The appropriate organization and operation of an anesthesia department is an issue that was recently addressed by the Council on Nurse Anesthesia Practice in a special study. The results of this study form the basis for the following article.

No single system can be identified as best or essential for every anesthesia department. It is recognized that such departments will vary from a unit headed by anesthesiologists to the small community hospital with one CRNA. Therefore, the following material represents an overview which should be considered as new departments are organized or as older departments are updated. Few departments, if any, will have every item identified here. Rather, this material is intended to identify specific items for consideration and inclusion or exclusion as determined by the local needs of your hospital. It is intended that the following may serve as a check list so that any item eliminated will be by conscious decision, rather than through default.

Guidelines for organization and operation of an anesthesia department

I. ORGANIZATION
   A. Philosophical statement of the department or service.
   B. Organizational chart showing relationship of administration, department or service director, and other anesthesia employees. Depending upon the size of the hospital, anesthesia services may be provided by a CRNA, by a group of CRNAs, by CRNAs and anesthesiologists alone or other personnel as permitted by local codes. The larger hospitals will have a department of anesthesiology, while smaller hospitals may be unorganized and simply have an anesthesia service. Regardless of which system is used, responsibility must be defined and the method of function of the department, division or service must be spelled out.

II. DIRECTION OF ANESTHESIA
   Physician responsibility for the anesthesia service shall be defined and identified.

   The responsibility of the anesthesiologist (if available) shall be defined and his role in working with the CRNA and other personnel delivering anesthesia care should be explained.

   Requirements for special consultation on specific cases should be spelled out. Where an anesthesiologist is not available, the interrelationship between the CRNA and the staff physician responsible for the patient shall be defined.

III. SUPERVISION
   Line item authority should be established for supervision of the members of the department or service.
Day-to-day supervision may be provided by an anesthesiologist or may be performed by a CRNA in charge of nurse anesthetists. This area usually deals with patient assignment, call schedules and vacation times.

IV. EMPLOYMENT PRACTICES

A. Personnel

1. Types of personnel used within the department.
   a. Anesthesiologists
   b. CRNAs
   c. Others (osteopaths, M D anesthetists and technicians)

2. Job descriptions
   Should identify the specific job responsibilities for each person in the department or service.

3. Delineation of privileges
   Should define what types of anesthetics may be given, any that are not approved for use by this person, use and revision of standing orders (see Section V), etc. Should identify special requirements for special procedures, if any.

4. Hospital non-departmental responsibilities.
   Should identify potential committee responsibilities such as infection committee, audit committee, pharmacy committee, medical records committee, long-range planning, etc. upon which members of the service may be called upon to serve.

5. Employment contracts
   Should define whether the contract is written or oral. The contract should include:
   a. Monetary compensation based on specific hours per week;
      (1) minimum/maximum levels of compensation,
      (2) experience differential,
      (3) education differential,
      (4) incremental wage adjustments and
      (5) compensation for additional hours worked.
   b. Monetary compensation for "call"
      (1) Call policy should include amount per week, in or out of house and responsibilities and supervision;
      (2) holiday classification, vacation time;
      (3) personal days policies and
      (4) sick leave—accrual and pay.
   c. Monetary Benefits
      (1) Health and pension insurance;
      (2) malpractice insurance;
      (3) Tuition refund program.

B. Non-Monetary Section

1. Professional practitioner status
   a. Appointment to position
   b. Position description
   c. Promotion
   d. Evaluation procedure
   e. Continuing education program

2. Employee status
   a. Classification
      (1) Full-time
      (2) Part-time
      (3) Per diem
   b. Probationary period
   c. Seniority—definition and types

C. Grievance Procedure

1. Conditions of employment
   a. Restrictions
      Any restrictions on practice should be spelled out as they affect all CRNAs, eg, are CRNAs allowed to do spinals, area blocks, etc?
   b. Responsibility
      Define persons’ responsibility as to availability, second call, ability to make decision on patient care.
   c. Supervision
      Define what supervision is available and procedure for its utilization. Outline the lines of authority within the department.
   d. Consultations
      Who may ask for a consultation? If an anesthesiologist is not available, who should be contacted? Is there a consulting anesthesiologist available?
   e. Case assignments
      Who assigns cases, when is this done,
what are the criteria for such assignments?

