Email to Temple Anesthesia Providers dated 8/24/15:

Temple Anesthesia Providers,

Please review the policy below re **ICU patients in endoscopy**. This will be distributed to the endoscopy nursing and physicians as well. I have enlisted the front desk staff and AAU RN to alert us if there any ICU patients on the schedule for the current or next day. At that point, we can send the anesthesia resident in endoscopy to pre-op. If no resident assigned to endoscopy, please call the Hall Runner to coordinate pre-op.

At nights and weekends, we will ask the GI fellows to call extension 24-3684 to alert anesthesia that there is patient in the ICU on the schedule for the next day. We should make every effort to have these patients pre-op and consented, just as we would for Operating Room cases.

In addition to pre-op the patient, we should also assess whether the patient is stable to have the procedure in endoscopy. The policy below categorizes at least the most common reasons why a patient would not be suitable for care in 3D.

Keep in mind that exceptions to this policy can be made at the discretion of the senior staff anesthesiologist working that day in endoscopy.

**Anesthesiology Transport Policy on ICU patients for 3D (Endoscopy Area)**

ICU patients (MICU, STICU) will require an anesthesia pre-evaluation and consent prior to transport to endoscopy

ICU patients (MICU, STICU) should be signed out from ICU RN directly to Senior Staff Anesthesiologist (or their designee) and to the endoscopy RN

The following subset of ICU patients who require anesthesiology services should be booked for the main OR:

1. Patients requiring invasive hemodynamic monitoring (i.e. arterial line, Pulmonary Capillary Wedge Pressure)
2. Patients needing vasoactive medications/drips to maintain hemodynamic stability
3. Patients currently intubated
4. Patients deemed unstable by senior staff anesthesiologist (or there designees)

NOTE: Per Senior Staff Anesthesiologist discretion exceptions to above policy may be made

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