Stony Brook University
School of Health Technology and Management
Health Science
Anesthesia Technology Program

ANESTHESIA TECHNOLOGIST (AT) CLINICAL
NON-CREDIT, NON-DEGREE CERTIFICATE
PROGRAM POLICIES AND PROCEDURES

Students are bound by the academic standards, policies and procedures listed in this handbook as well as the policies and procedures that detailed in the School of Health Technology and Management Policies and Procedure manual (found at the first webpage link below) and the Stony Brook University’s Student Conduct Code (found at the second link below):


https://www.stonybrook.edu/commcms/studentaffairs/ucs/conduct.php?accordion=undefined
Anesthesia Technology Program: Mission Statement and Student Learning Outcomes

The anesthesia technology program is two years in length. The first year of the anesthesia technology program (the Health Science senior year) is designed to provide the didactic foundation required for the ASATT national certification. The second year is a continuation of study in a clinical non-credit, non-degree certificate program which is designed to foster clinical competency at the level of an anesthesia technologist. Successful completion of both years is an eligibility requirement to qualify for the ASATT national certification examination.

The overarching vision of the Health Science major is to provide the highest quality undergraduate education that integrates the principles of scholarship, ethics, cultural competency, communication skills, critical thinking, evidence-based practice, and civic orientation to meet the diverse regional needs of the evolving health care industry.

Anesthesia Technology (AT) Program Mission Statement: The mission of the AT program is to develop the knowledge, attitudes, skills and competencies required to function as an integral member of an anesthesia team in diverse surgical settings. Through didactic lessons and clinical work students will hone their skills that are required to provide the highest quality patient care while maintaining the ethical standards and professionalism required in this dynamic profession.

Goal 1: Students will demonstrate clinical competence of an entry-level anesthesia technologist.

Student Learning Outcomes:
- Students will demonstrate basic knowledge relative to the surgical procedures conducted in each surgical service.
- Students will demonstrate technologist level skills relative to the surgical procedures conducted in each surgical service.

Goal 2: Students will possess critical thinking skills

Student Learning Outcomes:
- Students will adequately respond to challenges faced during a surgical procedure.
- Students will show the ability to perform multiple tasks in a timely manner.

Goal 3: Students will practice with professional values

Student Learning Outcomes:
- Students will display professional conduct
- Students demonstrate life-long learning

Goal 4: Students will display effective communication skills

Student Learning Outcomes:
- Students will demonstrate written communication skills
- Students will demonstrate oral communication skills
General Information

1) The Anesthesia Technologist Clinical Program is considered to be a full-time program
   a. Sign in: 0600-0615 & Sign out: 1400-1415, 5 days a week.
   b. Students (AT Interns) are expected to complete the program within one academic year. The program consists of clinical rotations in the operating rooms, obstetric suite and other clinical locations at Stony Brook University Medical Center as well as didactic (classroom) teaching sessions. The AT Intern will be expected to participate fully and actively in the clinical rotations and teaching sessions.

2) As per the School of Health Technology and Management, students participating in clinical programs must provide evidence of health insurance.

3) NO STUDENT WILL BE PERMITTED TO ENTER THE CLINICAL SETTING WITHOUT MEDICAL CLEARANCE FROM STUDENT HEALTH SERVICES.

4) Students will not be permitted to enter the clinical setting without proper identification (e.g. student identification badge). Badges will not be issued to students if there is a hold (e.g. outstanding balance, lack of medical clearance, etc.) on their account.

5) Students must abide by University Hospital policies and procedures including but not limited to accessing clinical areas, use of equipment and medical records, infection control, influenza vaccinations (or other approved procedures for infection control), etc. More detail will be provided by your program director and clinical faculty.

Tuition and Refund Policy

1) Tuition will be charged at the rate of $5,000.00 for the clinical non-credit, non-degree certificate program plus university fees. See the following link for a list of required university fees:
   https://www.stonybrook.edu/commcms/bursar/tuition/certificate-program

2) This tuition must be paid in full one week prior to the start of the program. Students will not be permitted to attend classes or clinical education beyond the posted tuition deadline date.

3) Students who withdraw from the Anesthesia Technology Program are liable for payment of tuition in accordance with the following schedule:

<table>
<thead>
<tr>
<th>Withdrawal</th>
<th>Liability</th>
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</thead>
<tbody>
<tr>
<td>First Week</td>
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</tr>
<tr>
<td>Second Week</td>
<td>30%</td>
</tr>
<tr>
<td>Third Week</td>
<td>50%</td>
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</table>
Fourth Week 70%
Fifth Week 100%

4) Orientation will be held on the first day of the program. Absence from classes does not constitute an official withdrawal and does not relieve the student of his or her financial obligation or entitle the student to a refund. Students must officially request to withdraw, in writing, to the Dean’s office.

5) Students will be responsible for other fees incurred during the duration of the program. Such fees include, but are not limited to, background checks or drug testing required by clinical affiliates, books, malpractice insurance, hospital parking fees, etc.

Performance Skills and Attitudes – Assessment Procedures

In addition to mastery of cognitive skills and knowledge, students will be evaluated on their performance skills and attitudes. These include:

- Adherence to the University Code of Conduct and University Hospital policies and procedures
- Ability to work with and relate to peers, patients, faculty and other members of the health care team
- Attitude
- Attendance and punctuality
- Appearance and professional demeanor

In addition to the General Rules of Conduct:

Only designated faculty (such as the Attending Anesthesiologist assigned to the case or the AT Interns Preceptor) can document and/or authorize time and sign your request to be released from clinical responsibilities. In the Ambulatory Surgical Center, only the Attending Anesthesiologist present at 1430 can document and/or authorize time and sign your request to be released from clinical responsibilities.

- It should be within the AT Committee’s discretion to determine if an intern has earned the credit for that day based on their clinical performance, productivity and professionalism.

- After set-ups interns should meet with the anesthesia team to discuss their cases. This is to communicate and learn more about the cases.

- No hanging in the hallways between case set-ups and start-ups, in the name of “waiting”.

No such thing as “my rooms are done for the day”. In days wherein the case schedule in the assigned room/s is completed or cancelled prior 1400-1415, the student (AT intern) is required to communicate immediately with the clinical faculty (AT preceptor or Drs. Lagade) to be reassigned to other room/s.

Anticipate and judge the beginning/finish of the cases before taking breaks or leaving rooms.

Interns should remain in the assigned clinical area for the entire 8 hours. During off site rotations, an intern should report to the main OR whenever case schedule is not in progress or cancelled.

L & D rotation (0700-1200), an intern should report at 1230 to the main OR after lunch (1200-1230).

ASC rotation, an intern should report to ASC on MTRF. On Wednesdays, attendance to morning teaching sessions, then an intern should report to Endoscopy Suite.

