Trauma Surgery and Surgical Critical Care Privileges
Department of Surgery

Name: _____
(Please print)

- ' Initial privileges (initial appointment)
- ' Renewal of privileges *(reappointment, on 2-year specialty cycles)*
- ' Modification of privileges *(request for any additional privileges beyond those previously granted)*

Basic Education: MD or DO

Minimal formal training: Successful completion of ACGME or AOA accredited fellowship in surgical critical care and/or current certification or active participation in the examination process (with achievement of certification within 5 years of training completion) leading to subspecialty certification in surgical critical care by the ABS or the AOBS.

Maintenance of Advanced Trauma Life Support (ATLS)

Required current experience: At least 50 trauma surgeries/surgical critical care cases, reflective of the scope of privileges requested, in the past 12 months or successful completion of an ACGME or AOA accredited residency or clinical fellowship within the past 12 months.

Facility (Check ALL that are applicable to your request)				
Baroness*	Children's**	North	East	Bledsoe/Sequatchie

** Includes BEH Main Hospital, Miller Eye Center, Plaza Surgery and all Erlanger Ambulatory Clinics*
***Includes Children's Hospital Inpatient, Children's Ambulatory clinics, Children's OR and Kennedy Children's Outpatient Center*

Core Surgical Critical Care Privileges:

Core privileges for surgical critical care include the ability to admit, evaluate, diagnose, and manage patients of all ages presenting with acute, life-threatening, or potentially life-threatening surgical conditions by utilizing specialized expertise relating to both the physiologic responses to tissue injury from trauma, burns, operation, infections, acute inflammation, or ischemia, and to the ways these responses interact with other disease processes; this includes management of management of patients with hemodynamic instability, multiple system organ failure, and complex coexisting medical problems. Critical care surgeons may provide care to patients in the intensive care setting in conformance with unit policies, and can assess, stabilize, and determine the disposition of patients with emergent conditions consistent with medical staff regulations regarding emergency and consultative call services.

The core privileges in this specialty include the following procedures and such other procedures that are extensions of the same techniques and skills.

Airway

- Tracheotomy, open and percutaneous
- Cricothyroidotomy
- Nasal and oral endotracheal intubation, including rapid sequence induction

Head/face

- Nasal packing
- Intracranial pressure monitoring
- Lateral canthotomy

Neck

- Exposure and definitive management of vascular and aerodigestive injuries
- Thyroidectomy
- Parathyroidectomy

Chest

- Exposure and definitive management of cardiac injury, pericardial tamponade
- Exposure and definitive management of thoracic vascular injury
- Repair blunt thoracic aortic injury (open or endovascular)
- Partial left-heart bypass
- Pulmonary resections
- Exposure and definitive management of tracheobronchial and lung injuries
- Diaphragm injury repair
- Definitive management of empyema, including decortication (open and video-assisted thoracic surgery [VATS])
- VATS for management of injury and infection
- Bronchoscopy, including diagnostic and therapeutic treatment for injury, infection, and foreign body removal
- Exposure and definitive management of esophageal injuries and perforations
- Spine exposure (thoracic and thoraco-abdominal)
- Advanced thoracoscopic techniques as they pertain to the above conditions
- Damage control techniques

Abdomen and pelvis

- Exposure and definitive management of gastric, small intestine, and colon injuries
- Exposure and definitive management of gastric, small intestine, and colon inflammation, bleeding, perforation, and obstructions
- Gastrostomy (open and percutaneous) and jejunostomy
- Exposure and definitive management of duodenal injury
- Hepatic resections
- Management of splenetic injury, infection, inflammation, and diseases
- Management of pancreatic injury, infection, and inflammation
- Pancreatic resection and debridement

