



ANAESTHESIA & PERI-OPERATIVE SERVICES CLINICAL PRACTICE GUIDELINES

1st Edition
2010

Introduction

This first edition of the guidelines published in 2010 was drafted by Dr Luke Nasedra, Consultant Anaesthetist, Labasa Hospital and Chairperson of the National Anaesthetic Clinical Services Network (CSN). The guidelines have been revised with the support of FHSIP (Clare Whelan, Dr Asinate Boladuadua) and the members of the National Anaesthetic CSN.

Acknowledgement

The support from every individual involved in the publication of this first edition is acknowledged.

MISSION STATEMENT

To provide a high quality Anaesthesia and Peri-operative Service by a caring and committed team which will work closely with other departments through good governance, appropriate technology and appropriate risk management facilitating a focus on patient safety and best outcomes for the people of Fiji.

Preface

The publication of the first edition of the Anaesthesia Clinical Practice Guidelines represents the efforts of the Anaesthesia CSN. We have published these guidelines for anaesthetists working at hospital settings and centers where anaesthesia services are delivered and was done for the main purpose of improving the care of surgical patients.

While every effort has been made to ensure that these guidelines are in accordance with the current acceptable international practice and standard which was based on clinical evidence, the information requires that users exercise in all cases independent professional judgment and understanding of the clinical scenario when referring to them.

The guidelines have taken into account the available resources in our daily practice and have been endorsed by the Ministry of Health.

It is hoped that these guidelines will be used by all health care workers in their daily care of surgical patients requiring monitored anaesthesia.



Dr Luke Nasedra

Chairman

National Anaesthesia Clinical Services Network

TABLE OF CONTENTS

Acknowledgement	2
Mission statement	2
Preface	2
Pre-operative preparation of surgical patients	4
<i>Standard statement 1</i>	4
<i>Standard statement 2</i>	5
<i>Standard statement 3</i>	6
<i>Standard statement 4</i>	7
<i>Standard statement 5</i>	8
Practical preparation of the anaesthetic system	9
<i>Standard statement 6</i>	9
<i>Standard statement 7</i>	10
<i>Standard statement 8</i>	11
<i>Standard statement 9</i>	12
The practical conduct of anaesthesia	13
<i>Standard statement 10</i>	14
<i>Standard statement 11</i>	15
<i>Standard statement 12</i>	16
References	17
Appendix - Checklist for anaesthetic equipment	18
Appendix - Definitions	20
Appendix - Pre-operative chart/form	21
Appendix - Anaesthesia Information	22

Pre - operative preparation of the surgical patient

Purpose

This standard provides guidance for the development of policies and processes for the appropriate evaluation of the practice for preparation of patients presenting for surgery.

Background

Several of the large-scale epidemiological studies (e.g. the CEPOD study) have indicated that inadequate preoperative preparation of the patient may be a major contributing factor to the primary anaesthetic causes of perioperative mortality. It is therefore essential that the anaesthetist visits every patient in the ward before surgery to assess '*fitness for anaesthesia*', as this function cannot be undertaken by surgical or medical staff.¹

The purposes of the pre-operative visit are to:

1. Establish rapport with the patient.
2. Obtain a history and perform a physical examination.
3. Order special investigations.
4. Assess the risks of anaesthesia and surgery and decide on further pre-operative management of any underlying medical condition.
5. Prescribe premedication as necessary.
6. Discuss about the need for fasting.
7. Develop and discuss with the patient and relatives (parents in case of children) about the anaesthetic plan and any post-operative care plan.
8. Seek a second opinion, from the Consultant or HOD, in predicted high risk cases.

Principle

²The anaesthetist must decide:

- If the patient is fit for anaesthesia.
- How urgent the surgery is. May need to clarify with the surgeons.
- If the surgery can be delayed until the patient is in the best possible condition.
- If the patients condition can be improved by further treatment.
- What the best anaesthetic technique for the patient and the planned surgery is.
- How to care for the patient after surgery.

