COMMITTEE ON QUALITY MANAGEMENT AND DEPARTMENTAL ADMINISTRATION

AMERICAN SOCIETY OF ANESTHESIOLOGISTS

ANESTHESIOLOGY DEPARTMENT QUALITY CHECKLIST

The following series of questions has been developed by the Committee on Quality Management and Departmental Administration (QMDA) of the American Society of Anesthesiologists (ASA) as a compendium of anesthesia safety and quality measures suitable as a reference for anesthesiology departments of any size as they develop a comprehensive set of quality standards. It must be understood that this is a work product of this and other ASA committees and does not represent official policy of the House of Delegates of ASA.

Subject headings below are provided for ease of assignment of the items contained within each area. Because many topics are germane to multiple positions, there is deliberate duplication of a number of elements.

The Committee on QMDA hopes that ASA members and their institutions find this document helpful in the creation and maintenance of their quality programs. Comments from members are appreciated and solicited.

The notations of "R" and "O" after each element in these lists are the committee's recommendation as to whether this item is <u>Required</u> for departments or whether it can be considered <u>Optional</u> but desired in appropriate circumstances.

Questions for: Chair of Anesthesia

	Standard	R/O	Compliance	Notes
1	Is safety the top priority in the anesthesia department?	R		
2	Is there open and effective collegial communication between your department and other departments?	R		
3	Does the department medically direct or appropriately supervise all CRNA/AA practice?	R		
4	Quality of Care: As the Chief/Chair of Anesthesiology, you must be able to demonstrate that: •The facility has a medical director or governing body that establishes policy and is responsible for the activities of the facility and its staff. The medical director or governing body is responsible for ensuring that facilities and personnel are adequate and appropriate for the type of procedures performed. •Policies and procedures exist for the orderly conduct of the facility and are reviewed on an annual basis. •The medical director or governing body ensures that all applicable local, state and federal regulations are observed. •Policies exist to require that all personnel involved in direct patient care hold valid licenses or certificates to perform their assigned duties. •All operating room personnel who provide clinical care are qualified to perform services commensurate with their levels of education, training and experience. •Your department participates in ongoing quality improvement and risk management activities. •There is recognition, in the form of written policy, of the basic human rights of your patients, and that this policy is available for patients to review.	R		
5	Patient and Procedure Selection: As the Chief/Chair of Anesthesiology, you must be able to demonstrate that: •Procedures to be undertaken are within the scope of practice of the health care practitioners and the capabilities of the facility. • Procedures to be undertaken are of a duration and degree of complexity that will permit the patient to recover and be discharged from the facility. •Patients, who by reason of pre-existing medical or other conditions may be at undue risk for complications at your facility, are referred to an appropriate facility for performance of the procedure and the administration of anesthesia.	R		
6	Perioperative Care: As the Chief/Chair of Anesthesiology, you must be able to demonstrate that: • Anesthesiologists adhere to the "Basic Standards for Pre-anesthesia Care," "Standards for Basic Anesthetic Monitoring," "Standards for Post-anesthesia Care" and "Guidelines for Ambulatory Anesthesia and Surgery" as currently promulgated by the American Society of Anesthesiologists. [HTTP://WWW.ASAHQ.ORG/FOR-MEMBERS/STANDARDS-GUIDELINES-AND-STATEMENTS.ASPX link] • Anesthesiologists are physically present during the intraoperative period and immediately available until the patient has been discharged from anesthesia care.	R		

