including Friday, May 5, 2017. Persons wishing to obtain copies of the text of this rule should contact Patricia E. Shaner, Office of General Counsel, (334-242-4116), PO Box 946, 848 Washington Avenue (36104), Montgomery, Alabama 36101-0946, email ckruger@albme.org, or obtain it from the Board's web site, www.albme.org.

FINAL DATE FOR COMMENT AND COMPLETION OF NOTICE: May 5, 2017

CONTACT PERSON AT AGENCY: Patricia E. Shaner, Office of General Counsel, 334-242-4116; PO Box 946, Montgomery, AL 36101-0946; 848 Washington Avenue, Montgomery, AL 36104

Norris W. Green, Executive Director

American Society of Anesthesiologists®

BASIC STANDARDS FOR PREANESTHESIA CARE

Committee of Origin: Standards and Practice Parameters

(Approved by the ASA House of Delegates on October 14, 1987, and last affirmed on October 28, 2015)

These standards apply to all patients who receive anesthesia care. Under exceptional circumstances, these standards may be modified. When this is the case, the circumstances shall be documented in the patient's record.

An anesthesiologist shall be responsible for determining the medical status of the patient and developing a plan of anesthesia care.

The anesthesiologist, before the delivery of anesthesia care, is responsible for:

1. Reviewing the available medical record.
2. Interviewing and performing a focused examination of the patient to:
    - 2.1 Discuss the medical history, including previous anesthetic experiences and medical therapy.
    - 2.2 Assess those aspects of the patient's physical condition that might affect decisions regarding perioperative risk and management.
3. Ordering and reviewing pertinent available tests and consultations as necessary for the delivery of anesthesia care.
4. Ordering appropriate preoperative medications.
5. Ensuring that consent has been obtained for the anesthesia care.
6. Documenting in the chart that the above has been performed.

American Society of Anesthesiologists®

STATEMENT ON DOCUMENTATION OF ANESTHESIA CARE

Committee of Origin: Committee on Quality Management and Departmental Administration (QMDA)

(Approved by the ASA House of Delegates on October 15, 2003 and last amended on October 28, 2015)

Accurate and thorough documentation is an essential element of high quality and safe medical care, and accordingly a basic responsibility of physician anesthesiologists. Anesthesia care is a continuum including three general phases of care: preanesthesia, intraoperative/intraprocedural anesthesia and postanesthesia care. To contribute to accuracy in medical records and to facilitate any future necessary chart review, anesthesiologists should ensure that accurate and thorough documentation is accomplished in all three phases of anesthesia related care. Information that is relevant to the perioperative care of a patient that exists elsewhere in the medical record need not be duplicated in the preanesthesia evaluation, the anesthesia record or postanesthesia evaluation. Departments and practices should develop local policies that address how information may be provided when documenting patient evaluations. These policies may include how information should be referenced and incorporated in an evaluation without requiring duplication of information from elsewhere in the medical record.

Depending upon several local factors, documentation may be provided on a paper record or within an electronic record. Anesthesiologists may delegate to appropriately trained and credentialed anesthesia care team members any portion of the periprocedural record keeping, but they should play an active role to ensure that accurate and thorough medical record keeping is accomplished. Documentation should meet all applicable regulatory, legal and billing compliance requirements.

In specific circumstances (e.g. emergencies, rapidly developing critical events, time sensitive sequential clinical care activities) an anesthesiologist or anesthesia care team member may be in conflict between a primary obligation to ensure patient safety and best clinical care, and contemporaneous medical record documentation. In these circumstances, attention to clinical care requirements remains the primary obligation. Medical record documentation should be provided as soon as appropriate in view of competing, primary clinical care requirements. The record should include documentation of:

I. Preanesthesia Evaluation*

A. Patient interview to assess:
   1. Patient and procedure identification
   2. Anticipated disposition
   3. Medical history – includes patient's ability to give informed consent
   4. Surgical History (PSHx)
   5. Anesthetic history
   6. Current Medication List (preadmission and postadmission)

7. Allergies/Adverse Drug Reaction (including reaction type)
8. NPO status
9. Documenting the presence of and the perioperative plan for existing advance directives.

B. Appropriate physical examination, including vital signs, height and weight and documentation of airway assessment and cardiopulmonary exam.

C. Review of objective diagnostic data (e.g., laboratory, ECG, X-ray) and medical records.

D. Medical consultations when applicable.

E. Assignment of ASA physical status, including emergent status when applicable.

F. The anesthetic plan – including plans for post-anesthesia care and pain management.

G. Documentation of informed consent (to include risks, benefits and alternatives) of the anesthetic plan and postoperative pain management plan.