Standard statement 1

Every patient shall be seen by the anaesthetist before surgery.

Criteria

- 1.1 *Medical history* – the anaesthetist must take a proper medical history including why the patient is having surgery. The current general health of the patient should be evaluated
- 1.2 *Medication* – the anaesthetist should find out if the patient is taking any regular medication and determine any drug allergies.
- 1.3 *Anaesthetic history* – the anaesthetist should ask about previous anaesthetics (if any). Any old anaesthetic record should be cited.
- 1.4 *Family history* – the anaesthetist should ask if anyone in the family has had a bad reaction to anaesthesia.
- 1.5 *Smoking* – the anaesthetist should always ask about smoking and note the details. Patient should be encouraged to STOP smoking prior to surgery.
- 1.6 *Physical examination* – the anaesthetist must perform a physical examination and must pay attention to the patient's airway, cardiovascular and respiratory systems.
- 1.7 *Investigations* – the anaesthetist must review available blood, x-ray, and test results that have been done and determine whether other tests needed to be done.
- 1.8 *Documentation* – the pre-operative assessment details should be documented clearly on the pre-operative assessment form and/or in the patient's folder. Documentation is important both for quality assurance and for medico legal purposes.⁴
- 1.9 *Anaesthetic plan* – the anaesthetist must discuss all the anaesthetic options available to the patient, and any '**responsible adult**' (see appendix 2), together with the procedures and risks involved. The patient or the responsible adult should be allowed to choose the anaesthetic unless contraindicated. All questions should be answered clearly.

Standard statement 2

Special investigations should be ordered only after screening through history and physical examination.

Criteria

- 2.1 Routine investigations for healthy patients are invariably of little use.
- 2.2 Before ordering extensive investigations, the anaesthetist should ask him or herself the following questions:
 - 2.2.1 *Will this investigation yield information not revealed by physical examination?*
 - 2.2.2 *Will the results of the investigation alter the management of the patient?*
- 2.3 Further special investigations should be done on an individual case basis assessment.
- 2.4 All investigation results should be documented in the preoperative assessment form.
- 2.5 It is advisable to seek further opinion from other specialists for abnormal test results, like ECG or CXR.

Standard statement 3

The anaesthetist may give premedication to the patient before surgery and must also review the patient's current medications.

Criteria

- 3.1 Unless there is a special reason many patients receive no premedication.
- 3.2 Premedication shall be given on an individual case basis assessment and should be given with clear understanding of the reasons and risks involved:
 - 3.2.1 To provide relaxation and relieve anxiety.
 - 3.2.2 To provide analgesia if patient is in pain prior to surgery or to provide analgesia during and after the operation.
 - 3.2.3 To reduce the risk of aspiration pneumonitis.
- 3.3 Regular medications should be continued and should be taken on the morning of surgery unless contraindicated.

- 3.4 Some medications should be stopped prior to surgery:
 - 3.4.1 Anticoagulants should be stopped a week prior to surgery or may need changing, e.g. warfarin to be changed to heparin.
 - 3.4.2 Aspirin and NSAIDs should be stopped a week prior to surgery.
 - 3.4.3 Oral hypoglycemic should be stopped on the day prior to surgery since patient will be fasted.
 - 3.4.4 Some traditional remedies should be stopped as they might interact with anaesthetic drugs.
- 3.5 Some medications should be continued into the intraoperative and postoperative period like, steroids, antibiotics, and anti-epileptics.
- 3.6 Prophylactic antibiotics and medications that will definitely be needed intraoperatively should be readily available.

Standard statement 4

Every patient booked for elective surgery must fast before surgery EXCEPT in emergency.