	•The decision to discharge patients is made by a physician and documented in the medical record. •Personnel with training in advanced resuscitative techniques (i.e., ACLS, PALS) are immediately available until all patients are discharged home.			
7	Monitoring and Equipment: As the Chief/Chair of Anesthesiology, you must be able to demonstrate that: • All anesthetizing locations have a reliable source of oxygen, suction, resuscitation equipment and emergency drugs. (See specific reference in the ASA "Statement on Non-operating Room Anesthetizing Locations." [HTTP://WWW.ASAHQ.ORG/FOR-MEMBERS/STANDARDS-GUIDELINES-AND-STATEMENTS.ASPX] •There is 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. • All anesthesia equipment is maintained, tested, and inspected according to the manufacturer's specifications. • Back-up power sufficient to ensure patient protection in the event of an emergency is available. • In any location in which anesthesia is administered there is appropriate anesthesia apparatus and equipment, that allow monitoring consistent with ASA "Standards for Basic Anesthetic Monitoring." [HTTP://WWW.ASAHQ.ORG/FOR-MEMBERS/STANDARDS-GUIDELINES-AND-STATEMENTS.ASPX] • In any location where anesthesia services are to be provided to infants and children, the required equipment, medication and resuscitative capabilities are appropriately sized for a pediatric population.	R		
8	Are protocols for the ASA Difficult Airway algorithm, latex allergy, and Malignant Hyperthermia readily available in every anesthetizing location?	R		
9	Are policies or guidelines in place for management of perioperative glycemic control, including the availability of bedside glucose testing equipment?	R		
10	Do all anesthetizing and regional anesthesia placement locations have immediate access to emergency drug and airway supplies and equipment?	R		
11	Are policies or guidelines in place to provide management recommendations for patients with sleep apnea?	O		
12	Would you allow any member of this anesthesia department to anesthetize you or a family member?	R		
13	Are cardiopulmonary emergency drills (mock codes) and malignant hyperthermia drills practiced regularly?	O		
14	Are policy and/or guidelines in place to provide appropriate, age-specific NPO standards?	O		
15	Are anesthesiologists and CRNSA's in a regular simulation/CRM program (as per MOCA requirements)?	O		
16	Is an evidence-based pre-anesthetic testing matrix in place and used routinely?	O		
17	Is blood product availability satisfactory? Is there a massive transfusion protocol? Is it employed and effective?	O		
18	Is there a protocol for patients at high risk for PONV?	O		
19	Is there a management protocol for patients with chronic pain, or is there easy access to pain management specialty preoperative consultation?	O		
20	Is there a policy to preclude having medical, AA or CRNA students in a room alone with an anesthetized patient?	O		
21	Are radios or other music sources allowed in the OR? Is there a policy? Does the anesthesiologist have veto power to turn music down or off?	O		
22	Is there an effective cellphone or other two-way pager system in place to locate key people in larger (>6 room) surgical suites? If so, is it used and effective?	O		
23	In any area where large-volume local anesthetics are administered, is there Intralipid™ and a protocol for its use available?	O		

24	Does the department participate actively in the teaching of trainees (students, interns, residents, SRNA's)?	O		
25	Is there a hospital/department policy describing the anesthesia department's role and responsibility in responding to codes/traumas throughout the facility?	O		
26	Does the department/group provide adequate time and resources for members to participate in CME activities?	O		
27	Do department members consistently support colleagues' decisions regarding scheduling, anesthetic choice, need for additional tests, and/or case cancelling decisions?	O		
28	Is ultrasound routinely recommended and available for central line access?	O		
29	Does the department have a policy to address wellness/family/support/diversion issues?	O		
30	Does the department provide Continuous Professional Performance Evaluations?	O		
31	Does the department track: Start time delays, turnover times, unexpected ICU admissions, PACU backlog/stay-overs, and unplanned admissions?	O		
32	Does the department have sufficient anesthesia technician support?	O		
33	Are the anesthesia techs ASATT certified or on track to be certified?	O		
34	Does the facility have the ability to provide chronic pain care or is there a relationship with another entity to provide such service?	O		
35	Are acute pain service patients seen daily and their care documented?	O		
36	Does the acute (postoperative) pain order set provide for adequate pain assessment, monitoring (if necessary), and supplemental pain coverage?	O		
37	Are consults to the department performed in a timely fashion (i.e., < 24 hours) and is documentation of the consultation promptly recorded in the medical record?	O		
38	Does the anesthesia department/service encourage and support membership involvement in organized medicine (Membership/participation in local, state, and national medical and/or specialty societies)?	O		
39	Can the department demonstrate an awareness and commitment to involvement in governmental and legislative affairs?	O		
40	Does the department have processes in place to allow for feedback from patients, nurses, surgeons, and/or administrators (i.e., surveys, peer review evaluations, 360° feedback)?	O		
41	Is ultrasound used in the placement of regional anesthesia blocks?	O		
42	Do a significant number of the department members share in administrative responsibilities and serve on hospital committees?	O		
43	Is there a culture of professionalism in the department?	O		
44	Are anesthesiologists involved in the interviewing/hiring of key perioperative nursing leadership positions?	O		
45	Is there evidence of leadership development within the department (i.e, mentorship)?	O		
46	Is there a management structure in your anesthesia group?	O		
47	If the department cares for pediatric patients, is there a separate pediatric cart containing routine equipment for all sizes/ages?	O		
48	Do you have a designated group leader who is elected or selected by the group on a termed basis?	O		
49	How regularly does the group membership meet? Is attendance greater than 75%?	O		
50	Does your group have a designated quality officer or program within the department?	O		

