



AMERICAN OSTEOPATHIC ASSOCIATION

INSPECTION WORKBOOK

FOR

RESIDENCY TRAINING PROGRAMS

IN

ANESTHESIOLOGY

American Osteopathic Association

and the

American Osteopathic College of Anesthesiologists

COPT, Revised, 1990
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**INSPECTION WORKBOOK
FOR
RESIDENCY TRAINING PROGRAMS
IN
ANESTHESIOLOGY**

Identification Data (please type)

Name of Institution

City and State

Name of Program Director

Year Certified by the American Osteopathic Association

Name of Sponsoring Institution (if applicable)

Name of Affiliated College of Osteopathic Medicine

- | | | |
|----|---|-------|
| 1. | Number of members in the department or service | _____ |
| 2. | Number of certified Anesthesiologists in the department | _____ |
| 3, | Number of residents in training: | _____ |
| | a. Special Emphasis Anesthesia Tract | _____ |
| | b. First year | _____ |
| | c. Second year | _____ |
| | d. Third year | _____ |

Administrator/DME Signature

Date

Inspector Signature

Date

The ADCA requests all minutes of meetings on formal education attendance require sign in validation.

EVALUATION OF PROGRAM

1. Are there written bylaws, rules, and regulations for the department of anesthesiology? Yes No
2. Are there written minutes of meetings? (Dated and Timed) Yes No
3. Were departmental meetings held at least monthly? Yes No
4. Is attendance required? Yes No
5. Is a record of attendance kept? Yes No
6. Is it a part of departmental and hospital permanent records? Yes No
7. Is the department under the supervision of an Anesthesiologist certified by the AOA? Yes No
8. Is membership in the department based on educational qualifications and experience? Yes No

Please document qualifications required for membership.

How are the department members credentialed and re-credentialed? Is performance credentialing a part of this process?

Comment: _____

9. List department members participating in this training program.

<u>Names</u>	<u>Certified</u>		
_____	Yes <input type="checkbox"/>	AOA/ABMS	No <input type="checkbox"/>
_____	Yes <input type="checkbox"/>	AOA/ABMS	No <input type="checkbox"/>
_____	Yes <input type="checkbox"/>	AOA/ABMS	No <input type="checkbox"/>
_____	Yes <input type="checkbox"/>	AOA/ABMS	No <input type="checkbox"/>
_____	Yes <input type="checkbox"/>	AOA/ABMS	No <input type="checkbox"/>

10. List anesthesia equipment in this institution. Attach list to report noting:

a. Anesthetic machines: Make & Model _____
Year Purchased _____

b. Monitoring equipment: Make & Model _____
Year Purchased _____

Other: _____

11. Is the recovery room under the active direction of the Department of Anesthesiology?

Yes No

12. Does the written program meet the standards of the AOA and the Basic Standards for Residency Training in Anesthesiology?

Yes No

Comment: _____

13. Does the Department of Anesthesiology regularly conduct mortality reviews?

Yes No

14. Has this residency complied and is it complying with the requirement that the resident administer no fewer than 500 and no more than 900 anesthetics yearly?

Yes No

15. What number of the following resources that are pertinent to this specialty are available in the medical library? (Titles)

Journal _____ Audio cassettes _____

Films _____ Other _____

16. Is the progress of the residency periodically evaluated?

Yes No

By what method? _____

17. Is the educational program periodically evaluated?

Yes No

By what method? _____

18. State the strengths and/or weaknesses disclosed by the resident's log and summary for the past year:

19. State the resident's opinion of his training program. (*Progressive, graded, comprehensive, adequate, deficiencies, etc. Describe fully*).

20. Is there evidence of progressive and increasing supervised responsibility by the resident as his training progresses?

Yes No

21. Is the resident(s) thoroughly knowledgeable about the Code of Ethics of AOA?

Yes No

22. Is there evidence of cooperative assistance in the training of the resident by other departments? Yes No

If yes, how is this cooperation evidenced?

