How the new JCAH standards on anesthesia services affect nurse anesthetists

The Board of Commissioners of the Joint Commission on Accreditation of Hospitals (JCAH) recently issued new standards on anesthesia services. The interpretative section of these standards includes a number of new provisions which either pertain specifically to nurse anesthetists or should be of interest to nurse anesthetists.

Standard I states that "anesthesia services shall be organized, directed and integrated with other related services or departments of the hospital." The interpretation of this standard, for the most part, deals with the responsibilities of the director of anesthesia services. Two new areas of responsibility are listed, both of which reflect on the practice of anesthesia services by anesthetists.

The first of these two new areas includes the "recommending of privileges for all individuals with primary anesthesia responsibility, which shall be processed through established medical staff channels." This provision treats nurse anesthetists in the same manner as other anesthesia personnel (at least for the purpose of reviewing their professional performance), and indicates a recognition by the JCAH of the importance of the functions performed by nurse anesthetists.

The second new area of responsibility requires that the director of anesthesia services establish "a program of continuing education for all individuals having anesthesia privileges, which includes in-service training and is based in part on the results of the evaluation of anesthesia care." This requirement parallels the recent AANA adoption of the concept of continuing education as a condition of maintaining membership. It is conceivable that the in-service training program eventually established under this JCAH requirement will satisfy the AANA requirement for participation in a continuing education program.

The interpretative section to Standard I closes with a requirement that the quality of anesthesia care shall be measured as a part of the facility's patient care evaluation program, and that the work performed by all categories of personnel administering anesthesia shall be included in the retrospective care review. This provision specifically defines such personnel to include: "anesthesiologists; other qualified physician, dentist, and nurse anesthetists; in-
dividuals in an approved anesthesia training program; and those physicians, nurse, or dentist anesthetists who are associated with or employed by a surgeon or group of surgeons rather than employed by the hospital.” [Emphasis added.]

Once again, JCAH has indicated a recognition of the nature of the anesthesia responsibilities that nurse anesthetists customarily assume by subjecting their work to the same review procedures as are applied to anesthesiologists and physician anesthetists. This provision also requires that the findings and resulting follow-up of any anesthesia care evaluation be recorded. Nurse anesthetists should welcome this requirement of a written review procedure. Such a procedure may serve to raise professional standards among nurse anesthetists and protect the individual nurse anesthetist in the event of a future challenge to his or her standing at a particular facility.

Standard II remains unchanged, providing that “staffing for the delivery of anesthesia care shall be related to the scope and complexity of the services offered.” The interpretative section to Standard II sets out the various procedures and duties that physician anesthetists and nurse anesthetists must be qualified to perform. This section continues to view the role of the nurse anesthetist narrowly, requiring that the nurse anesthetist only be able to provide general anesthesia. Notwithstanding this failure to acknowledge the actual extent of the capabilities of a nurse anesthetist, JCAH does leave to the particular facility the task of defining the extent of the nurse anesthetist’s responsibilities “in a policy statement, job description, or other appropriate document.”

In other words, the JCAH requirement that nurse anesthetists be able to administer general anesthesia may be viewed as merely a minimum requirement. Certainly, the JCAH interpretation does not prohibit nurse anesthetists from administering other forms of anesthesia. The final decision as to the extent of responsibilities assumed by a nurse anesthetist clearly rests with the hospital, which is in the best position to evaluate the individual’s training and experience.

Standard II also expands the functions that a nurse anesthetist must have competence to perform. A nurse anesthetist must now be able to support life functions, including induction and intubation procedures, while anesthesia is being administered. In addition, the nurse anesthetist’s responsibility to provide professional observation in resuscitative care, until the patient has regained control of his or her vital functions, is expanded to include “requesting of consultation when necessary.”

While actual practice may already reflect the performance of these two functions by nurse anesthetists, their inclusion in the JCAH interpretation is significant, insofar as JCAH standards are often used in the course of malpractice litigation to ascertain the standard of care applicable to the practitioner’s conduct.

Other new provisions also appearing in the interpretation of Standard II include a requirement calling for clearance with the director of anesthesia services before any elective general anesthesia is administered to a patient whose primary attending physician is other than a surgical specialist or obstetrician. In addition, the JCAH interpretation now requires that a physician be immediately available in case an emergency, such as a cardiac standstill or cardiac arrhythmia, should arise whenever “the operating/anesthesia team consists entirely of non-physicians (for example, dentists with nurse anesthetists, dentists with dentist anesthetists, podiatrists with dentists or nurse anesthetists).”

Standard III continues to state that “precautions shall be taken to insure the safe administration of anesthetic agents.” JCAH continues to require that regulations be devised by the director of anesthesia services for the control of electrical and anesthetic explosion haz-
ards. In addition, it now requires that such regulations be written. The interpretation section of Standard III lists the various areas which must be covered by these regulations. While nurse anesthetists should familiarize themselves with all of these regulations, particular attention should be given to certain areas.