Cell phones should not be visible while in the OR.

- Cellphones must be set on vibrate.
  - Only acceptable use of a cell phone in clinical setting is to communicate with AT intern preceptor (i.e. receive messages from program director and faculty).
  - Students using cellphones for other purposes during the clinical hours will be subject to probation/termination.

No hanging out, sitting inside or passing by the Anesthesia work room without related purposes.

Interns should not be permitted to use the computer inside the Anesthesia work room or anywhere in the OR. Instead, use it in the library after clinical hours.

Successful completion of each sub-specialty rotation requires that the student continuously maintain high standards. This means that regardless of one’s level of achievement in cognitive skills and knowledge, if one’s professional behavior is not appropriate, he/she may not meet minimum requirements for successful completion of the sub-specialty rotation.
Unsatisfactory Performance Skills or Attitudes

Unsatisfactory behavior, such as disruption of class activities during seminars and workshops, expression of derogatory, disrespectful remarks to the clinical staff, faculty, peers, or patients, inability to work with peers, or excessive unexcused absences (full or partial days and returning late from breaks) may be cause for warning or further action.

A student who has exhibited unsatisfactory behavior that may affect his or her final evaluation and academic standing shall receive a warning from the clinical faculty that stated behavior may jeopardize successful completion and lead to failure of the sub-specialty rotation. If the student does not amend behavior subsequent to verbal warning they will be placed on probation.

☐ Clinical staff include the Attending Physicians, Residents, Nurses, Nurse Anesthetist, CRNA educator, Anesthesia technologists and technicians, and OR staff.
☐ Clinical faculty include: Drs. Lagade, Vitkun, and the AT Student Intern Preceptors (Shoba Sanu, CRNA and Melissa Day, CRNA). The clinical faculty also includes the Chair of the department, Dr. Deborah Zelizer.

General Rules of Conduct and Safety

Students are expected to conduct themselves in a professional manner, adhere to all hospital policy and procedure safety guidelines at all times.

OR Attire in all semi restricted (OR/Procedure Hallways) and restricted (ORs/Procedure rooms) areas

Any student not complying with the policy below will be removed from the procedural area, and termination from the program.

In accordance with our existing policy:

☐ OR Attire in all semi restricted (OR/Procedure Hallways) and restricted (OR’s/Procedure rooms) areas

☐ Only hospital issued and hospital laundered scrubs may be worn in OR/Procedure rooms and must be changed daily.

☐ All Head & Facial Hair must be covered – NO EXCEPTIONS. Knight hoods and masks required for facial hair.

☐ All head and neck jewelry except stud earrings must be removed – NO EXCEPTIONS
  o Stud earrings may remain only if they are covered at all times
☐ No Cover Jackets from outside the operating/procedure rooms may be worn

☐ No personal belongings including but not limited to purses/backpacks/computer bags are to be taken into the OR/procedural restricted and semi restricted areas.

☐ When leaving a procedural suite scrubs must be covered by a buttoned lab coat or closed single use gown.

☐ No lanyards may be worn

☐ Only hospital supplied disposable head coverings may be worn.

Leadership surveillance will be conducted during all shifts to ensure compliance with this immediate corrective action. This surveillance begins at the point of the semi-restricted area. This surveillance will also include roaming observations.

**Conduct:**

☐ Students will address the staff, faculty, patients, and fellow students by their appropriate title and/or last name.

☐ Sign in time is from 0600-0615 and Sign out time is 1400-1415. Students will document their time using the punch machine.
  o Punching in or out for someone is considered an incident of academic dishonesty.
  o Students must be in scrubs ready to work by 0615. [Note: students are not permitted to wear scrubs home and must obtain a clean pair of scrubs each morning from the scrub machine before entering the clinical setting].
  o Students are not to leave their clinical duties until 1400.
  o If a student signs in at any time other than the designated time, without prior approval, student will under no circumstances be given credit for that day.

☐ Students may **not** work through lunch breaks in order to leave clinic early.

☐ Only designated faculty (such as the AT Student Intern Preceptor) can document and/or authorize your request to be released from your clinical responsibilities. In the absence of the AT Student Intern Preceptors: Shoba Sanu, CRNA and Melissa Day, CRNA students must contact Drs. Lagade, or Vitkun.

☐ Students cannot work at their assigned unit for more than eight (8) hours in any single day.

☐ Signing in or out for a fellow student will be considered a case of academic dishonesty and will result in a recommendation to the Dean for the student(s) termination.
Eating and drinking are permitted in designated areas only. Students are required to complete the 30-minute lunch break by 1200. Students permitted one 15-minute break which must be completed prior to 10am. Smoking is prohibited.

- A student who fails to return on time from break or lunch break may be sent home at the discretion of the clinical faculty (Drs. Lagade and Vitkun, or AT Student Intern Preceptors: Shoba Sanu, CRNA and Melissa Day, CRNA) and not be credited with time for that day.

Students are expected to complete the 30-minute lunch break by 1200. Students permitted one 15-minute break which must be completed prior to 10am. Smoking is prohibited. A student who fails to return on time from break or lunch break may be sent home at the discretion of the clinical faculty (Drs. Lagade and Vitkun, or AT Student Intern Preceptors: Shoba Sanu, CRNA and Melissa Day, CRNA) and not be credited with time for that day.

- Students are expected to remain visible AND productive in the clinical arena at all other times.

  - For an AT intern to learn they must be present in cases, therefore, student are expected to set-up cases and remain in that case unless otherwise directed. Students are expected to participate in numerous cases, in at least but not limited to 2 to 3 rooms, within their sub-specialty rotation per day unless otherwise directed by clinical staff or clinical faculty.
  - Note if the student believes they have completed the required number of cases for the day, they are to report to the preceptor so they may be assigned additional cases.

- Personal relationships between students and clinical staff, faculty, or patients are forbidden. Engaging in personal relationships will be considered unprofessional conduct and will result in a recommendation to the Dean for termination.

- Personal conversation and discussions with classmates or staff is in poor taste and should be limited to off duty hours.

- Grievances and personal dislikes should be aired in private and with the appropriate persons.

- Accidents involving students or patients must be reported immediately according to SBUMC policies. For example, in the case of a ‘dirty’ needle sticks students must immediately report the incident to the Attending Physician, complete an Incident Report and be seen at Employee Health prior to the end of the shift.

**Late/Absence:**

1) AT Interns are expected to be dressed in clean scrubs by 0615. AT Interns are expected to be in their assigned rooms at 0615, no exceptions.

**Sickness:**

1) AT Interns who are ill are expected to call before 2200 (10:00pm) the night before or between 0500-0530 the morning of the scheduled start time. This is the same process for informing program faculty of lateness. For all illness related absences/lateness students
will need to provide documentation (a physician’s note stating the student could not be in clinic).