Criteria

- 4.1 The aim for fasting is to minimize the risk of aspiration pneumonia which can cause subsequent death. This fact should be clearly communicated to the patient and the accompanying responsible adults.
- 4.2 Attempts should be made to avoid prolonged fasting. Proper communication and planning between the anaesthetist, surgeon, and nurses is very important. This is a critical issue in some disease states.
- 4.3 A fasting guideline should be available and communicated to the ward nurses as follows:

4.3.1	Clear fluids	2 hours
4.3.2	Breast milk	4 hours
4.3.3	Infant formula	6 hours
4.3.4	Solids (foods) and non-human milk	6 hours

- 4.4 All patients must be allowed to take their usual medications before surgery with 20mls of water.
- 4.5 The preoperative assessment must try to identify those patients with increased risk of aspiration.
- 4.5.1 Those patient-factors included:
- History of gastro-esophageal reflux disease
 - Diabetes
 - Obesity
 - Pregnancy
 - Drugs, like alcohol
 - Gastrointestinal motility disorders
 - Reduced level of consciousness
 - Un-fasted patients
- 4.5.2 Surgical conditions that affect gastric emptying:
- Intra-abdominal infections
 - Obstructive bowel disorders
 - Trauma
 - Burns
- 4.6 The anaesthetist may consider measures (pharmacological or non-pharmacological) that will reduce the risk of aspiration:
- Fasting – this might mean deferring the surgery.
 - Emptying the stomach with nasogastric tube
 - Reducing stomach acidity
 - Increase the speed of gastric emptying
- 4.7 The anaesthetist must consider the fasting time and should also determine the fasting status of a patient.
- 4.8 The anaesthetist should have an anaesthetic plan that will further reduce the risk of aspiration in such patients.

Standard statement 5

The anaesthetic plan and procedures shall be communicated clearly to the patient and any accompanying responsible adult.

Criteria

- 5.1 All the available anaesthetic options should be discussed with the patients and/or care-givers and parents.
- 5.2 The patient should be allowed to make their preferred choice of anaesthetic. Patient refusal is a contraindication to any procedure.

- 5.3 The anaesthetist should discuss and seek approval from the patient or responsible adults for other special procedures that will be done in the operating theatre, e.g. invasive monitoring. The informed consent should be well described.
- 5.4 The postoperative plan should also be discussed with the patient and the responsible adult.
- 5.5 The anaesthetist should also emphasise that unexpected outcomes or events do occur even if the patient is fit and well.
- 5.6 All discussions should be documented in the preoperative assessment form (appendix 3).

Summary

The anaesthetist shall be responsible for determining the medical status of the patient, developing a plan of anaesthesia care and communicate clearly the proposed plan the patient or the responsible adult with the proposed plan.⁵

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

The practical preparation of the anaesthetic system

Purpose

This standard provides guidance, and a means to evaluate practice associated with the safety check, preparation and use of the anaesthetic machine, equipments, monitors and drugs.

Background

³Anaesthesia is usually administered in the operating room but may be required in intensive care units, emergency departments or other locations such as radiology suites. There are clear requirements for the provision of safe anaesthesia services and recommended approaches for purchasing equipment. Even if there are financial constraints, it is the responsibility of the hospital management to maintain operating rooms and equipment and to provide appropriate supply of medications and other consumables

³The provision of safe anaesthesia depends on careful preparation, which is facilitated by a systematic approach to reviewing the patient, machine, equipment and medication. This is ideally based on a formal check of the anaesthesia system. In addition to the personnel involved in delivering anaesthetic, the anaesthesia system includes:

1. Any machine or apparatus that supplies gases, vapours, local anaesthesia or intravenous anaesthetic agents to induce or maintain anaesthesia.
2. Any equipment necessary for securing the airway.
3. Any monitoring devices necessary for maintaining continuous evaluation of the patient; and
4. The patient himself or herself correctly identified, consensual and evaluated preoperatively.

Principle

The safe checking, preparation and use of the anaesthetic system has a positive influence on the outcome of a patient's anaesthesia. Many mishaps can be prevented and lives will be saved if the items in the list are available.

Standard statement 6

It is the responsibility of the anaesthetist to check the anaesthetic machine before starting anaesthesia (appendix 1).