23. How are the basic sciences taught and correlated with clinical anesthesia?

24. Is there a format printed reading assignment for the resident?

Yes No

25. Is there a formal journal club meeting?

Yes No

26. Has the resident prepared an annual scientific paper as required?

Yes No

27. Does the resident participate in the training of interns and/or in undergraduate programs?

Yes No

How does this evidence itself?

28. Do hospital staff, anesthesia department personnel, and other assign lecture and teaching duties to the residents?

Yes No

Comment: _____

29. Is the resident encouraged to participate in research projects?

Yes No

Name projects completed and/or in progress:

30. Is there evidence of utilization of osteopathic concepts and philosophy in this residency training program?

Yes No

Comment: _____

31. How much time was spent by the resident outside of the parent institution to gain instruction and experience in the areas not being provided for by the department?

32. What postgraduate course(s) in Anesthesiology had the resident attended?

33. What postgraduate course(s) has the resident participated in?

34. Does the resident attend postmortem examinations?

Yes No

35. Does the resident attend the monthly department meetings?

Yes No

36. Is there written documentation of resident presence at department meetings and department lectures?

Yes No

37. Does the resident keep a log with a copy submitted to the program director on a weekly or monthly basis?

Yes No

38. Does the resident participate in meetings of the medical audit and mortality review committees to the staff?

Yes No

FOR THE THIRD YEAR

1. Has the resident successfully completed a two (2) year approved osteopathic residency program in Anesthesiology?

Yes No

2. What subspecialty area has been selected for the third year?

3. Is there an adequate volume and variety of cases in the subspecialty area for which there has been program approval?

Yes No

4. Is the program director experienced and trained in the subspecialty area?

Yes No

5. Has the resident spent time in outside rotations?

Yes No

If so, where? _____

In what areas? _____

For how many weeks or months? _____

(No more than three (3) months outside parent institution is permitted.)

6. Other pertinent comments:

QUALITY ASSURANCE

1. Does the department have a quality assurance program? (Attach form to the inspection report)

Comment: _____

2. How does the department collect data to monitor quality issues? How is this data used to correct quality issues?

Comment: _____

3. Do residents participate in the quality assurance process?

Comment: _____

4. Does the department have an infection control program?

Comment: _____

5. Does the department and quality assurance committee of the hospital have a mechanism to respond to the allegations of the local peer review organization?

Comment: _____

6. Is the resident given instruction in the quality assurance program?

Comment: _____

CHART REVIEW

All of the following questions should be answered for each of the fifteen (15) charts selected for review.

Case Number _____

1. Does the patient's hospital record show that an Anesthesiologist interviewed and examined the patient, reviewed the medical record, dated and timed the recorded findings before administering anesthesia?

Yes No

Comment: _____

2. Was the patient assigned a physical status according to the A.S.A. 1 through 5?

Yes No

Comment: _____

3. Does the Department of Anesthesiology participate in:

- a. Pre-anesthetic evaluation? Yes No
- b. Pre-operative consultation and management? Yes No
- c. Post-operative consultation and management? Yes No

Comment: _____

4. Was the order for the pre-medication dated and timed?

Yes No

Comment: _____

5. Are all medications administered during anesthesia clearly indicated as to:

a. Time of administration (including onset and termination of continuously administered drugs?)

Yes No

Comment: _____

b. Dosage Yes No

Comment: _____

c. Route of administration? Yes No

Comment: _____

6. Were physiological parameters monitored and recorded during anesthesia?
Yes No

7a. Were the following parameters monitored and recorded at no longer than five (5) minute intervals?

1. Blood pressure
2. Pulse
3. Respiratory rate
4. Oximetry (include SAO₂ and FIO₂)
5. Capnography, if indicated
6. Ecg (rhythm, etc.)
7. Temperature

7b. Were the following parameters recorded at fifteen (15) minute intervals?

1. Train of four
2. Urine Output
3. Ebl

8. Taking into consideration the patient's condition, surgery performed and anesthesia utilized, was the patient adequately monitored?