2) Repeated illness/lateness may require an extension of time in the program or may result in dismissal from the program.

   a. Students are limited to a total of 2 weeks of combined excused absence time; excused absences must be made up immediately following the program end (this will amend your completion date of the program).
   b. Students that have combined excused absences that exceed two weeks may subject to a leave of absence or dismissal from the program.

**Failure to contact program:**

1) If you do not call at the appropriate time, your lateness or absence will be considered Unexcused. You will be counseled for unexcused lateness or absence and a note will be placed in your file. TWO (2) UNEXCUSED LATENESS episodes will count as ONE (1) UNEXCUSED ABSENCE.

2) Students with ONE (1) UNEXCUSED ABSENCE will be placed on PROBATION. TWO (2) UNEXCUSED ABSENCES will result in DISMISSAL from the program.

3) More than THREE (3) EXCUSED ABSENCES will require students to make-up the missing clinical hours at the conclusion of the program.

   a. All students are required to submit an excused absence petition with appropriate documentation to Dr. Zelizer, if they want to petition for an excused absence.

**Rotation Schedules and Vacation Time:**

1) Clinical rotations begin on Wednesday, September 4, 2019 and end on Friday, June 5, 2020. Dr. Ladage will present each student with their surgical suite rotation schedule at orientation.

2) There is no release time from clinical hours. THERE ARE NO EXCEPTIONS! You are expected to remain in your assigned area for the entire clinical day.

3) The Vacation/Holiday Schedule for 2019-2020:

   - **Columbus Day**: Mon, Oct. 14, 2019
   - **Thanksgiving**: Weds, Thurs and Fri, Nov 27-29, 2019
   - **Martin Luther King**: Mon, Jan 20, 2020
   - **Memorial Day**: Mon, May 25, 2020
4) Students may request an excused absence (from Dr. Zelizer) for religious observance; otherwise, there are NO other scheduled or unscheduled vacation times. Returning late from a scheduled vacation will be considered an UNEXCUSED absence. Individual vacation requests will NOT be accepted.

**Clinical Education Policies and Procedures**

The application of theory learned in the classroom is applied to the clinical environment throughout the student’s clinical education.

**Evaluation of Performance**

**Academic assignment:** Students will be submitting weekly journals in Blackboard.

AT Interns Journal Report Guidelines, this journal report is part of your evaluation grade.

1. Log all your cases to file for the week.
2. Select an interesting case to research (read in depth about) and prepare a case report
3. Written case report must include:
   a. Detailed overview of the case
   b. Detailed discussion of the case
   c. Summary
   d. References

**Clinical rotation performance:** Students are expected to request five written evaluations for each clinical rotation from five separate individuals (3 different Attending physicians, CRNA educator, and the AT preceptor) at the start of the third week of the rotation. At the conclusion of the rotation, students must collect each evaluation form (the form must be in a sealed and signed envelope) and deliver the evaluations to Dr. Lagade’s mailbox in the anesthesia office.

Students who fail to submit the required number of written evaluations will be subject to probation. Tampering with a clinical evaluation is considered academic dishonesty will result in a recommendation to the Dean for termination. Failure to submit the required number of evaluations in two rotations will result in a recommendation for termination.

The following procedures are to be utilized when a student attempts to satisfy all Performance Objectives:

- The student will observe the clinical staff/faculty perform the specific procedure before assisting in the procedure. Once the student is deemed ready to perform the procedure the clinical staff will:
  - Observe the student enact the same procedure.
  - Critique and correct any possible errors.
  - Provide remediation, if deemed necessary, from the clinical staff/faculty which the student must accept.
Prior to the student’s attempt to satisfy a specific performance objective, the clinical staff/faculty must observe the student successfully perform the procedure a minimum of three (3) times.
   - Having satisfied the above criteria, the student can request (at their own discretion), that the clinical staff evaluates their performance of Objective(s) (a maximum of one (1) per day).
   - The student must perform (unaided) each step of the procedure correctly, consistently, and within an optimal time frame to be deemed successful in satisfying any attempted objective at the technologist level.

Clinical evaluation forms must be completed by three Attending physicians, the CRNA educator, and the AT preceptor by the conclusion of the rotation. Students should avoid repeated evaluations from any individual clinical faculty or staff. This means students should work with numerous clinical staff and faculty during their sub-specialty rotation. A summative evaluation, which determines if the student has passed the clinical rotation, will be completed by clinical faculty.

In addition, performance may be measured by unscheduled written and/or oral examinations as well as participation in didactic sessions, evidence of preparedness (e.g. completion of readings or other assignments in a timely manner) and the level of involvement in the clinical rotations. Lateness and absence will have a negative impact on performance evaluation.

Clinical competency evaluation forms are maintained to record student grades and progress and to communicate their performance. All records are maintained in the Program Director’s Office. A student not successful in completing their clinical requirements will be ineligible for graduation. The program uses the clinical behavioral evaluation form, performance objectives, and clinical testing to document and evaluate the clinical practicum.

All educational activities and clinical evaluations are maintained with various channels of communications. Methods of communication include, but are not limited to, written evaluation forms, scheduled clinical site visits by the Program Director, intermittent telephone calls with clinical staff, written correspondence, advisory committee meetings, and formal and informal conversations with the clinical staff.

The student will be provided with a written summary of performance at the end of each clinical rotation, subsequent to review of clinical evaluation forms. If a student’s performance in a clinical rotation is unsatisfactory at the technologist level, they will be required to retake (and pass) that rotation at the conclusion of the clinical non-credit, non-degree certificate program. Failure to perform at the technologist level (technologist level includes all basic competency of technician level) in two rotations will result in the request for termination. Note: it is expected that by January students are preforming at the technologist level by the conclusion of each clinical rotation.

**Clinical Supervision:**

All clinical activities involving patients require appropriate supervision by a clinical faculty or staff as follows:
Until a student achieves and documents competency in any given procedure, all clinical assignments shall be carried out under the direct supervision of a qualified clinical faculty or staff.

After demonstrating competency, students may perform patient related procedures only with direct supervision.

In support of professional responsibility for provisions of quality patient care, unsatisfactory procedures shall be repeated only in the presence of a qualified clinical faculty or staff, regardless of the student’s level of competency.