Criteria

- 6.1 In preparing for anaesthesia, the anaesthetic machine should be checked by the anaesthetist:
 - 6.1.1 before each anaesthesia.
 - 6.1.2 before the start of each operating day.
 - 6.1.3 after any repairs or maintenance to the anaesthetic machine.
 - 6.1.4 at the introduction of a new anaesthetic machine.
- 6.2 A checklist (appendix 1) for anaesthetic machine should be available at each operating room.
- 6.3 Every anaesthetic machine should meet some minimum standard requirements present on them.
 - 6.3.1 oxygen and medical air flow-meters
 - 6.3.2 colour-coding system compatible with international standards.
 - 6.3.3 visual labeling of gauges and meters
 - 6.3.4 anti-hypoxic device
 - 6.3.5 oxygen-flush button and an oxygen failure system (visual/audible)
 - 6.3.6 a back-bar that can fit two vapourisers
 - 6.3.7 a separate built-in oxygen flow-meter
 - 6.3.8 a breathing system that can also accommodate paediatric patients.
 - 6.3.9 a mounted ventilator that can also be used for children and ICU patients.
 - 6.3.91 a scavenging system
- 6.4 The anaesthetist should be aware of the checklist and follow them exactly.
- 6.5 There should always be an alternative oxygen supply.
- 6.6 An alternative method of ventilating (self inflating resuscitation bag) the patient must always be available.
- 6.7 All failure alarms should be checked and working.
- 6.8 There should be an oxygen analyser present on the anaesthetic machine.
- 6.9 No anaesthesia should commence until after every machine defect, if found, is fixed.

Standard statement 7

The anaesthetist shall ensure that all monitoring devices are checked and working before starting an anaesthetic.

Criteria

- 7.1 The anaesthetist should physically check all monitors prior to starting.
- 7.2 Any malfunction should be reported to Biomed who should take the monitor for servicing.
- 7.3 A daily log of defects should be kept updated for reference.
- 7.4 Every anaesthetic monitor should meet the minimum standard requirements present on them.
 - 7.4.1 *all-in-one* type of monitor that have:
 - Electrocardiogram (ECG)
 - Non-invasive blood pressure (NIBP)
 - Pulse oximetry
 - Capnography
 - Agent monitoring
 - 7.4.2 added features would be appreciated but not necessarily needed.
 - Invasive monitoring (blood pressure/central venous pressure)
 - Temperature
 - 7.4.3 the monitor can be able to store a days vital signs which can be accessed at least 24 hours later.
 - 7.4.4 the monitor should have a one hour back-up battery life.
 - 7.4.5 the monitor should have visible colors and audible alarms
 - 7.4.6 the monitor should be portable for use on patient transfer.
 - 7.4.7 the monitor should not be bulky.
- 7.5 No anaesthetic should commence until a working monitor is available.
- 7.6 There should always be a separate back-up pulse oximeter for every operating suite³.

Summary

Apart from the monitors available the anaesthetist should be present in the room throughout the administration/delivery of all anaesthetic.

Standard statement 8

The anaesthetist shall ensure that all anaesthesia adjuncts should be available, in different sizes, and working before starting an anaesthetic.

Criteria

- 8.1 *Airway equipments* – the anaesthetist should have at least the following before starting an anaesthetic:
 - 8.1.1 two working laryngoscopes with ranges of blades suitable for the patient
 - 8.1.2 range of masks
 - 8.1.3 range of airways
 - 8.1.4 introducers and gum-elastic bougies
 - 8.1.5 range of endotracheal tubes
 - 8.1.6 range of laryngeal mask airways (LMA)
 - 8.1.7 emergency airway equipments
 - Proseal LMA or LMA Supreme
 - Fast-track LMA
 - Cricothyrotomy set
 - Ventilating bougie
- 8.2 *Suction* – should be available before any anaesthetic. It can be powered by either electricity, compressed gas or by hand/foot.
- 8.3 All suction accessories should be available in ranges.
 - Tubing
 - Catheters
 - Yankeurs
- 8.4 *Vapourisers* – should be filled adequately before every anaesthetic.
- 8.5 *Consumables* – should be available at good stock everyday with the help of the anaesthetic technicians and nurses.
 - Syringes
 - Needles
 - Cannulas
 - Adhesive plaster
 - Blankets
 - Pillows, etc.