51	Does your group have a designated compliance officer?	O		
52	Does your group have a policy for evaluation and hiring of new physicians? (i.e., probationary period or orientation protocol)	O		
53	Are group members willing to accept leadership actions and/or support leaders in their decisions?	O		
54	Do you track perioperative temperature management as a part of the SCIP process? (if applicable)	O		
55	If you care for children, are anesthesiologists and CRNA's PALS certified?	O		
56	Are all physicians Board certified by the ABA or are they in the certification process?	R		
57	Are all CRNA's certified or are they in the certification process?	R		
58	Are departmental members certified in ACLS and/or PALS?	R		

Remarks

American Society of Anesthesiologists Seal of Quality Program

Questions for: Staff Anesthesiologist

	Standard	R/O	Compliance	Notes
1	Is safety the top priority in the anesthesia department?	R		
2	Is there in continuous use a device with an audible alarm capable of detecting disconnection of the breathing system wherever inhalation anesthesia with mechanical ventilation is administered?	R		
3	Is pulse oximetry used for all sedated or anesthetized patients, and are the variable pitch pulse tone and the low threshold alarms audible?	R		
4	Is an oxygen analyzer with a low oxygen concentration limit audible alarm in use at all times?	R		
5	Does every patient receiving anesthesia or sedation have the electrocardiogram continuously displayed from the beginning of anesthesia until preparing to leave the anesthetizing location?	R		
6	Does every patient receiving general anesthesia have, in addition to the above, circulatory function continually evaluated by at least one of the following: palpation of a pulse, auscultation of heart sounds, monitoring of a tracing of intra-arterial pressure, ultrasound peripheral pulse monitoring, or pulse oximetry?	R		
7	Is every patient re-evaluated immediately prior to induction of anesthesia, and is this documented on the anesthetic record?	R		
8	Is the APSF Checklist (anesthesia machine checklist) performed at the beginning of the day and are critical elements repeated prior to each anesthetic? Is the checklist readily available on each machine?	R		
9	Are all drugs (except those to be given immediately) legibly labeled with at least minimum information including drug name and drug concentration (and the date if syringe/vial not to be disposed of after case)? [or a method exists to determine syringe content, concentration, and expiration] Are all admixtures appropriately labeled?	R		
10	Are scheduled medications under the personal control of a department member at all times?	R		
11	Are patients properly and timely prepared preoperatively and are pertinent facts communicated to whomever will be caring for the patient in the OR in a reasonable and timely manner?	R		
12	Is there a culture of professionalism in the department?	R		
13	Are you Board certified or on track to become Board certified?	R		
14	Is there open and effective collegial communication between you, the Chairman, and other members of the anesthesia department?	O		
15	Would you allow any member of this anesthesia department to anesthetize you or a family member?	R		
16	Are you ACLS and/or PALS certified (as applicable)?	R		

Remarks

American Society of Anesthesiologists Seal of Quality Program

Questions for: Surgeons

	Standard	R/O	Compliance	Notes
1	Is there open and effective collegial communication between your service and the anesthesia department?	R		
2	Is safety the top priority in the anesthesia department?	R		
3	Does the anesthesiologist participate in the time out and operating room briefings?	R		
4	Would you allow any member of this anesthesia department to anesthetize you or a family member?	R		
5	Are the anesthesiologists accessible to the surgeons?	R		
6	Do you feel the anesthesia department works with you and your service as a team to achieve mutual goals?	O		
7	Is there a culture of professionalism within the department?	O		
8	If requested, does the anesthesia department offer educational opportunities for you and/or your staff?	O		
9	Do the anesthesiologists actively assist in starting cases on time?	O		
10	Is the anesthesia department actively engaged in running the operating room, improving efficiency, and providing adequate access to the operating room?	O		