ACADEMIC POLICIES AND PROCEDURES

Academic Standing, Probation and Termination Policy:


The Program Director will recommend to the Dean in writing (within five working days) that the student be placed on probation. Probation/termination is indicated as follows;

- A student will be recommended for probation if a grade of less than satisfactory (equals minimum passing grade of ‘C’) in any required clinical rotation.
- A student who receives one or more unsatisfactory clinical evaluations will be recommended, by memo, to the Dean for termination from the program.
- Unethical clinical performance alone will result in a recommendation to the Dean for probationary status and/or possible termination from the program.
- Any student will be recommended for termination from the Anesthesia Technology Program if, while on probation, their clinical performance falls below satisfactory in any clinical education evaluation(s).
AT Interns Basic Assignment Guidelines

AT Interns Log book located in PACU main desk
Sign In: (0600-0615) 6:00 -6:15 am
Sign Out: (1400-1415) 2:15-2:30 pm

Text message AT Interns Preceptors / Core Faculty
Main OR cases room schedule assignment guideline:
General = 15, 16, 19, 20
Cardiac = Rooms 2, 8, 14
ENT = Rooms 4, 5
Neuro = Rooms 21, 22, 23, CVC
Ortho = rooms 17, 18, 12
Peds/Dental = 3, 4, 11
Urology = 9, 10, 6
Vascular = 24, 25

Room assignments will be text message by AT Interns Preceptor the day prior OR schedule for topic preparation and reading review. ml 08/24/19

AT Interns Specialty Assignment Guidelines

Clinical Subspecialty Rotation information to know and observe:
OB = Sign in / Sign out on the Log book located in PACU main desk
Proceed to OB suite SBUMC Level 5
Join the OB Anesthesia Team
At 12:30p report to Main OR unless an interesting OB case is in progress

ASC = Sign in at 6:00 – 6:15am with Anesthesia Tech Lloyd Boone
Sign out at 2:15pm with the late call Attending Anesthesiologist
Wednesdays: Sign in / Sign out on the Log book located in PACU main desk
After the seminar, report to Endoscopy Suite SBUMC Level 14
Join the Endoscopy Anesthesia Team

Off Site = Sign in / Sign out on the Log book located in PACU main desk
Special carts set up
Join the Off site Anesthesia Team
Report to AT Preceptor when cases are done, cancelled or not scheduled

Main OR = Sign in / Sign out on the Log book located in PACU main desk
Set Up room assignment. Join Anesthesia Team of the room. ml 08/24/19
AT Set-up Guidelines

***You are required to communicate with your Provider on the set-ups***

All cases are dependent on the Patient history, type of procedure, and Provider preference.

***Look at Case-See if “Difficult Airway”, BMI >30++, Communicate with Provider to see if Advanced Airway Equipment Needed***

- **Standard Set-up** – All items to remain sealed until used
  - **Anesthesia Machine Table**: 4x4’s, tegaderms, alcohol pads, disposable laryngoscope handle and blade-Mac #3, 80 and 90 oral airway, tongue depressor, #7.0 & #7.5 ETT, stylet, 10cc syringe. Make sure bougie is present.
  - Make sure Gases are filled and change Soda-lyme if needed. Yankaur and suction tubing connected and working. Make sure extra bottles of anesthesia gas present.
  - **Peripheral IV Set up** – tourniquet, alcohol pads, #16, #18, #20g angiocatheter, clave with 10cc NS flush, gauze, 2 tegaderms.

**General Surgery Cases (lap appe, chole, exploratory laparotomy, cysto’s)**

- Standard room set up
- Additional PIV set-up
- Fluid warmer with stopcocks & extension-communicate with Provider if needed
- Alaris with 1 channel/Syringe pump
- LMA’s/ IGEL’s available -#4, #5 for cysto’s- communicate with Providers

**Complex General Surgery Cases (look at length of surgery)**

- Standard room set-up
- Additional PIV set-up
- Fluid warmer with stopcocks & extension- communicate with Provider if needed
- Alaris with 1 channel/Syringe pump
- Communicate with Provider if Arterial line or CVP lines needed

**GYN Cases (D&C, Hysterectomies, Robotic hysterectomies)**

- Standard set-up
- Additional PIV set-up
- Fluid warmer in most hysterectomies/Robotic cases-communicate with Provider
- Extension set with additional stopcocks on IV line and Fluid warmer
- Alaris with 1 channel/Syringe pump
- **Robotic Cases** –Goggles, make sure Prone pillow present
- Arterial line with extension-communicate with Provider needed

**Kidney Transplants**

- Standard set-up
- Additional PIV set-up’s
• Fluid warmer with stopcocks and extension with NS
• May need additional stopcocks and extension to IV and Fluid warmer
• NS IV bags available
• Alaris pump with 4 channels/Syringe pump
• Arterial line set-up with kit, extension, have micro-puncture kit available
• Ultrasound available
• Sterile Gown, Gloves, Drapes for Central line insertion
• CVP line, Sideport with 4 stopcocks-communicate with Provider if needed
• Black/Yellow Tackle box

Orthopedic Cases (knees, hips)
  **Knees** – Most cases will be MAC (Monitored Anesthesia Care), Sedation, because they have received a Spinal and Peripheral Nerve block.
  • Always have standard set-up
  • Alaris with 1 channel/Syringe pump
  • 100% NRB with 16g angiocath connected to ETCO2

  **Hips**
  Most cases will be Sedation because they have received a spinal. Check with Provider, depending on patient status may be GETA (General Endotracheal Anesthesia)
  • Always have standard set-up.
  • Alaris with 1 channel/Syringe pump
  • Additional PIV line
  • Fluid Warmer with stopcocks and extension-communicate with Provider if needed.
    Hips may lose a large amount of blood.
  • 100% NRB with angiocath attached to ETCO2

Dental
• Standard set up, IV line with stopcocks and extension
• 3 Nasal trumpets (#26, #28, #32) with lubricant – used to dilate nare
• Nasal Rae tubes-#6.5, #7.0, #7.5, lubricant available – warm Normal Saline (Provider will put tube utilized in warm NS)
• McGill forceps-Adult/Peds size, dependent on case
• Alaris with 1 channel/Syringe pump
• **Dr. Epstein** – 2 Syringe pumps

Complex Spine Cases (look at OR schedule, length of case and Surgeon, see if Cell Saver requested)
• Standard Set-up
• Additional Peripheral IV set-ups
• Fluid warmer with stopcocks and extension-communicate with Provider if needed
• Additional stopcocks with extension set to IV
• Arterial Line kit and set-up, extension available-communicate with Provider if needed
• Alaris pump with 2-3 channels
• Syringe pump
- Additional Bair Hugger – Upper and lower

**Pediatric Spine Cases – Dr. Carrion**
- Ask Provider if Spine Protocol will be used
- Standard Set-up
- Additional PIV set-ups, IV tubing with stopcocks and extension
- Fluid warmer with stopcocks and extension
- Arterial line kit and set-up, extension-confirm with Provider
- Alaris with 4 channels/Syringe pump
- Bair hugger – communicate if both upper and lower needed
- Hemodilution will be performed- T-connector for Arterial line with Blood Bank Bags for blood. Stopcocks available.