Standard statement 9

The anaesthetist shall ensure that all anaesthetic and emergency drugs are available before starting an anaesthetic.

Criteria

- 9.1 All drugs used for the proposed anaesthetic should be drawn-up with the correct doses and ready to be given.
- 9.2 once drugs drawn up, syringes should be labeled immediately (written or stickers)
- 9.3 Emergency drugs should be immediately available.
- 9.3 Spare drugs should be available in stock within the operating room.
- 9.4 The anaesthetic technician with the help of the Pharmacists should ensure good stock management of anaesthetic drugs.
- 9.5 Every effort should be made to ensure that the patient does not receive the wrong drug or dose. With the anaesthetic set-up and case turnovers and challenges, drug error poses a major risk in the anaesthetic care delivery.
- 9.6 These drugs should be readily available even in cases for regional, local or ketamine anaesthesia.

The practical conduct of anaesthesia

Purpose

This standard provides guidance to evaluate practice associated with the safe management and delivery of anaesthesia to patients.

These standards apply to all patients who receive anaesthesia or monitored anaesthesia 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.

Background

Planning the management of anaesthesia starts normally after details concerning the surgical procedure and the medical condition of the patient have been ascertained at the preoperative visit.

Principle

General anaesthesia is a state of induced, reversible loss of consciousness, during which the patient will be unaware of their surroundings and of painful stimuli.⁶

The effects of anaesthesia and of the surgical procedure may have profound physiological consequences for the patient, and require monitoring and if needed correction throughout anaesthesia.

The continuous presence of an appropriately trained and experienced anaesthetist is essential as the main determinant of patient safety during anaesthesia.

Monitors with appropriately set alarms may detect critical incidents and provide an early warning of the consequences of an error.

The safe provision of anaesthesia requires the help of competent anaesthetic assistance at all times.

Anaesthetic equipment is subject to frequent, repetitive use and needs regular servicing according to manufacturer's specification to prevent malfunction.

Standard statement 10

In Fiji, only an anaesthetist (physician who had training or had attachment in anaesthesia) shall provide general, regional, ketamine and any monitored anaesthesia care.

Criteria

- 10.1 The anaesthetist shall at all times abide by the ethics of the Medical profession and the Code of conduct of the Public Service.

- 10.2 **All anaesthetists have ethical responsibilities to their patients and shall:**
 - 10.2.1 be dedicated to providing competent medical care with compassion and respect for human dignity and rights.
 - 10.2.2 uphold the standards of professionalism, be honest in all professional interactions, and strive to report physicians deficient in character or competence, or engaging in fraud or deception to appropriate entities.
 - 10.2.3 continue to study, apply and advance scientific knowledge, maintain a commitment to medical education, make relevant information available to patients, colleagues and the public, obtain consultation, and use the talents of other health professionals when indicated.
 - 10.2.4 while caring for a patient, regard responsibility to the patient as paramount.
 - 10.2.5 keep confidential patients' medical and personal information.

- 10.3 Share with all physicians the responsibility to provide care for patients irrespective of their ability to pay for their care. Anaesthetists should provide such care with the same diligence and skill as for patients who do pay for their care.

- 10.4 **Anaesthetists have ethical responsibilities to medical colleagues.**

Anaesthetists should promote a cooperative and respectful relationship with their professional colleagues that facilitate quality medical care for patients. This responsibility respects the efforts and duties of other care providers including physicians, medical students, nurses, technicians and assistants.