JCAH, for example, now requires that all personnel who work in areas where anesthetic agents are administered be familiar with the procedures to be followed whenever the device which monitors electrical equipment in the operating room indicates a hazard. In addition, such personnel must be notified of the results of any required testing of the condition of operating room electrical equipment. Finally, anesthesia personnel are now required to familiarize themselves with the "rate, volume, and mechanism of air exchange within the surgical and obstetrical suites, as well as with humidity control."

Standard IV has been rewritten, but its meaning remains substantially the same. It provides, "There shall be written policies relating to the delivery of anesthesia care." The interpretation section of Standard IV enumerates the areas that these policies must cover and contains a number of new provisions. Referring to the preanesthesia evaluations that the physician is required to make of the patient, JCAH has included the following new provision:

"Except in extreme emergency cases, this evaluation should be recorded prior to the patient's transfer to the anesthesia and operating area and before preoperative medication has been administered. While the choice of a specific anesthetic agent or technique may be left up to the individual administering the anesthesia, the preanesthesia medical record entry should at least refer to the use of general, spinal, or other regional anesthesia. When other than anesthesia personnel are involved, reference in the medical record to the use of spinal, regional, topical, or local anesthesia should be made by the responsible physician (e.g., surgeon, obstetrician) or dentist when administered within the limits of his privileges."

Nurse anesthetists should be sure to check the actual policy devised by their hospital relative to this new requirement, particularly to find out whether the hospital permits the nurse anesthetist to choose the specific anesthetic agent or technique to be used (as is allowed by JCAH) or whether the attending physician must make that choice. The individual nurse anesthetist can best insulate his or her conduct from challenge by conforming to the actual policies adopted by his or her hospital in this area.

JCAH has also adopted some new provisions relating to the safety of the patient during the anesthetic period. Prior to the administration of anesthesia, anesthetists must now check the sterility, where required, of all equipment used in the administration of anesthetic agents. Another new provision requires that all reusable anesthesia equipment, including laryngoscopes, air bags, breathing bags, masks, and endotracheal tubes, be cleaned after each use.

JCAH has further expanded the requirement that the anesthetist, or his or her qualified designee, remain with the patient following the procedure for which anesthesia was administered. Formerly, the anesthetist, or his or her designee, was to remain with the patient "as long as necessary". Now, the anesthetist, or his or her qualified designee, must remain with the patient "as long as required by the patient's condition relative to the anesthesia status, and until responsibility for proper patient care has been assumed by other qualified individuals". Likewise, such care should be provided when the patient is returned to the nursing floor for recovery, where there is no postanesthesia care unit in the hospital.

On the subject of the discharge of patients from a postanesthesia care unit, the old JCAH provisions stated, "De-
cisions relative to the discharge of patients from any postanesthesia care unit should be made by the physician.” This provision has been replaced by a more lengthy one, which defines this process more clearly. The provision specifically states that the decision to discharge a patient from a postanesthesia care unit cannot be made by “nursing service personnel”, but must be made by a physician.

On the other hand, neither the presence of a physician nor the signature of a specific physician is required by JCAH at the time of release of the patient. Such a requirement may be adopted by a specific hospital, and the nurse anesthetist should be familiar with the specific requirement of his or her hospital. Where, however, release of the patient occurs both in the absence of the physician and in the absence of a written or verbal release order authenticated by that physician, the medical record must reflect which physician was responsible for the patient’s release.

The provision requiring the recording of postanesthetic visits has, likewise, been substantially expanded. This provision now contains the following new requirement:

“A note made in the surgical or obstetrical suite, or in the postanesthesia care unit (or nursing floor anesthesia recovery phase when there is no such unit), does not ordinarily constitute a visit. While the number of visits will be determined by the status of the patient in relation to the procedure performed and anesthesia administered, a visit should be made early in the postoperative period, and once after complete recovery from anesthesia. Complete recovery is determined by the clinical judgment of the anesthetist or the discharging surgeon/obstetrician. Each postanesthesia note shall specify the date and time. It is recommended that a postanesthesia medical record entry be made by a physician. However, all anesthesia personnel are encouraged to make pertinent postanesthesia entries in the medical records of patients to whom they have administered anesthesia. [Emphasis added.] When the postanesthetic visit and record entry by anesthesia personnel is not feasible because of early patient release from the hospital, the physician or dentist who discharges the patient from the hospital should be responsible for meeting the requirement.”

In view of this provision, nurse anesthetists should take care to document any postanesthesia attention rendered to patients to whom they administer anesthesia. Likewise, the nurse anesthetist should review the specific policies adopted by his or her hospital on this subject in order to determine whether or not nurse anesthetists are required to make postanesthesia visits.

Finally, the JCAH interpretation of Standard IV requires hospitals to devise two new sets of written guidelines on anesthesia care. The first set of guidelines must define the role of anesthesia services and of all postanesthesia care areas in the hospital’s infection control program. The second set of guidelines, to be developed by a staff anesthesiologist or a practicing consultant anesthesiologist, is to relate to the safe use of all general anesthetic agents used in the hospital and is to be applied “to all personnel, physician and non-physician, who administers anesthesia.” Once again, nurse anesthetists should familiarize themselves with these guidelines, when developed, especially considering the importance such guidelines can have in the event of malpractice litigation.