Management of renal, ureteral, and bladder injury
Management of injuries to the female reproductive tract
Management of acute operative conditions in pregnant patients
Management of abdominal compartment syndrome
Damage control techniques
Abdominal wall reconstruction following resectional debridement for infection and ischemia
Advanced laparoscopic techniques as they pertain to the above procedures
Exposure and definitive management of major abdominal and pelvic vascular injury
Exposure and definitive management of major abdominal and pelvic vascular rupture or acute occlusion
Placement of inferior vena cava filter

Extremities
Radical soft tissue debridement for necrotizing infection
On-table arteriography
Exposure and management of upper-extremity vascular injuries
Exposure and management of lower-extremity vascular injuries
Damage control techniques in the management of extremity vascular injuries, including temporary shunts
Acute thrombo-embolectomy
Hemodialysis access, permanent
Fasciotomy, upper extremity
Fasciotomy, lower extremity
Amputations, lower extremity (hip disarticulation, AKA, BKA, Trans-met)
Reduction of dislocations
Splinting fractures
Application of femoral/tibial traction

Other procedures
Split- and full-thickness skin grafting
Thoracic and abdominal organ harvesting for transplantation
Operative management of burn injuries
Upper-gastrointestinal endoscopy
Colonoscopy
Core rewarming (e.g., continuous arteriovenous rewarming and continuous venovenous rewarming)
Diagnostic and therapeutic ultrasound
Deep Sedation

Special Non-Core Privileges in Surgical Critical Care Medicine:

If desired, noncore privileges are requested individually in addition to requesting the core. Each individual requesting noncore privileges must meet the criteria governing the exercise of the privilege requested, including training, required previous experience, and maintenance of clinical competence. Noncore privileges may include:

Procedure	Baroness	Children's	North	East	Bledsoe/Sequatchie
Management of patients on ECMO Requirements: • Completion of an ECMO training course in the last 5 years. • 3 supervised ECMO management weeks, including initiation, daily management, and weaning. • Competency maintained through involvement in 2 ECMO cases per year and regular meeting attendance. • Approval by the ECMO Medical Director					
Large-bore cannulation for ECMO • Initial privileging requires a minimum of 5 proctored cases • Competency maintained by performing or participating in 4 cannulations every 3 years					
Management of the patient on CRRT					
Robotic surgical procedures [Criteria: Initial = robotic training as part of residency, fellowship, or an approved robotics course. Reappointment = minimum 10 cases per year]					
Administration of Moderate sedation and analgesia [see below for criteria - 5 per year required]					
Deep Sedation [see criteria below – 10 per year required]					

Request for Privilege Not Listed in Core or Special Non-Core *(please list the privilege and provide justification as well as any accompanying certifications or case logs)*

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Special Procedures Privileges Criteria
Moderate Sedation
CRITERIA – To administer Moderate Sedation
Moderate Sedation (formerly Conscious sedation) is defined as: A medically controlled state of depressed consciousness that (1) allows protective reflexes to be maintained; (2) retains the patient's ability to maintain an airway independently and continuously; and (3) permits age-appropriate response by the patient to physical stimulation or verbal command, e.g. "open your eyes").

1. Basic education: MD, DO, DDS, or DMD
2. Successful completion of a post-graduate residency training program of at least three years' duration.
3. Trained in the professional standards and techniques to administer pharmacologic agents to predictably achieve either minimal or moderate sedation and monitor patients carefully in order to maintain them at either of these levels of sedation-either intentionally or unintentionally. Acceptable training may be the completion of a course offered by any local hospital or the local Medical Society. Documentation of completion is required.
4. Must be able to evaluate and document evaluation of the patient prior to performing minimal or moderate sedation.
5. Must be qualified to rescue patients from *deep* sedation and trained to manage a compromised airway and to provide adequate oxygenation and ventilation.
6. Current proof of ACLS, PALS, or ATLS
7. Able to demonstrate that he/she has administered minimal or moderate sedation or analgesia to at a minimum of five (5) patients during the past 12 months.

