



**INSPECTION WORKBOOK**  
**FOR**  
**RESIDENCY TRAINING PROGRAMS**  
**IN**  
**ANESTHESIOLOGY**

American Osteopathic Association  
and the  
American Osteopathic College of Anesthesiologists

COPT, Revised, 1990

**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. First year \_\_\_\_\_
  - b. Second year \_\_\_\_\_
  - c. Third year \_\_\_\_\_

\_\_\_\_\_  
*Administrator Signature*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Inspector Signature*

\_\_\_\_\_  
*Date*

## EVALUATION OF PROGRAM

1. Are there written rules and regulations for the department of anesthesiology?  
Yes ☐ No ☐
2. Are there written minutes of meetings? 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 ☐

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/AMA_____ No <input type="checkbox"/>
_____	Yes <input type="checkbox"/>	AOA/AMA_____ No <input type="checkbox"/>
_____	Yes <input type="checkbox"/>	AOA/AMA_____ No <input type="checkbox"/>
_____	Yes <input type="checkbox"/>	AOA/AMA_____ No <input type="checkbox"/>
_____	Yes <input type="checkbox"/>	AOA/AMA_____ 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?
- Yes ☐ No ☐
- Comment: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
13. Does the Department of Anesthesiology supervise the Inhalation Therapy Service?
- Yes ☐ No ☐
14. Does the Department of Anesthesiology regularly conduct mortality reviews?
- Yes ☐ No ☐
15. Has the residency complied and is it complying with the requirement that the resident administer no fewer than 500 and no greater than 800 anesthetics yearly?
- Yes ☐ No ☐
16. What number of the following resources that are pertinent to this specialty are available in the medical library?
- Journal \_\_\_\_\_ Audio cassettes \_\_\_\_\_
- Films \_\_\_\_\_ Other \_\_\_\_\_
17. Is the progress of the residency periodically evaluated?
- Yes ☐ No ☐
- By what method? \_\_\_\_\_

18. Is the educational program periodically evaluated?

Yes ☐

No ☐

By what method? \_\_\_\_\_

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

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

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

Yes ☐

No ☐

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

Yes ☐

No ☐

23. Is there evidence of cooperative assistance in the training of the resident by other departments?

Yes ☐

No ☐

If yes, how is this cooperation evidenced?

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

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

Yes ☐

No ☐

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

Yes ☐

No ☐

How does this evidence itself?

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

Yes ☐

No ☐

Comment: 

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

Yes ☐

No ☐

Name projects completed and/or in progress:

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

Yes ☐

No ☐

Comment: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

30. 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?

\_\_\_\_\_  
\_\_\_\_\_

31. Is there an adequate formal reading program for the resident?

Yes ☐

No ☐

Comment: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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 spend a minimum of two (2) weeks' rotation in the Department of Radiology?

Yes ☐

No ☐

35. Does the resident attend postmortem examinations?

Yes ☐

No ☐

36. Does the resident attend the monthly department meetings?

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 of 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 the parent institution is permitted.)*



6. Other pertinent comments:

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### **QUALITY ASSURANCE**

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

Comment: 

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

Comment: 

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3. Do residents participate in the quality assurance process?

Comment: 

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4. Does the department have an infection control program?

Comment: 

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

Comment: 

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

Comment: 

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## 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 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) minutes intervals?

1. Blood pressure
2. Pulse
3. Respiratory rate

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

1. Ecg
2. Fio<sub>2</sub>
3. Sao<sub>2</sub>
4. Etco<sub>2</sub>
5. Temperature
6. Train of four
7. Urine output
8. 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 ☐

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?

	<u>Yes</u>	<u>No</u>
a. Delineation of anesthetics being administered with notation of dosages and flow rates?	<input type="checkbox"/>	<input type="checkbox"/>
b. Notation of monitoring equipment being used and the information obtained from such equipment?	<input type="checkbox"/>	<input type="checkbox"/>
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"/>

		<u>Yes</u>	<u>No</u>
e.	Oral or nasopharyngeal 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 _____		Other _____	
<u>General</u>		<u>Nitrous Oxide</u>	
Inhalation	_____	Ethrane	_____
Intravenous	_____	Pentothal	_____
Endotracheal	_____	Curare	_____
Other _____		Succinylcholine	_____
		Narcotics	_____
		Other _____	
		_____	

B. Surgery – Total Number \_\_\_\_\_

<u>Methods</u>	<u>Number</u>	<u>Agents</u>	<u>Number</u>
Inhalation	_____	Nitrous Oxide	_____
Intravenous	_____	Ethrane	_____
Endotracheal	_____	Forane	_____
I.V. Regional	_____	Flouthane	_____
Spinal	_____	Pentothal	_____
Epidural	_____	Narcotics	_____
Caudal	_____	Curare	_____
Nerve blocks	_____	Succinylcholine	_____
Brachial	_____	Pancuronium	_____
Axillary	_____	Artracurium	_____
Sciatic	_____	Xylocaine	_____
Radial	_____	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.	Other _____	_____

Period reported from \_\_\_\_\_ to \_\_\_\_\_  
(Date) (Date)