H. Appropriate premedication and prophylactic antibiotic administrations (if indicated).

II. Intraoperative/procedural anesthesia (time-based record of events)

A. Immediately prior to the start of anesthesia care and anesthesia procedures:

1. Patient re-evaluation
2. Confirmation of availability of and appropriate function of all necessary equipment, medications and staff.

B. Physiologic monitoring data** (e.g., recording of results from routine and nonroutine monitoring devices).

C. Medications administered: dose, time, route, response (where appropriate).

D. Intravenous fluids: type, volume and time.

E. Technique(s) used.

F. Patient positioning and actions to reduce the chance of adverse patient effects/complications related to positioning.

G. Additional Procedures performed: vessel location, catheter type/size, specific insertion technique (e.g., sterile technique, use of ultrasound), actions to reduce the chance of related complications (ex., catheter based infection prevention measures), stabilization technique and dressing.

H. Unusual or noteworthy events during surgery and anesthesia care.

I. Patient status at transfer of care to staff in a Postanesthesia Care Unit (PACU) or an area which provides equivalent postanesthesia care (e.g., ICU, SDS or floor nurse).

III. Postanesthesia (time-based record of events)

A. Patient status at transfer of care to staff in a Postanesthesia Care Unit (PACU) or an area which provides equivalent postanesthesia care (e.g. ICU, SDS or floor nurse).

B. If the PACU is bypassed, criteria demonstrating that patient status at transfer of care are appropriate.

C. It is not the responsibility of the anesthesiologist to document the patient's condition throughout the PACU stay or when leaving the PACU.

D. Significant or unexpected post-procedural events/complications.

E. Postanesthesia evaluation documenting physiologic condition and presence/absence of anesthesia related complications or complaints.

* See Basic Standards for Preanesthesia Care

** See Standards for Basic Anesthetic Monitoring

Appendix B

STANDARDS OF THE AMERICAN SOCIETY OF ANESTHESIOLQGISTS

As defined in the *Policy Statement on Practice Parameters,* Standards are rules e.g., minimum requirements for sound practice. They are generally accepted principles for patient management.

Appearing on the following pages are the standards listed below:

Basic Standards for Pre-anesthesia Care
Standards for Basic Anesthetic Monitoring
Standards for Post-anesthesia Care

BASIC STANDARDS FOR PREANESTHESIA CARE
(Approved by House of Delegates on October 14, 1987)

These standards apply to all patients who receive anesthesia or monitored anesthesia care. Under unusual circumstances, e.g., extreme emergencies, these standards may be modified. When this is the case, the circumstances shall be documented in the patient's record.

Standard I: An anesthesiologist shall be responsible for determining the medical status of the patient, developing a plan of anesthesia care and acquainting the patient or the responsible adult with the proposed plan.

The development of an appropriate plan of anesthesia care is based upon:

1.Reviewing the medical record.

2.Interviewing and examining the patient to:

a. Discuss the medical history, previous anesthetic experiences and drug therapy.

b. Assess those aspects of the physical condition that might affect decisions regarding perioperative risk and management.

3.Obtaining and/or reviewing tests and consultations necessary to the conduct of anesthesia.

4.Determining the appropriate prescription of preoperative medications as necessary to the conduct of anesthesia.

The responsible anesthesiologist shall verify that the above has been properly performed and documented in the patient's record.

http://www.asahq .org/Standards/02.html

DEPARTMENT OF ANESTHESIOLOGY - PRE-ANESTETIC HISTORY / PHYS. EXAM .

PATIENT: AGE ____

PROPOSED OPERATION:

EVAL. DATE:
PREOPERATIVE DIAGNOSIS:

BP ________ HR ______ RR ____ TEMP ______

ASA PS
1 2 3 4 5 E

HEIGHT __________

Past Medical History
To be completed by patient

Head & Neck	Neurological	Lungs	Cardiovascular	Gastrointestinal
Decreased hearing	Seizures: last seizure ___	Asthma	CV Risks FHx HTN	Cirrohosis of the liver
Neck stiffness	Stroke TIA	Bronchitis	Heart attack When:	Hepatitis / yellow jaundice
Jaw problems	Fainting spells	Emphysema / COPD	Chest pain Last pain:	Hiatal hernia
Dentures	Muscle weakness	Tuberculosis	Irregular heart beat	Ulcers
Bridges/crowns	Numbness anywhere	Pneumonia	Pacemaker	Recent nausea & vomiting
Loose or chipped teeth	Muscular disease	Wheezing	Heart murmur	Severe indigestion / reflux Only after meals? Any time?
Vocal cord problems	Back problems	Productive cough / recent cold	Congenital heart defect	
Sleep apnea	Arthritis: where ____.	Smoke pks per day __ Years	Congestive heart failure	
Heavy snoring				
			Poor circulation	
			Heart valve disease	