- 10.5 Anaesthetists should provide timely medical consultation when requested and should seek senior consultation when appropriate:
 - 10.5.1 attending to a minor (less than 14 years of age)
 - 10.5.2 any patient with an ASA 2 classification or more
 - 10.5.3 attending to any medical staff or their immediate family
 - 10.5.4 any Police case (appendix 2)
 - 10.5.5 any patient with a potential difficult airway
 - 10.5.6 any potential or suspected difficult patient
- 10.6 Anaesthetist should notify the senior staff urgently for any anaesthetic incident, including mortality.
- 10.7 One anaesthetist cannot provide direct care for more than one patient receiving general or regional anaesthesia, or sedation.
- 10.8 The anaesthetic assistant must be immediately available throughout the entire anaesthetic procedure.
- 10.9 Regional anaesthesia should be initiated and maintained only in locations in which appropriate resuscitation equipment and drugs are immediately available to manage procedurally related problems.

Standard statement 11

The anaesthetist shall be present in the operating room throughout the delivery of all monitored anaesthesia care.

Criteria

- 11.1 All monitors shall be attached prior to induction of anaesthesia.
- 11.2 During the period of the anaesthesia the patient's oxygenation, ventilation, circulation and temperature shall be continually evaluated. Basic anaesthesia monitoring is one component of anaesthesia care.
- 11.3 The intraoperative record should be done regularly for early detection of any problems during anaesthesia. Electronic records are now recommended.
- 11.4 The anaesthetist should maintain good communication with the surgical team during the anaesthesia.
- 11.5 The anaesthetist should ensure that, apart from the surgery, no other injury occurs to the patient. The patient should be protected from:
 - 11.5.1 falling off the bed or operating table
 - 11.5.2 electrocution and burns
 - 11.5.3 injuries associated with positioning; nerve, joints, eyes, genitals.

Standard statement 12

All patients who have received monitored anaesthesia care shall receive post-anaesthesia management.

Criteria

- 12.1 A patient can be transferred out of the operating room at the discretion of the anaesthetist, who can be sure that the care of the patient can safely be handed over to the PARU nurse.
- 12.2 A patient transported to the PARU shall be accompanied by the anaesthetist who provided the anaesthesia for the patient.
- 12.3 Upon arrival to the PARU, the patient shall be re-evaluated and a verbal report provided to the PARU nurse by the accompanying anaesthetist.
- 12.4 The patient's condition shall be evaluated continually in the PARU.
- 12.5 The anaesthetist should be immediately available if needed by the PARU staffs.
- 12.6 An anaesthetist is responsible for the discharge of a patient from the PARU. In the absence of the physician responsible for the discharge, the PARU nurse shall determine that the patient meets the discharge criteria. The name of the physician accepting responsibility for discharge shall be noted on the record.

Summary

Anesthetized patients are particularly vulnerable, and anaesthetists should strive to care for each patient's physical and psychological safety, comfort and dignity. Anesthetists should monitor themselves and their colleagues to protect the anesthetized patient from any disrespectful or abusive behavior.

Once unconscious, the anaesthetist is responsible for the total care of the patient.

ABOVE ALL DO NO HARM!!

References:

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2. Pescod D; Developing anaesthesia textbook; VI.1. 2005.
3. WHO Guidelines for Safe Surgery: 2009: 'Safe surgery save lives'.
4. Morgan and Mikhail; Clinical anaesthesiology; 1st edition: 1992.
5. Standards of the American Society of Anaesthesiologists; Approved by House of Delegates: 1993
6. Intra-operative Care; Royal College of Anaesthetists; 2009
7. Guidelines for the Practice of Anaesthesia; Canadian Journal of Anaesthesia (2010): 57: 58 – 87.

Appendix 1

CHECKLIST FOR ANAESTHETIC EQUIPMENT

Modified from: 'The Checklist for Anaesthetic Equipment 2004; The Association of Anaesthetists of Great Britain and Ireland'.

The following checks should be made prior to each operating session.