Remarks

American Society of Anesthesiologists Seal of Quality Program

Questions for: Perioperative Nursing Manager

	Standard	R/O	Compliance	Notes
1	Is safety the top priority in the anesthesia department?	R		
2	Is there open and effective collegial communication between your service and the anesthesia department?	R		
3	Is there 100% compliance with patient identification and participation in the time-out prior to initiating any anesthetic and procedure (including regional anesthesia and central lines; peripheral IV's excluded)?	R		
4	Do you observe department members reviewing the medical record, patient drugs and allergies and identifying potential anesthesia problems, particularly those that may suggest potential complications or contra- indications to the planned procedure (i.e., difficult airway, ongoing infection, limited intravascular access)?	R		
5	Do you observe the anesthesiologists interviewing and examining the preoperative patient, developing a plan for the patient's anesthesia care, and assessing those aspects of the patient's physical condition that might affect decisions regarding preoperative risk and management? In the event that non-physician personnel (CRNAs or AAs) are utilized in the process, does the anesthesiologist verify the information, and repeat and record essential key elements of the evaluation?	R		
6	Do department members use and document the ASA Physical Status of the patient?	R		
7	Do you observe anesthesiologists obtaining informed consent? Is an anesthesia specific consent obtained or anesthesia specific language included in the general consent discussed by the anesthesiologist? Do you observe appropriate alternatives, if available, being discussed with patient and team?	R		
8	Is the pre-anesthesia evaluation performed in an appropriate area (i.e., not in the operating room)?	R		
9	Is equipment for managing difficult airways and equipment for resuscitation immediately available?	R		
10	Would you allow any member of this anesthesia department to anesthetize you or a family member?	R		
11	In any area where large-volume local anesthetics are administered, is there Intralipid™ and a protocol for its use available?	O		
12	Does the anesthesia department have or offer preoperative screening/evaluations?	O		
13	If requested, does the anesthesia department assist in providing educational opportunities for your staff?	O		
14	Does the department of anesthesia have standard order sets in place?	O		
15	Has the department developed standard preoperative screening criteria?	O		

Remarks

American Society of Anesthesiologists Seal of Quality Program

Questions for: Operating Room Nurses

	Standard	R/O	Compliance	Notes
1	Does the department designate an anesthesiologist to help manage the day-to-day schedule?	R		
2	Is safety the top priority in the anesthesia department?	R		
3	Is there open and effective collegial communication between your service and the anesthesia department?	R		
4	Are qualified anesthesia personnel present in the operating room and vigilant throughout all anesthetics?	R		
5	Is the end-tidal CO2 alarm audible (any time the monitor is in use)?	R		
6	Are necessary drugs, code cart, defibrillator, and help available for crisis management in all anesthetizing locations?	R		
7	Is a pre-surgical "time-out" conducted in every case, and do anesthesiologists and CRNA's willingly and courteously participate in it?	R		
8	If music is played during surgery, does it detract from care?	O		
9	Is music attenuated during critical portions of the procedure or when any member of the team requests it?	O		
10	Does a mechanism exist to call for help and declare an emergency? Do OR nurses know what this mechanism is, how to describe it, and how to activate it?	R		
11	If medically directing non-physician anesthesia providers, are anesthesiologists immediately available and responsive to their needs and are they present for critical portions of the anesthetic?	R		
12	Do you work toward goals as a team?	O		
13	Would you allow any member of this anesthesia department to anesthetize you or a family member?	R		
14	If requested, does the anesthesia department assist in providing educational opportunities for you and/or your colleagues?	O		
15	Is the anesthesia department actively involved in "Clinical Quality Value Analysis" and/or other cost effectiveness measures?	O		
16	Is the anesthesia department actively involved in a recycling program and/or efforts to reduce waste?	O		
17	Is there a standard procedure for handoffs during anesthesia?	O		
18	Are mock codes, operating room fires, or other critical events in OR practiced and do anesthesia staff members participate if/when asked?	O		
19	Is the anesthesia department actively engaged in running the operating room, improving efficiency, and providing adequate access to the operating room?	O		
20	Are anesthesiologists attentive to patients and do you have confidence in the members of the department?	O		
21	Do members of the department request for help from colleagues when clinically indicated?			