Other		List Previous Operations & Anesthetics	Additional Questions	List Current Medications below
Pregnant Last menstrual period?	Diabetic Years? Insulin dept? Diet contrld? Pill contrld?	Malignant hyperthermia?	Have you or any family member ever had a complication from anesthesia? Yes No If yes, described	
Sickle cell	Glaucoma			
Hyperthyroid / hypothyroid	Iv drug use ever		**List Allergies to: drugs, tape, fish, eggs, latex, betadine, soybean etc. below**	
Prostate problems	Steroid use in past year?			
Kidney failure Last dialysis?	Alcohol drinker Rarely? Daily?			
Bleeding problems	Cancer – Where?			
Anemia				

Physical Examination
(Physician use only)

Head & Neck Critical to patient safety!	Lungs	Cardiovascular	Neurological	Mental Status
Dental hygiene Good Poor	Auscultation without abnormal sounds bilaterally	Regular rhythm Irregular rhythm	Grossly intact Deficient	Awake & alert
Neck ROM Good Poor	Abnormal Auscultation	Normal rate Tachy Brady		Other
Oral opening Good Poor		Murmur		
Possible anterior larynx (retrognathic)		S1 S4		
Airway Class: I II III IV		Carotid brults R/L		

CONSCIOUS SEDATION RECORD

Enter Date:____________ Time: ____ Room: ____ Procedure Room: _____ Permit Signed:

ARMBAND PRESENT AND Pt IDENTIFIED? __ YES __ NO BED IN LOCKED POSITION WITH SIDERAILS UP? __ YES __ NO

PATIENT HISTORY HAS PATIENT OR ANY BLOOD RELATIVES HAD PREVIOUS COMPLICATIONS RELATED TO SEDATION ANALGESIA OR ANESTHETIC

DOES PATIENT HAVE HISTORY OF:

HEART PROBLEMS __ YES __NO DESCRIBE ______________________________
HEAVY SNORING YES NO DRUG USE (i.e. tobacco, alcohol, unprescribed or illegal)
KNOWN PREGNANCY? YES NO SLEEP APNEA? YES NO
POTENTIAL DIFFICULT AIRWAY? YES NO

PATIENT AGREES TO SEDATION CHOSEN ____ YES ____ NO

ASA CLASSIFICATION: ASA Class 1: No Organic, physiologic. biochemical, or psychiatric disturbance
ASA Class 2: Mild to moderate systemic disturbance that may or may not be related to the reason for the procedure.
ASA Class 3: Severe systemic disturbance that may or may not be related to the reason for the procedure
ASA Class 4: Severe systemic disturbance that is life-threatening with or without the procedure
ASA Class 5: Moribund patient who has little chance of survival but Is submitted to the procedure as a last resort
Emergency Procedure: Any patient in whom an emergency procedure is required

NKA:__________ **ALLERGIES:** _________________

PROCEDURE, MEDICATIONS, AND EQUIPMENT EXPLAINED. QUESTIONS ENCOURAGED. VERBALIZES UNDERSTANDING.

YES NO

DOCUMENTATION OF ANESTHESIA CARE

(Approved by House of Delegates on October 12, 1988)

Documentation is a factor in the provision of quality care and is the responsibility of an anesthesiologist. While anesthesia care is a continuum, it is usually viewed as consisting of pre-anesthesia, peri-anesthesia and post-anesthesia components. Anesthesia care should be documented to reflect these components and to facilitate review.

The record should include documentation of:

I. Pre-anesthesia Evaluation*

A. Patient interview to review:

1. Medical history
2. Anesthesia history
3. Medication history

B. Appropriate physical examination.

C. Review of objective diagnostic data (e.g., laboratory, ECG, X-ray).

D. Assignment of ASA physical status.

E. Formulation and discussion of an anesthesia plan with the patient and/or responsible adult.

II. Perianesthesia (time-based record of events)

A. Immediate review prior to initiation of anesthetic procedures:

1. Patient reevaluation
2. Check of equipment, drugs and gas supply

B. Monitoring of the patient** (e.g., recording of vital signs).

C. Amounts of all drugs and agents used, and times given.

D. The type and amounts of all intravenous fluids used, including blood and blood products, and times given.

E. The technique(s) used.

F. Unusual events during the anesthesia period.

G. The status of the patient at the conclusion of anesthesia.

III. Post-anesthesia

A. Patient evaluation on admission and discharge from the postanesthesia care unit.

B. A time-based record of vital signs and level of consciousness.

C. All drugs administered and their dosages.

D. Type and amounts of intravenous fluids administered, including blood and blood products.

E. Any unusual events including post-anesthesia or post-procedural complications.

F. Post-anesthesia visits.

*See Basic Standards for Pre-anesthesia Care

**See Standards for Basic Anesthetic Monitoring

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