Deep Sedation

CRITERIA – To administer deep sedation

Deep Sedation is defined as: A medically controlled state of depressed consciousness or unconsciousness from which the patient is not easily aroused. It may be accompanied by partial or complete loss of protective reflexes, and by the inability to maintain a patient airway independently and respond to physical stimulation or verbal command. Agents considered deep sedatives when used in any dose include, but are not limited to, Propofol, Etomidate, and Ketamine as well as sufficient doses of other analgesics such that the patient achieves the clinical state outlined in the deep sedation definition above. Use of these medications in life-threatening situations or for rapid sequence intubation (RSI) is considered an exception to this definition and is not considered use of deep sedation.)

1. Basic Education: MD, DO, DDS, or DMD and completion of residency/fellowship in at least one of the following:
    a. Anesthesiology, Emergency Medicine, Medical Critical Care, Surgical Critical Care, Pediatric Critical Care
2. Be a credentialed practitioner to order and/or select the medication(s) to achieve Deep Sedation.
    a. Must be credentialed to provide Moderate Sedation, Deep Sedation, and to perform intubation
3. Be familiar with proper dosages, administration, adverse reactions, and interventions for adverse reactions and overdoses. Know how to recognize airway obstruction and demonstrate skill in airway management resuscitation.
4. Have ACLS and/or PALS Certification.
5. Agents likely to produce deep sedation must be administered only by a qualified credentialed physician.
    a. This credentialed physician must be specifically and solely focused on the administration of the medication and monitoring of the patient's response to the medication.
        i. Exception 1: It is recognized that the Emergency Department is a unique environment where patients present on an unscheduled basis with problems that often require urgent or emergent interventions to prevent morbidity and mortality.
        ii. The supervising Emergency Medicine physician may be the same physician that is performing the procedure ONLY when a delay may increase morbidity and mortality, provided that the procedure may be abandoned without compromise to patient safety and there is not a second physician available to provide deep sedation.
        iii. If the patient has a secured airway (well positioned endotracheal or tracheostomy tube), deep sedation medications can be given for the purposes of performing a procedure by a CCRN (provided a second RN is present to record vital signs and record assessments). In this case a single credentialed physician may perform the procedure.
6. Pre-Procedure Assessment Responsibilities of the Physician
    a. Obtain baseline history. Assess the airway including mouth and neck and note ASA status. An airway assessment and ASA classification must be present prior to the administration of sedation. Obtain and document appropriate informed consent. Address NPO status.
    b. The patient will be reassessed by the physician performing the sedation immediately prior to the procedure, and the reassessment will be documented in the record.
7. Intra-Procedure Monitoring • Qualified personnel will be present in the room throughout the conduction of all cases requiring deep sedation.
    a. The minimum number of personnel available for all cases requiring deep sedation shall be two: (1) the operator (physician) and (2) the qualified personnel administering and monitoring sedation unless one of the exception rules is met as outlined above.
    b. Please see the full policy for details of required documentation for the sedation procedure
8. Post-Procedure Assessment Responsibilities of the Physician For Deep Sedation, the physician who administered the sedation and analgesia will perform and document a post-procedure evaluation no later than 48 hours following the deep sedation procedure but no earlier than the time from which the patient is considered sufficiently recovered from the sedation so as to participate in the evaluation (e.g. answer questions appropriately, perform simple tasks).
    a. The elements of an adequate post anesthesia evaluation should be clearly documented and include the following: Respiratory function including respiratory rate, airway patency, and oxygen saturation; Cardiovascular function including pulse rate and blood pressure; Mental status; Temperature; Pain; Nausea and vomiting; Post procedure hydration.

NOTE: Deep Sedation is limited to Anesthesia/CRNAs, Critical Care, and Emergency Medicine and full Anesthesia is limited to Anesthesiologists and CRNAs and is outlined in their delineation of privileges.

Department Chief Recommendation:

I have reviewed the requested clinical privileges and supportive documentation for the above named applicant.

' Recommended as Requested

' Recommended with Modifications (See comments below)

' Not Recommended (See comments below)

Chief Comments: _____

_____ _____

Chief Signature Date

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