1. High Pressure System

1.1. Check with a 'tug-test' that each pipeline is correctly inserted into the appropriate gas supply terminal.

- a. Check that the anaesthetic machine is connected to a supply of oxygen.
- b. Check that adequate supplies of other gases (nitrous oxide and medical air) are available and connected as appropriate.
- c. Check that all pipeline pressures gauges in use on the anaesthetic machine indicate 400 – 500kPa.

Note:

1. Carbon dioxide cylinders should not be present on the anaesthetic machine unless requested by the anaesthetist.
2. A blanking plug should be fitted to any empty cylinder yoke.

2. Low Pressure System

2.1. Check the operation of flow-meters

- a. Check that each flow valve operates smoothly and that the bobbin moves freely throughout its range.
- b. Check the anti-hypoxia device is working correctly.
- c. Check the operation of the emergency oxygen by-pass control.
- d. Check the operation of the oxygen failure alarm (audio and visual, if present) system.

2.2. Check the vapourizer(s)

- a. Check that each vapourizer is adequately, but not over, filled.
- b. Check that each vapourizer is correctly seated on the back bar and not tilted.
- c. Check the vapourizer for leaks (with vapourizer on and off) by temporarily occluding the common gas outlet.
- d. Turn the vapourizer off when the checks are completed.
- e. Repeat the leak test immediately after changing any vapourizer.

3. Breathing System

3.1. Check the breathing system to be employed

- a. Inspect the system for correct configuration. All connections should be secured.
- b. Perform a pressure leak test on the breathing system by occluding the patient end and compressing the reservoir bag.
- c. Repeat the test above using a fresh gas flow of 300ml and ensure that the pressure gauge to be maintained at 30cmH₂O for 1minute.
- d. Check the operation of all valves, unidirectional within the circle system, and all exhaust valves.
- e. Check for patency and flow of gas through the whole breathing system.

Note:

3. A new single use bacterial filter must be used for each patient.
4. Packaging must not be removed until point of use.

3.2. Check that the ventilator is configured appropriately for its intended use.

- a. Check that the ventilator tubing is securely attached.
- b. Set the controls for use and ensure that an adequate pressure is generated during the inspiratory phase.
- c. Check the pressure relief valve functions.
- d. Check the disconnection alarms function correctly.
- e. Ensure that an alternative means to ventilate the patient's lungs is available (see below).

4. Scavenging System

4.1. Check that the anaesthetic gas scavenging system is switched on and is functioning correctly.

- a. Check that the tubing is attached to the appropriate exhaust port of the breathing system, ventilator or workstation.

5. Back-up system

5.1. Check that an alternative means to ventilate and resuscitate the patient is immediately available.

Check that an adequate supply of oxygen is available. Anaesthetist - doctors who institute anaesthesia. They have special training in this special field of medicine.

Preoperative – the period of time from when the patient arrives into the hospital to prior to the commencement of anaesthesia.

- a. Intraoperative – the period of time from the commencement of anaesthesia to the time the patient able from a reserve oxygen cylinder.
- b. Check that a self-inflating bag is available.
- c. Check the defibrillator is available and working.
- d. Check the emergency airway kit is available.
- e. Check that a spare pulse oximeter is available and working.

Appendix 2: DEFINITIONS

Anaesthesia - a state of carefully controlled unconsciousness which is done so that you will be unaware and not feel pain while you have your surgery. It is different from 'normal sleep'.

is handed over to the PARU nurses.

ASA – American Society of Anaesthesiologists grading of fitness for anaesthesia and surgery. The ASA classification/grading are as follows:

- 1: a healthy patient
- 2: a patient with mild systemic disease
- 3: a patient with severe systemic disease limiting activity but not incapacitating
- 4: a patient with incapacitating systemic disease that is a constant threat to life
- 5: an extremely ill (*moribund*) patient who is unlikely to survive 24hours with or without surgery
- E: an emergency surgery
- T: a trauma patient

General anaesthesia - you are put into a state of unconsciousness for the entire duration of the operation. This is achieved by injecting special medicines into your drip or by breathing a mixture of 'sweet-smelling' gases.