**Crani’s**
- Standard Set-up
- NS with micro-drip tubing, additional stopcocks with extension set
- Additional peripheral IV set-ups
- Fluid warmer with additional stopcocks and extension tubing with NS
- Arterial line kit and set-up, extension- communicate with Provider if needed
- Alaris with 3-4 channels/Syringe pump

**Vascular (AV fistula’s)**

- Usually sedation cases – **ALWAYS PATIENT DEPENDENT AND PROVIDER PREFERENCE**
- NS with microdrip → ESRD, minimal fluid needed
- Alaris with 1 channel/Syringe pump
- May use LMA, majority GETA due ESRD, Diabetes(gastroparesis)
- Have NRB’s with angiocath attached to ETCO2/NC available if sedation case

**Complex Vascular Cases (Open AAA, Fem-pops etc. Verify Cell Saver requested.)**
- Standard set-up
- Additional PIV set-up, stopcocks and extension to IV
- Fluid warmer with stopcocks and extension with NS
- Arterial Line kit with set-up, extension, have micro-puncture kit available
- Anticipate Ultrasound machine
- CVP line-communicate with Provider if needed
- Sterile gown, gloves, drapes for Central line insertion
- Alaris pump with 3-4 channels for vasoactive drips
- Make sure Hemochron cassettes available
- ***Cell Saver available, 225 bowl*** For Open AAA’s

**CVC Room #1 and #7 , Access to room #2772**
- Standard set-up
- Additional PIV set-up with stopcocks and extensions
- IVF line with stopcocks and extension with NS-push line
- IVF line with stopcocks and extension with LR
• Alaris with 2 channels/Syringe pump
• Arterial line kit and set-up with extension –communicate with Provider if needed.
• 100% NRB with extenders, angiocath to ETCO2/NC
• Extra stylet to suspend tubes

Pediatrics

Always check age and weight of patient. Check with Provider for specific set-ups

• Standard set-up
• LR with buretrol for infants, < 2 years
• LR with microdrip > 2 years
• PIV-#20, #22g, #24g (yellow) with extension
• Pediatric armboard, gauze and tape available
• Room warmed for Pediatric patient
• 1-liter Circuit for machine, < 8 years
• Make sure Sevoflurane is filled for Inhalation Induction
• Make sure to have appropriate size masks -#2, #3, #4
• Suction catheters connected to suction with 1-inch tape to vent port

### Table 8-3. Suggested Uncuffed Endotracheal Tube Sizes (Pediatric Cuffed Tubes: use half size smaller)

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<thead>
<tr>
<th>Age</th>
<th>Size mm l.D.</th>
<th>Depth (cm)</th>
<th>Miller</th>
<th>Mac</th>
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</thead>
<tbody>
<tr>
<td></td>
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<td>age in yrs/2 + 12</td>
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<td></td>
</tr>
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<td>Premature</td>
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<td>8</td>
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<td>0</td>
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<td>16</td>
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<td>2, 3, 4</td>
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</table>
**Off Site – Cheat Sheet from Adam Stein 9/6/17**

Anesthesia BMDI Monitor, Anes Machine and Bis Hook-up.

Please follow steps in order. Following this process shortens boot time and ensures connectivity.

**Step 1.** Connect the Ethernet cable from the Cerner Connectivity engine to the network Jack marked “BMDI”. Connect the anesthesia computer Ethernet cable to the other available network jack.

**Step 2.** Start the Connectivity engine. Plug in or press switch next to the power cord connection. Note; if engine was already on before the Ethernet cable was connected please reboot the engine by pressing the power switch. (Boot process may take a few minutes).

**Step 3.** Once the engine has started and completed its boot process you should observe in the upper left corner of the display screen an Icon with a green check mark. This indicates connectivity to the network. Figure 1.

![Figure 1](network_icon.png)

**Step 4.** Select “Devices” on the touch screen and you should see all the devices attached to that connectivity engine. Typically, the Mon, Anes and Bis devices will display.

**Associating Monitors to Case**

1. When opening case, this pop up will appear asking to select devices for association. Choose area where the devices are located by clicking on the Title tabs at the top of the box. If associating devices from the specials location or when using Travel anesthesia machines, click on the “Out of OR” tab, if using the TAVR machine, click on the “Heart Center” tab.
2. Select the devices you wish to associate to. You will notice them populate into the Selected Devices section of the window. Once you have selected the devices, click “OK”. Devices will now be associated.
You can also associate the devices from within the document. Click on “Task” from the file menu bar and select “Associate D

MRI – 4th Floor, Personnel there 24hrs, Number for Access #4-2515, #4-3210

New to MRI need to watch MRI Video (20-30 min) and complete the Safety Screening Form Checklist – (631) 444-3210,

- Dr. Jacobs, Dr. Tateouan, Dr. Jasiewicz, CRNA’s
- Cases consist of Adult and Pediatric cases
- *GA with LMA/Sedation on most cases, plan accordingly
- Check schedule- # of Peds cases, 10 circuits stocked, #2/#2.5 LMA’s, #60/#70 oral airways, nasal cannulas, NRB, suction.
- Prior to entry of room – Remove all metallic items
- MRI compatible syringe pump and tubing are available in MRI cabinet
- Bring MRI cart, MRI pump present
- Standard set-up
- LMA’s available
- Do machine check-fill Sevo-used in all cases, check soda lyme, make sure suction connected
- MRI blades remain there
- NS/LR IV set-up with stopcocks and extension

Special Procedures – Code #2481, 4th floor on the way to CT Scan

Middle Room – General Cases *Anesthesia machine already in room, cart needed

Biplane room *Nephrectomy tube cases *No anesthesia machine, must bring machine

CT Room – Biopsy cases *Anesthesia machine in room, cart needed

Specials Room #1 *No anesthesia machine in room, bring machine. Cart needed

Nuclear Medicine Cases/CT Scan – Depending on Attending Anesthesiologist, the small compatible anesthesia machine can be used (preferably with Dr. Jacob) with paper charting.

Anesthesia Travel carts – located across special procedure, code #9731

Communicate with Special Procedure Nurse Coordinator on which room will be utilized.

- Bring off-site cart
- Standard set-up
- Machine check-soda lyme checked and gases filled, make sure suction is connected
- Check with Provider if Fluid Warmer, Arterial line is needed for the case, may need additional stopcocks and extension to IV, Fluid warmer and Arterial line
- Check with Provider if Glidescope is needed
• Monitor set-up with internet ***Instruction sheet being worked on by Adam Stein*** (will follow-up with)

Radiation Oncology – located on Level 2
• Cases have studies ranging from 3-5 days, always ideal to communicate with Attending and Radiology staff to determine length of study.
• Need to bring and set-up – Small anesthesia machine, Anesthesia cart.
• Pharmacy tray and box - depends on Anesthesiologist
• After cases, equipment stays (for same case next day) ➔ Pharmacy tray and box returned each day.