Remarks

American Society of Anesthesiologists Seal of Quality Program

Questions for: PACU Nursing

	Standard	R/O	Compliance	Notes
1	Is safety the top priority in the anesthesia department?	R		
2	Is there open and effective collegial communication between your service and the anesthesia department?	R		
3	Do all patients who have received GA, regional anesthesia or monitored anesthesia care receive appropriate post-anesthesia management?	R		
4	Are patients transported to the PACU accompanied by a member of the anesthesia care team who is knowledgeable about the patient's condition? Are patients continually evaluated and treated (as necessary) during transport with monitoring and is support appropriate to the patient's condition?	R		
5	Upon arrival in the PACU, are patients re-evaluated and a verbal report provided to the responsible PACU nurse by the member of the anesthesia care team who accompanies the patient?	R		
6	Is pulse oximetry routinely employed in the initial phase of recovery?	R		
7	Is there a policy to assure the availability of a physician capable of managing complications and providing cardiopulmonary resuscitation to PACU patients, and is there consistently a prompt response from the anesthesiologist to PACU patient needs/PACU nurse requests?	R		
8	Is a physician responsible for the discharge of patients from the PACU?	R		
9	Is a crash cart/defibrillator immediately available in PACU/Phase II recovery?	R		
10	Are patients transported with supplemental oxygen from operating room to PACU (except a select portion of minimally sedated patients)?	R		
11	Are post-anesthesia rounds made regularly in the PACU after patients have recovered from the effects of their anesthesia? Is there documentation made of these rounds?	R		
12	Is there a policy requiring patients who receive sedation, general or regional anesthesia to be discharged into the care of a responsible adult?	R		
13	Do anesthesiologists and CRNA's conducting post-anesthesia visits evaluate: (1) the assessment of stability or satisfactory control of respiratory function (respiratory rate, airway patency, oxygen saturation); (2) Stable cardiovascular function (pulse rate, blood pressure, hydration status); (3) temperature; (4) mental status (patient participates in the evaluation); (5) pain assessment; and (6) nausea/vomiting?	R		
14	Would you allow any member of this anesthesia department to anesthetize you or a family member?	R		
15	Is there a mechanism in place for patients to contact an anesthesiologist after discharge?	R		
16	Is there a standard procedure for handoff (i.e., SBAR) from a member of the care team to PACU RN?	O		
17	Are cardiopulmonary emergency drills (mock codes) and malignant hyperthermia drills practiced?	O		
18	Is the response to PACU pages (for routine matters) adequate? For emergencies?	O		
19	If requested, does the anesthesia department offer educational opportunities for PACU staff?	O		
20	Does the department of anesthesia have standard order-sets in place?	O		
21	Do members of the anesthesiology department treat PACU staff members with respect?	O		

22	Are PACU staff questions to anesthesiology staff members answered courteously and intelligently?	O		
23	If the department cares for pediatric patients, is there a separate pediatric cart containing routine equipment for all sizes/ages?			
24	If your department cares for children, are anesthesiologists and CRNA's PALS certified?	O		
25	Do you have locally derived benchmarks for PONV and postoperative pain?	O		

Remarks

American Society of Anesthesiologists Seal of Quality Program

Questions for: Obstetric Nursing Manager

	Standard	R/O	Compliance	Notes
1	Is a physician with appropriate privileges available during regional anesthetics to manage anesthetic complications until the patient's post-anesthesia condition is satisfactory and stable?	R		
2	Do all patients recovering from regional anesthesia receive appropriate post-anesthesia care? Following cesarean delivery and/or extensive regional blockade, are the ASA standards for post-anesthesia care applied? [HTTP://WWW.ASAHQ.ORG/FOR-MEMBERS/STANDARDS-GUIDELINES-AND-STATEMENTS.ASPX]	R		
3	Is an intravenous infusion established before the initiation of regional anesthesia and maintained throughout the duration of the regional anesthetic?	R		
4	Is there a licensed practitioner privileged to administer an appropriate anesthetic and maintain support of vital functions in any obstetric emergency available? Is there a required pre-anesthesia exam performed by a qualified anesthesiologist (or other physician if no anesthesiologist is available)?	R		
5	Does the anesthesia department strive to provide a response time for emergent C-section consistent with the Joint ASA-ACOG Optimal Goals for C-section response (currently 30 minutes from decision/notification of anesthesiologist to incision)? [HTTP://WWW.ASAHQ.ORG/FOR-MEMBERS/STANDARDS-GUIDELINES-AND-STATEMENTS.ASPX]	R		
6	Is there a policy requiring the immediate availability of appropriate facilities and personnel, including obstetric anesthesia, nursing personnel, and a physician capable of monitoring labor and performing an emergency cesarean delivery, in cases of trial of labor after cesarean delivery (TOLAC)? (The definition of immediately available personnel and facilities remains a local decision based on each institution's available resources and geographic location.)	R		
7	Is safety the top priority in the anesthesia department?	R		
8	Is there open and effective collegial communication between your service and the anesthesia department?	R		
9	Are there qualified personnel (other than the anesthesiologist attending the mother) immediately available to assume responsibility for neonatal resuscitation ?	R		
10	Is there a policy to assure the availability of a physician to manage labor anesthetic complications and to provide cardiopulmonary resuscitation for patients receiving post-anesthesia care?	R		
11	Does the department provide an average response time of less than 20 minutes with a maximum response time of less than 1 hour for epidural requests?	O		
12	Is there documentation of mock code practice in obstetrics?	O		
13	Is a designated anesthesiologist appointed as a liaison to the OB department?	O		
14	If requested, does the anesthesia department offer educational opportunities for your staff?	O		
15	Does the department of anesthesia have standard order-sets in place?	O		
16	Is the response time to most pages to the department of anesthesia timely?	O		
17	Are pencil-point needles the usual spinal needle utilized in OB regional anesthesia?	O		