CEPOD – Confidential Enquiry into Peri-Operative Deaths

PARU – the post anaesthesia recovery unit is a special room where nurses will continue to monitor the patient carefully well after surgery is finished to ensure recovery is as smooth and trouble-free as possible.

Only when fully awake and comfortable will the patient be transferred either back to the ward or returning home.

Police cases – any case that will be followed up by the Police and included any:

- Injury from motor vehicle, assault, attempted suicide, and burns.
- Indecent assault or rape victim
- Suspected child abuse

Other cases as specified

Postoperative – the period of time from PARU to 24hrs after the surgery.

Regional anaesthesia - this is where nerve block is done which numbs the part of the body where the surgeon operates. You will be awake but feels no pain.


These can also be combined with general anaesthesia

Responsible adult – refers to any care-giver, guardian or parent of the patient who should be consulted as necessary.

Sedative anaesthesia - The anaesthetist administers drugs to make you relaxed and drowsy. This is sometimes called 'twilight sleep'.

Sentinel events – any incident that occurred during the course of the anaesthesia that resulted in loss of function or life.

Appendix 3 : PRE OPERATIVE FORM

 MINISTRY of Health <i>Shaping Fiji's Health</i>	ANAESTHESIA and PERI-OPERATIVE SERVICES
HOSPITAL: <input type="checkbox"/> CWMH <input type="checkbox"/> LAUTOKA <input type="checkbox"/> LABASA <input type="checkbox"/>	

NOTE: 1. Please tick (√) and circle (©) where appropriate 3. Ensure that all sections of the chart is completed for every case
 2. Document everything clearly in the spaces provided 4. Patients, relatives, and parents SHOULD be well informed

PATIENT DETAILS		SMOKER: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Quit	GORD: <input type="checkbox"/> Yes <input type="checkbox"/> No
NHN: _____ Race: _____		VOMITING: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Name: _____		Fasted from: <i>Foods</i> _____ <i>Liquids</i> _____	
D.O.B: _____ Age: _____ Sex: _____		Pre-Med: _____	
Religion: _____		Consent: <input type="checkbox"/> Surgery <input type="checkbox"/> Blood Transfusion	
ALLERGIES: _____		Procedure(s): _____	
Weight: _____		_____	

RELEVANT HISTORY:

AIRWAY:

Mallampati: 1 2 3 4 Jaw: A B C Thyro-mental Distance: <input type="checkbox"/> <5cm <input type="checkbox"/>
<i>Normal</i> Other:


PROBLEMS: _____

ASSESSMENT: **ASA:** 1 2 3 4 5 E **NYHA:** 1 2 3 4

ANAESTHESIA PLAN / RISKS DISCUSSED	INVESTIGATIONS Hb: _____ WCC: _____ PLT _____ INR: _____ U: _____ Cr: _____ Na: _____ K: _____ RBS: _____ ECG: _____ Other: _____
--	--

Anaesthetist: _____ Signature: _____ Date: _____ Time: _____

Anaesthetic CSN 3/2010

Scope and Application	This CPG is intended for use by all anaesthetists and other health care workers in their daily care of surgical patients requiring monitored anaesthesia.
Effective Date	October, 2010
Supercedes Policy Number	Not applicable
Review Responsibilities	The Chairperson of the National Anaesthesia CSN will initiate the review of these guidelines every 3 years from the date of issue or as required.
Further Information	Dr Luke Nasedra Chairperson – National Anaesthesia CSN
RESPONSIBILITY:	
CPG Owner: National Anaesthetic CSN	Sign:  Chairperson - National Anaesthesia CSN
CPG Writer: Ministry of Health	Date: October 2010
Endorsed: National Medicines & Therapeutic Committee, MOH Date: 23 November 2010	
Endorsed: National Health Executive Committee, MOH Date: 25 November 2010	