TEE - Room #5-737, Combination #9570, 5th Floor – Heart Center
• Standard set-up
• Machine check- Adult set-up #7.0/#7.5, #80/#90 oral airway, Mac #3 with adult handle, gauze, tongue depressor, check soda lyme and fill gases, make sure suction is connected.
• PIV set up
• Pharmacy box –placed in anesthesia cart – bottom drawer

5th Floor – Heart Center

Anesthesia Closet -Room #5-865A, Code #3345
EP lab orders the supplies for the Jet Ventilator and stores them here.

EP - Room #4 – Pacemakers, cardioversions
• Standard set-up
• Anesthesia Machine-Adult set-up
• Anesthesia Machine check –O2 sensor check, Ventilation Mode check, Leak Test (APL to 70, manual (hand) ventilation). Check soda lyme and fill gases, extension tubing for suction set-up
• NS 500 ml w/15 gtt Alaris tubing, stopcocks and extension
• Alaris pump with 2 channels
• Additional PIV set-up
• Arterial line kit and set-up with extension, pressure bag.
• Have a back up PIV/Arterial line set-up in the bottom drawer
• Make sure fluid warmer present
• Extra soda lyme
• Bair Hugger present

Room #5 - Afib ablations
• Standard set-up
• Machine check-same as EP#4, check soda lyme and fill gases, extension tubing for suction set-up
• Additional PIV set-up
• IVF with LR ready, stopcocks and extension
• Arterial line kit and set-up with extension
• Alaris pump with 2-3 channels
• Fluid warmer – communicate with Provider if needed
• Make sure Bair Hugger is present
• Make sure McGrath is present with extra blades
• Extra soda lyme in room
• Check to make sure Jet-Vent equipment available-Room 5-865A, Code #3345
• Check for McGrath difficult intubation blade, spare battery
• Check for McGrath #3 & #4 disposable blades (4 of each)

Attending Preference Card  *Preference* for Off-Site
Dr. Jacob - Pediatric cases
• Pharmacy Tray with medication box
• *Extra Propofol
• Mostly designated in MRI, CT Scan & Nuclear Medicine

Dr. Jasiewicz-Pediatric cases
• Pharmacy tray with medication box, *Precedex*
• Mostly designated in MRI, CT scan, Nuclear Medicine

Dr. Stellaccio
• Pharmacy tray with medication box, *extra sticks of Ephedrine, Neosynephrine
• General cases-mostly designated in Special Procedures, Core, Radiation Oncology
• *Syringe Pump
• *Glidescope #3, #4, back up

Transcatheter Aortic Valve Replacement- TAVR

What is a TAVR? (Also called TAVI)

This minimally invasive surgical procedure repairs the valve without removing the old, damaged valve. Instead, it wedges a replacement valve into the aortic valve’s place. The surgery may be called a transcatheter aortic valve replacement (TAVR) or transcatheter aortic valve implantation (TAVI).

Valve-within-valve — How does it work?

Somewhat similar to a stent placed in an artery, the TAVR approach delivers a fully collapsible replacement valve to the valve site through a catheter.

Once the new valve is expanded, it pushes the old valve leaflets out of the way and the tissue in the replacement valve takes over the job of regulating blood flow.

How is TAVR or TAVI different from the standard valve replacement?

This procedure is fairly new and is FDA approved for people with symptomatic aortic stenosis who are considered an intermediate or high risk patient for standard valve replacement surgery. The differences in the two procedures are significant.

What is involved in a TAVR procedure?
Usually valve replacement requires an open heart procedure with a “sternotomy,” in which the chest is surgically separated (open) for the procedure. The TAVR or TAVI procedures can be done through very small openings that leave all the chest bones in place.

A TAVR procedure is not without risks, but it provides beneficial treatment options to people who may not have been candidates for them a few years ago while also providing the added bonus of a faster recovery in most cases. A patient's experience with a TAVR procedure may be comparable to a balloon treatment or even an angiogram in terms of down time and recovery, and will likely require a shorter hospital stay (average 3-5 days).

The TAVR procedure is performed using one of two different approaches, allowing the cardiologist or surgeon to choose which one provides the best and safest way to access the valve:

- Entering through the femoral artery (large artery in the groin), called the transfemoral approach, which does not require a surgical incision in the chest or
- Using a minimally invasive surgical approach with a small incision in the chest and entering through a large artery in the chest or through the tip of the left ventricle (the apex), which is known as the transapical approach.

**Who is a good candidate for this type of valve surgery?**

At this time the procedure is reserved for those people for whom an open-heart procedure poses intermediate risk. For that reason, most people who have this procedure are in their 70s or 80 and often have other medical conditions that make them a better candidate for this type of surgery.

TAVR can be an effective option to improve quality of life in patients who otherwise have limited choices for repair of their aortic valve.

For more information or to view a video on TAVR ➔
http://www.heart.org/HEARTORG/

**TAVR Anesthesia Tech Set-up – Cath Lab 5th Floor in Heart Center**

1. **Anesthesia Machine**- older machine and you have to do checks, manual leak test, pressor sensor, calibrate O2 etc.
2. **Pharmacy Tray**- bring pharmacy tray to cart
3. **Standard Monitor set-up**- EKG (use the Cath Lab EKG stickies, the regular ones will cause interference) Aline & CVP cable, temp probe
4. **Non-rebreather mask** –with 16g catheter connected to ETCO2
5. **Alaris with 4 channels**
6. **Bair Hugger** - underbody bair hugger
7. **Fluid warmer-NS** with 2 stopcocks and extensions
8. **Adult Set-up** - #7.0, #7.5 ETT -cut
9. **Arterial line catheter** – with kit set-up on tray
   - **Dr. Scott** – likes #20g 2” catheter
10. **CVP Kit** – set-up with tri-furcation
11. **Sterile** – Gown, gloves, drapes
12. **Small ether screen** and bar is in RN’s tall cabinet in the room

### IVF Tubings

1. LR 1000cc with 10gtt tubing, 2 stopcocks, extension
2. 500cc NS with 60gtt tubing, 6 stopcocks, extension

### End of Day

1. Prepare back up set for next day
2. Restock cart for next shift or communicate items used-->needed for the cart.
3. Leave equipment in the old TEE room, leave the cart and machine.

### OFFSITE GUIDE - TROUBLESHOOTING

The cerner box

1) **ANES** – This box signifies the networks connection to the Anesthesia machine
2) **BIS** - This box signifies the network connection to the BIS monitor

3) **MON** - This box signifies the network connection status to the Vitals monitor

All of the lights in this picture are green and that shows a successful connection.