Remarks

American Society of Anesthesiologists Seal of Quality Program

Questions for: Quality Management (Department and Hospital Representatives together)

	Standard	R/O	Compliance	Notes
1	Is safety the top priority in the anesthesia department?	R		
2	Is there open and effective collegial communication between the hospital quality management service and the anesthesia department?	R		
3	Is there an established process by which sentinel events are referred to the anesthesia (or hospital) QM and/or risk management department?	R		
4	Is there an identified quality management professional for the department?	R		
5	Do sentinel events and major issues/cases reported to risk management go through a root-cause analysis?	R		
6	Can the department demonstrate that improvement ideas derived from root-cause analysis (RCA) have been implemented, and that subsequent review confirm a correction or improvement of a previous problem?	R		
7	Are there on-going chart reviews for quality, consistency, and legibility of documentation?	R		
8	Do quality assurance/improvement meetings occur regularly?	R		
9	Are periodic quality reports made available to department members?	O		
10	Are indicators reviewed by the department and process improvements suggested?	R		
11	Has the department established methods and criteria for granting non-anesthesia personnel privileges to perform sedation, including re-privileging and testing? If hospital policy permits non-anesthesiologists to administer or supervise deep sedation, has the department defined and monitored the training, experience, and qualifications necessary for these professionals to administer deep sedation?	R		
12	Is the department actively involved in achieving and documenting SCIP protocols?	O		
13	Is there an anonymous mechanism for reporting compliance issues?	O		
14	Is a method of reporting "near miss" events available, are practitioners are aware of it, and is it utilized?	O		
15	Does the department have processes in place to allow feedback from patients, nurses, surgeons, and administrators (i.e., patient surveys, peer review evaluations)?	O		
16	Do patient's comments enter the quality cycle?	O		
17	Does the department continuously review clinical data and outcomes in an effort to deliver high-quality and cost-effective patient services (if not in place, is this a stated goal of the department)?	O		
18	Is the anesthesia department actively involved in a recycling program and/or efforts to reduce waste?	O		
19	Does the department have a policy and procedure manual and is it retrievable electronically?	O		
20	Does the department have "best practice" pathways or are they developing such pathways (i.e., total joint pain, epidural wet tap, nausea and vomiting management, sleep apnea management, neuraxial anesthesia and anticoagulants, stents and plavix)? Are these published and routinely used?	O		
21	Does the department utilize a large quality data repository (such as AQI*) in order to obtain statistically significant benchmarking?	O		
22	Does the department participate in a hospital-wide quality program? Does the anesthesia department	O		

	participate in development of quality goals?			
23	Is the department outcomes data shared with other (involved) departments?	O		
24	Does the department regularly communicate specific issues related to quality and safety to department members?	R		
25	Does the department have a process to address poor outcomes that cross departmental boundaries, i.e., joint M& M conferences?	R		
26	Do patients on chronic beta-blockers have their medication continued through the perioperative period?	O		
27	Does the department have a locally derived policy addressing management of pediatric patients?	R		
28	Are there locally derived benchmarks for PONV and postoperative pain?	O		
29	Is a policy in place (and followed) to assure maximum sterile barrier technique (MSBT) and the use of ultrasound for the placement of invasive lines?	O		
30	Is there a CME requirement (hospital or state) for anesthesiologists and CRNA's and do all meet its provisions?	R		
31	Is perioperative temperature tracked per ASA standards?	O		
32	Is there a peer-review process in place?	R		
33	Are audit mechanisms in place to ensure non-fraudulent billing?	O		