Yes No

Comment: _____

9. Were times of events recorded?

Yes No

Comment: _____

10. Was there a post-anesthetic evaluation in three (3) to twenty-four (24) hours of administration of an anesthetic by the Anesthesiologist or Anesthesiology resident?

Yes No

Comment: _____

11. In the pre-anesthetic evaluation of the patient, is there an indication of the anesthetic agents, methods and procedures that are to be utilized?

Yes No

12. Do department members request consultation in high-risk patients?

Yes No

13. Does the anesthetic record include the following?

Yes No

a. Delineation of anesthetics being administered with notation on dosages and flow rates?

Yes No

b. Notation on monitoring equipment being used and the information obtained from such equipment?

Yes No

- | | Yes | No |
|---|--------------------------|--------------------------|
| c. Notation of the patient's position and positional changes? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Indication of time of intubation and extubation: | | |
| Size of tube | <input type="checkbox"/> | <input type="checkbox"/> |
| Use of cuffed or uncuffed tube | <input type="checkbox"/> | <input type="checkbox"/> |
| Amount of air used for cuff inflation | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Oral or nasopharyngeal or LMA airway inserted time and size | <input type="checkbox"/> | <input type="checkbox"/> |
| f. The recorded volume and rate of ventilation | <input type="checkbox"/> | <input type="checkbox"/> |
| g. The type and amount of fluids given: if blood, identification of type | <input type="checkbox"/> | <input type="checkbox"/> |
| h. The site of intravenous insertion and gauge of catheter | <input type="checkbox"/> | <input type="checkbox"/> |
| i. A listing of the surgical procedure, name of surgeon and assistants | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Indication of where the patient was taken, i.e., recovery Intensive Care Unit, or other area | <input type="checkbox"/> | <input type="checkbox"/> |

Statistics for the previous year for anesthetics administered

A. Obstetrics – Total Number

<u>Methods</u>	<u>Number</u>	<u>Agents</u>	<u>Number</u>
Spinal	_____	Xylocaine	_____
Epidural	_____	Marcaine	_____
Caudal	_____	Pontocaine	_____
Other _____		Carbocaine	_____
		Other _____	
<u>General</u>		Nitrous Oxide	
Inhalation	_____	Desflurane	_____
Intravenous	_____	Forane	_____
Endotracheal	_____	Seuoflurane	_____
LMA	_____	Pentothal	_____
		Succinylcholine	_____
		Narcotics	_____
		Propofol	_____
		Muscle Relaxants	_____
		Other _____	

B. Surgery – Total Number

<u>Methods</u>	<u>Number</u>	<u>Agents</u>	<u>Number</u>
Inhalation	_____	Nitrous Oxide	_____
Intravenous	_____	Desflurane	_____
Endotracheal	_____	Forane	_____
I.V. Regional	_____	Seuoflurane	_____
Spinal	_____	Fluothane	_____
Epidural	_____	Pentothal	_____
Caudal	_____	Propofol	_____
Nerve Blocks	_____	Narcotics	_____
Interscalene	_____		
Brachial	_____	Muscle Relaxants	_____
Axillary	_____	Sucinylcholine	_____
Sciatic	_____	Pancuronium	_____
Radial	_____	Artracurium	_____
Pepliteal	_____	Xylocaine	_____
Femoral	_____	Pontocaine	_____
Other _____		Marcaine	_____
		Other _____	

C. Breakdown of anesthetics according to surgical specialty.

	<u>Specialty</u>	<u>Number</u>
1.	Cardiac	_____
2.	Vascular	_____
3.	Thoracic	_____
4.	Neurological	_____
5.	Gynecological	_____
6.	Pediatric	_____
7.	Orthopedic	_____
8.	Ophthalmology	_____
9.	Otolaryngology	_____
10.	General	_____
11.	Urology	_____
12.	Plastic	_____
13.	Endo (Colonoscopy)	_____
14.	Other	_____

Period reported from _____ to _____
(Date) (Date)