If the light is a different color:

This signifies that there is no connection to the internet

Check the connection to the internet. Make sure that both Ethernet cords are plugged into the wall and the connector on the end is in good condition. If the cord is plugged in the connector may be broken and not making a proper connection.

If there are less than three boxes shown:

This signifies a broken connection between the Cerner Box and the specific component that is not working.

For example: If the BIS box isn’t appearing follow the cable from the BIS monitor to the Cerner box and make sure its connected. If it is connected on both ends remove the USB connector from the Cerner Box. Reconnect in a different port and check to see that corresponding box has appeared on the Cerner box.

If all boxes appear and all lights are green, but information doesn’t pull over to the EMR:

Make sure the provider has properly associated the machine to the EMR by selecting the proper machine. The machine names are displayed on the machines themselves. Inform the provider to check their “macros” which would be a software issue and we are not trained in using that software. Bio Med is responsible for hardware issues only. If your provider is having a software issue, please refer them to the help desk. 9/27/17-

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**Anesthesia Technician Interns – A few reminders when starting the day**

*Submitted by CRNA-AT Interns Preceptors: Melissa Day, CRNA & Shoba Sanu, CRNA
Approved by Maria Lagade, MD*

**Communication** – communicate with the staff Anesthesia Technician assigned to your room when you arrive in the morning that you will be in the room. Ask them questions if you are unsure, they will double check your set-up and make sure you have everything ready.

When the Provider comes in, introduce yourself, let them know what you have done and where you are in your training and what you can do to help them ie; help bring patient to room, assist with getting to OR table, place monitors on, arm board on, assist with intubation etc. and where you are in your training.
**Take the Initiative** – as you progress in your training, let Provider know what you know and what you have done. Take the initiative to show them what you know!!!

**Engage yourself** – It is very common to not know what to do when you do not know the Provider. As you progress in your training and Providers see you have an interest in learning and doing as much as you can…they will teach you. Ask questions when the case is settled and the Provider is set up.

**Few Reminders**

1. Turn on Anesthesia machine and do Machine check – make sure circuit not caught in lines etc. Make sure Christmas tree present in room.
2. Turn on the Monitor, push “new case” and also turn the BIS monitor on – you want to ensure they are working prior to the patient coming in the room.
   a. There may be “error messages” “module not working” messages – we need to make sure this is corrected prior to bringing patient in room.
3. Check suction – ensure connected properly, turn on and feel the suction
4. Make sure ambu bags present (side of supply cart) and bougies are present (on the Pyxis shelf under drawers)
5. Remove plastic from donut and center piece.
6. Make sure EKG leads, blood pressure cuffs, pulse oximeter, temp probe present and readily accessible for Provider.
7. Make sure arterial line cable present in the event you may need it.
8. Make sure twitch monitor present in the top anesthesia machine drawer. The Anesthesia Tech assigned to the room tracks these. If the twitch monitor is present in the morning, it should be available for all cases in the room and present at the end of your shift.
   The twitch monitor can easily get thrown away at the end of the case if left on the top of the machine with other items to be thrown away.
   **When the Provider takes the twitch monitor off the patient or puts on the anesthesia cart, clean it with the Germicidal wipes (purple top) and place back in the top drawer of the machine.**
   If not present/gets lost, please let the Anesthesia Technician assigned to room know asap.

9. **Standard Anesthesia set-up**
   #7.0, 7.5 ETT, handle and Mac #3. No need to open to “test the light”. You just need to depress the center of handle where the blade would go – you will see light. I showed some of you, share with your colleagues if they do not know. BIS and temperature
   #80, 90 oral airway, tongue blade, gauze, 2 tegaderms, alcohol pads, lubricant
**Do not open any items until you know or communicate with the Provider on what size tube they need. ** Once items are opened in the patient room and they need to be disposed of whether they are used or not at the end of the case,**

10. If there are IV fluids hanging without a label and you are the first to the room at ~0600….assume they have been hanging from the prior day/evening and they should be taken down and thrown away.

11. Make sure Alaris pump with at least one channel is present.

12. Set-up main IVF and label with date, time, no medications and your initials.

13. Assemble the items needed for peripheral IV insertion.

14. Assemble items needed for arterial line set up – leave on anesthesia cart. Do not need to spike or get bag until you communicate with Provider if they need for the case.

15. Communicate with your Provider if they will need the Fluid warmer set up – as you go along in your training you will learn which cases will require a fluid warmer.

16. Communicate with your Provider if they need any additional items – Glide scope, McGrath, Difficult airway tower, Arterial line or Central lines

17. **Glyscopesc/Glidescope stylet/McGrath/C-Mac/Magills**
   - These advanced airway items are signed out in the Anesthesia Technician room. There is a clipboard in the room in which ideally the Provider is to sign out the blade desired. They may ask you to obtain it.
   - The blades are locked in a safe, you will have to ask your Anesthesia Tech assigned to the room or another AT to obtain for you. When the Provider is done with the blade, it should then be signed back in on the clip board and taken to the dirty utility room to be sent to central sterile to be processed.
   - As an Anesthesia Technician assigned to the room, you need to keep track of the blades. These are expensive $$$ which is why they have to be signed in and out.
   - If a Provider wants it left in the room until extubation due to concerns about the airway, communicate to the Anesthesia Technician.

18. **Ultrasound** – if a Provider needs an ultrasound for line placement (central line or arterial line) these also need to be signed out – there is a white board in the AT room, just indicate what room the ultrasound is going to.

19. Communicate with your Provider if they need additional channels for the pump

20. Go with your Provider to get the patient – introduce yourself to patient as well. Help Provider bring patient to the room. Lock stretcher when alongside the bed.

21. Observe the **Time Out** when the patient enters the room – RN/Provider asks patient to confirm/state their name, what are they here for/type of surgery, what site/side they are working on (if right/left side) and if they have any allergies.

22. Assist with transfer of patient to OR table – ensure patient on table prior to moving stretcher and both sides of the patient have staff to make sure patient doesn’t fall off table when stretcher moves. Safety strap applied by RN.
23. Assist with putting arm board on – these are the most challenging aspect of being in the OR!!

24. Practice when you come in the a.m…..Your Provider will be SO appreciative if you are able to get these on! 

- **Supination = Palms up** – prevent ulnar nerve injury

- ≤ 90 degrees

- If patient has a challenging body habitus – allow the Provider to guide you or ask the Provider how you should apply the arm board.

- Padding such as gel pads, egg crate or blankets are appropriate if needed when positioning.