Remarks

American Society of Anesthesiologists Seal of Quality Program

Questions for: Administration (May be interviewed separately using two copies)

	Standard	R/O	Compliance	Notes
1	In your opinion, does the department provide quality care?	R		
2	Is there open and effective collegial communication between management and the anesthesia department?	R		
3	Is safety the top priority in the anesthesia department?	R		
4	Is the anesthesia department actively engaged in running of the operating room, improving efficiency, and providing adequate access to the operating room?	O		
5	Are members of the anesthesia department leaders in the day-to-day management of the operating room?	O		
6	Is the anesthesia department actively aiding the hospital in achieving strategic goals?	O		
7	Is the anesthesia department actively involved in “Clinical Quality Value Analysis” and/or other cost effectiveness measures?	O		
8	Does the anesthesia department participate in development of quality goals?	O		
9	Is the anesthesia department actively involved in a recycling program and/or efforts to reduce waste?	O		
10	Is there a culture of professionalism and ongoing professional development in the department?	O		
11	Would you allow any member of the department to anesthetize you or a member of your family?	R		
12	Do anesthesiologists participate actively and willingly in the peer review process?	R		
13	Do patient’s comments enter the quality cycle?	O		
14	Do anesthesiologists participate in the governance and committee work of the hospital?	O		

Remarks

American Society of Anesthesiologists Seal of Quality Program

Questions for: Anesthesia Technicians

	Standard	R/O	Compliance	Notes
1	Is there open and effective collegial communication between anesthesia technicians and anesthesiologists?	R		
2	Are there (in each anesthetizing location) provisions for adequate illumination of the patient, anesthesia machine (when present) and monitoring equipment? Is there a form of battery-powered illumination other than a laryngoscope immediately available?	R		
3	Is there (in each anesthetizing location) sufficient space to accommodate necessary equipment and personnel and to allow expeditious access to the patient, anesthesia machine (when present) and monitoring equipment?	R		
4	Is there (in each anesthetizing location or suite of locations) an emergency cart with a defibrillator, emergency drugs and other equipment adequate to provide cardiopulmonary resuscitation?	R		
5	Is there (in each anesthetizing location) a reliable source of oxygen adequate for the length of the procedure, including a backup supply? Is there a central source (piped) oxygen available in all usual anesthetizing locations?	R		
6	Is there (in each anesthetizing location) an adequate and reliable source of suction?	R		
7	In any location in which inhalation anesthetics are administered, is there an adequate and reliable system for scavenging waste anesthetic gases?	R		
8	Is there (in each anesthetizing location): (a) a self-inflating hand resuscitator bag capable of administering at least 90 percent oxygen as a means to deliver positive pressure ventilation; (b) adequate anesthesia drugs, supplies and equipment for the intended anesthesia care; and (c) adequate monitoring equipment to allow adherence to the "Standards for Basic Anesthetic Monitoring?" [HTTP://WWW.ASAHQ.ORG/FOR-MEMBERS/STANDARDS-GUIDELINES-AND-STATEMENTS.ASPX] In any location in which inhalation anesthesia is to be administered, is there an anesthesia machine equivalent in function to that employed in the standard operating room, and is it maintained to current operating room standards?	R		
9	Is there (in each anesthetizing location) adequate staff trained to support the anesthesiologist? Is there immediately available in each anesthetizing location a reliable means of two-way communication to request assistance?	R		
10	Are all anesthesia technicians ASATT certified or in the certification process, and does the department actively promote and encourage this goal?	O		