7. Patient charges
What are the policies on patient billing? Is this done in the name of the person in charge of the department? Is it done in the name of the person giving the anesthetic? Is it done by the hospital or by the individual or group providing the anesthetic service? If provided by the hospital, the discount for bad debt, collection costs, etc., should be spelled out.

V. STANDARDS OF CARE
A. Should include minimum standard of care for any patient which encompasses evaluation of anesthetic needs, administration of anesthetics, monitoring systems utilized, immediate and long range postoperative care.

1. Should define minimal standards for specific operational procedure and/or patient classification.
   a. Patient monitoring—general
   Is there a standard policy for monitoring patients? If so, who provides the equipment? What must be monitored? EKG, blood pressure, pulse, temperature, air volume, etc.
   b. Patient monitoring—specific case types
   Define the minimum standards for:
   (1) Open heart
   (2) Craniotomies
   (3) High risk
   (4) Infants

B. Quality Assurance Program
   1. Anesthesia audit
   Composition of committee should include representation from all personnel classification delivering care.
   Is there an internal audit of all cases that will identify:
   • Poor outcome of anesthetics
   • High risk patients
   • Complications of a specific type?
   Is this tied into the general hospital audit process? Is there feedback to the individual on problems that are identified?
   Is there a peer review procedure?
   The above section should be viewed as an attempt by the persons rendering professional service to the public as an assurance of universal minimum standard of care.

VI. EQUIPMENT
Are maintenance agreements required on equipment? Or is maintenance to be done by the CRNA? Who purchases the equipment? If done by the hospital, how is the CRNA assured that needed equipment will be provided? How much lead time is normally needed for obtaining new equipment?

VII. RECORDS
What is the content of the anesthetic record? Is a physician's signature required? Is a written preoperative evaluation done on every patient by the CRNA? What is required in the way of postoperative follow-up notes? Is a written preoperative evaluation form used to insure specific items are checked? Who provides the forms? Are they developed by the anesthesia service and provided by the hospital? What other approval is needed to change the content of forms?

VIII. BUDGETING AND LONG RANGE PLANNING
Who is responsible for budget development? Is budget established on the basis of need, on a specific dollar value, or on a percent of the department revenue generated? How does the CRNA make needs for large capital items known so that they are reflected in the budget? What is the lead time needed?
   Is there a specific input for long range planning for the department? Who is responsible for day-to-day supplies?
   What is the lead time for ordering such items?

IX. EQUIPMENT MANUAL
A. Content
1. Objective of the manual
2. Physical plant
   Floor plan with rooms and suites identified.
3. Machines
   Description and number of each
4. Gases and anesthetic agents and accessory drugs
   Location
   Storage
5. Monitors, Ventilators
   Specific data on use of units. Specific persons to call when service is needed.
6. Warming and cooling units
7. Crash carts — Hyperpyrexia carts, etc.
   Content and location of each.
8. Blood replacement equipment
   Warming coils, administration sets, micro filters, pressure equipment.
9. Refrigerator—Contents and location
10. Drug control and procurement
11. Specific case procedures. (Set up for special cases.)
12. Location of supplies and methods for restocking
13. Spinal and regional block equipment location
14. Arterial/venous monitoring
15. Sterilizing equipment
Who is responsible for doing this?
   (See item 12 of the Joint Commission Standards for Anesthesia Services.)

The Joint Commission on Accreditation of Hospitals Standards represent one standard used in the United States for those hospitals which wish to obtain the Joint Commission's accreditation. Those included within the preceding guidelines represent the current standards as of February, 1978. Before implementing them, you should check to be sure that these have not been significantly changed by update.

REFERENCES

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