25. **Place monitors on patient – Some things to consider**

   **Pulse oximeter**
   - Ideally chose the hand on the same side as peripheral IV. Avoid the index finder (2nd finger) as this is the most common finger the patient uses when they are waking up and they reach for their eyes…..we want to avoid any injury to the eyes.
   - Do not put on the hand if it’s the operative site
   - If you see 3 - *** (stars) and the pulse oximeter HR correlates with your EKG HR – we have a good reading.
   - If there are poor readings ie – poor waveform, 1-2 ** (starts) intermittent readings etc. choose another finger, put warm blankets around hand (patient can be clamped down peripherally) can also use the ear lobe.

26. **Blood Pressure cuff**

   - **PINK BANDS** – Do not use that limb, there should be no blood pressures or peripheral IV’s to this limb.
   - Various reasons – lymph node surgery, AV fistula etc.
   - **You CAN** put the pulse oximeter on this hand, as long as it’s not the operative site.
   - Place the blood pressure cuff on the opposite arm of the peripheral IV……as long as they are not operating on it.
   - Can also place on the lower extremities - communicate with your Provider if you are unsure where to place it

27. **EKG Leads**

   - Prior to placing – be aware of what type and where the surgery is taking place.
- Do not place leads in an area where it will cause pressure; patient positioned on that side
- If working on chest – place leads on back and laterally
- If patient will be placed prone – we do not want to place leads on chest as they will cause pressure sores, place on back away from surgical area.
- If patient turned laterally – place as close to the area as able without interfering with surgical site.
- Always ask Provider if you are unsure on where to place the leads
- “White to the upper right, snow over trees, “Smoke over Fire”
  “Chocolate close to the heart”
  **sorry…I know there are other pneumonics..best I could find**

V5 – placement of brown lead

V1 – placement of brown lead

6.1.2 5 lead configuration

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<tr>
<th>#</th>
<th>Color</th>
<th>Location</th>
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<tbody>
<tr>
<td>RA</td>
<td>White</td>
<td>Upper right portion of chest, 2 to 3 inches below clavicle</td>
</tr>
<tr>
<td>LL</td>
<td>Red</td>
<td>Between left breast and lower rib cages</td>
</tr>
<tr>
<td>LA</td>
<td>Black</td>
<td>Upper left portion of chest, 2 to 3 inches below clavicle</td>
</tr>
<tr>
<td>RL</td>
<td>Green</td>
<td>Lower right rib margin over bone</td>
</tr>
<tr>
<td>V5</td>
<td>Black</td>
<td>Fourth intercostal space at the right border of the sternum</td>
</tr>
</tbody>
</table>

28. BIS monitor – Bispectral index
- This is a processed electroencephalogram (EEG) monitor that measures the hypnotic effects of anesthetics and sedatives. It reports a single number from 0-100 that represents an integrated measure of cerebral electrical activity.
1. Some Providers like prior to induction, some like to place after the patient asleep
2. Communicate with Provider – “do you mind if I put BIS monitor on”
3. Look at diagram on where to place on forehead

Place a piece of gauze under the tab that connects to the monitor – this hard plastic has caused “indents”, “pressure to the area” or “cuts into the skin”

29. Induction
   • Induction and Emergence are the most critical periods of Anesthesia, be aware…
   • Stand on patient’s right side and have ETT ready with stylet and 10cc syringe
   • Hand to Provider after they do laryngoscopy and reach for it
   • Make sure you have bougie in room in the event Provider needs to utilize after they do laryngoscopy
   • May be asked to assist with Cricoid pressure
   • Remove stylet if Provider asks and then inflate balloon cuff – minimal occlusive volume, you will learn this when Provider inflates
   • Have tape available to secure ETT
   • Have Tegaderm /tape available to tape eyes – some Providers do as soon as patient falls asleep, some after the tube in place and secured.

30. Peripheral IV
   • Additional IV may be placed – have all items available and anticipate the steps so you can assist Provider
   • Provider picks site they will insert PIV
   • Puts tourniquet on
   • Cleans with alcohol
   • Chooses size of catheter #20, #18, #16 – the lower the number the larger the catheter is
   • Flush the Clave with NS so it is ready after Provider inserts catheter, Provider attaches
   • Hand Tegaderm to Provider or if it’s appropriate – place over the catheter, usually 2 needed to secure catheter and tubing in place. Some providers will also use a piece of the silk (white) tap

31. Positioning
   • Assist Provider with positioning of patient
   • Dependent on type of surgery, you may be removing leads and placing them back on in different positions
   • After positioning always make sure that blood pressure works, EKG reads properly as well as pulse oximeter • Make sure IVF’s still flow
• Make sure no pressure and patient padded appropriately to prevent pressure sores – utilize gel pads, egg crate, donuts, foam cushions, blankets etc.

32. **Bair Hugger**
   • Assist to place bair hugger on patient, sticky side down
   • Be aware of surgical area – may have to use upper or lower or even both for some types of cases and if they are long cases.
   • You can always ask Provider to guide you on how to place initially until you have progressed in your rotations.
   • We have upper and lower body bair huggers.

33. **During the case**
   • After case underway and Provider appears settled, ask questions to learn about the case.
   • If you have another case starting after this, it is acceptable to put a “set-up” on the top of the pyxis. Your Anesthesia Technician assigned to the room can help you with this.
   • Basically, you are taking a clean blue towel and putting the items you need for your next case in it ie; ETT, handle, blade, oral airway etc.

34. **Emergence**
   • Be available during this critical period of anesthesia.
   • Watch how the Provider wakes the patient up, have mask available
   • Make sure that supplemental oxygen available with oxygen tank on bed for transport to the PACU.
   • Help to transport the patient from the OR table to the stretcher or bed and bring them to the PACU, PSA or ICU.

35. **Cleaning of OR after case is completed**
    All dirty items are removed by housekeeping. They clean all dirty items off the top of anesthesia machine and remove the dirty anesthesia circuit.
    
    Please make sure there is no anesthesia equipment that may inadvertently be thrown away ie; head strap, twitch monitor, glides cope, glide scope stylet, McGrath etc.
    
    After all dirty items removed, they will mop the room. The mop is the last to leave the room and then starts the **5 minute Dwell Time**, the time the mop leaves the room is placed on the window of the room.

    **What is the 5 minute Dwell Time?**
    
    It’s **5 minutes** in which NOBODY…….. I mean NOBODY may go into the room.
    
    It’s **5 minutes** after the time placed on the window of the door to the room.
After 5 minutes, you may now go into the room to set-up for your next case.

36. Start off with putting a new circuit and doing a circuit check. Then set up items needed for your next case as you did in the a.m.

37. Take the initiative, stay engaged, ask questions….you will all do GREAT!!!
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<thead>
<tr>
<th>Orientation: September 4th</th>
<th>Last Day: June 5th, 2020</th>
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<tr>
<td>Review Rotation: June 1st - June 5th</td>
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<td>End of Year Dinner: June 4th, 2020</td>
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