Remarks

American Society of Anesthesiologists Seal of Quality Program

Questions for: CRNA's and AA's

	Standard	R/O	Compliance	Notes
1	Is safety the top priority in the anesthesia department?	R		
2	Is there (in continuous use) a device with an audible alarm capable of detecting disconnection of the breathing system wherever inhalation anesthesia with mechanical ventilation is administered?	R		
3	Is pulse oximetry used for all sedated or anesthetized patients, and are the variable-pitch, pulse tone and the low threshold alarms audible?	R		
4	Is an oxygen analyzer with a low oxygen concentration limit audible alarm in use at all times during a general anesthetic?	R		
5	Does every patient receiving anesthesia or sedation have the electrocardiogram continuously displayed from the beginning of anesthesia until preparing to leave the anesthetizing location?	R		
6	Does every patient receiving general anesthesia have, in addition to the above, circulatory function continually evaluated by at least one of the following: palpation of a pulse, auscultation of heart sounds, monitoring of a tracing of intra-arterial pressure, ultrasound peripheral pulse monitoring, or pulse oximetry?	R		
7	Is every patient re-evaluated immediately prior to induction of anesthesia, and is this documented on the anesthetic record?	R		
8	Is the full APSF Checklist (anesthesia machine checklist) performed at the beginning of the day and critical elements repeated prior to each anesthetic? Is the checklist readily available on or near each machine? (for practices that utilize anesthesia machines)	R		
9	Are all drugs (except those to be given immediately) legibly labeled with minimum information including drug name and drug concentration (and the date if syringe/vial not disposed of after each case)? [or a method exists to determine syringe content, concentration, and expiration] Are all admixtures appropriately labeled?	R		
10	Are scheduled medications under the personal control of the anesthesiologist or CRNA at all times?	R		
11	Do anesthesiologists promptly respond when called to the room of a non-physician anesthesia provider?	R		
12	Is there a culture of professionalism in the department?	O		
13	Does the department support your practice and do you have appropriate latitude for your professional activities?	O		
14	Are patients properly and timely prepared preoperatively and is this communicated to the anesthesiologist or CRNA who will be caring for the patient in a reasonable and timely manner?	O		
15	Do you have clinical support for the decisions you make?	O		
16	Are you certified or on track to become certified?	R		
17	Is there open and effective collegial communication between you, the Chairman, and other members of the anesthesia department?	O		

18	Would you allow any member of this anesthesia department to anesthetize you or a family member?	R		
18	Are you ACLS and/or PALS certified?	R		

Remarks

American Society of Anesthesiologists Seal of Quality Program

Questions for: Office Based Anesthesia Facilities

	Standard	R/O	Compliance	Notes
1	Patient and Procedure Selection: The applicant must be able to demonstrate that: •Anesthesiologists are satisfied that the procedures to be undertaken are within the scope of practice of the health care practitioners and the capabilities of the facility. • The procedures are of a duration and degree of complexity that permit the patients to recover and be discharged from the facility. •Patients who by reason of pre-existing medical or other conditions that may be at undue risk for complications are referred to an appropriate facility for performance of the procedure and the administration of anesthesia.	R		
2	Perioperative Care: The applicant must be able to demonstrate that: • Anesthesiologists and CRNA's adhere to the "Basic Standards for Pre-anesthesia Care," "Standards for Basic Anesthetic Monitoring," "Standards for Post-anesthesia Care," and "Guidelines for Ambulatory Anesthesia and Surgery" as currently promulgated by the American Society of Anesthesiologists. • Anesthesiologists and CRNA's are physically present during the intraoperative period and immediately available until the patient has been discharged from anesthesia care. •The decision to discharge patients is made by a physician and documented in the medical record. •Personnel with training in advanced resuscitative techniques (i.e., ACLS, PALS) are immediately available until all patients are discharged home.	R		
3	Monitoring and Equipment: The applicant must be able to demonstrate that: • At a minimum, all facilities have a reliable source of oxygen, suction, resuscitation equipment and emergency drugs. Specific reference is made to the ASA "Statement on Non-operating Room Anesthetizing Locations." •There is 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. • All equipment is maintained tested and inspected according to the manufacturer's specifications. Backup power sufficient to ensure patient protection in the event of an emergency is available. • In any location in which anesthesia is administered there is appropriate anesthesia apparatus and equipment, which allow monitoring consistent with ASA "Standards for Basic Anesthetic Monitoring." • In an office where anesthesia services are to be provided to infants and children, required equipment, medication and resuscitative capabilities appropriate for the pediatric population.	R		
4	Is there a method to identify an unconscious patient (i.e., name tag, name band)?	O		
5	4 Does the practice contact the patient/family prior to the day of surgery?	O		
6	5 Does a mechanism exist to allow the anesthesiologist to review the patient's medical record prior to the day of surgery?	O		
Remarks				