



Purdue University
Veterinary Technology Distance Learning Program
Lynn Hall, Purdue University, West Lafayette, Indiana 47907

Small Animal Anesthesia Clinical Mentorship VM 21000

Criteria Handbook and Log Book

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STUDENT INFORMATION

GOALS OF VM 21000 SA ANESTHESIA CLINICAL MENTORSHIP

Working with a small animal veterinary care facility, the student will practice several tasks under the supervision of a clinical mentor (veterinarian or accredited veterinary technician).

In order to achieve the goals for this Clinical Mentorship, the tasks must be performed to the level of competency as outlined by the *Criteria* for each task.

The student is responsible for providing documentation for each task as defined by the *Materials Submitted for Evaluation and Verification* section on each task.

In addition to the documentation, the student will be evaluated by the Clinical Mentorship site supervisor on how well the student met the outlined *Criteria* for each task.

Final approval of successful performance and completion of the Clinical Mentorship will be made by the Purdue University instructor in charge of the Clinical Mentorship. This approval will be based upon the documentation provided by the student.

The Purdue University instructor in charge has the option to require additional documentation if, in their judgment, the student has not performed and/or documented the task to the level set by the *Criteria*.

Documentation of completed tasks is essential to validating the educational process and insuring that the performance of graduates of the Veterinary Technology Distance Learning Program meets the standards of quality required by the Purdue University School of Veterinary Medicine faculty and the American Veterinary Medical Association accrediting bodies.

CONTACT PERSON

Any questions regarding the Clinical Mentorship process should be directed to:

Pam Phegley, BS, RVT
1240 Lynn Hall
Purdue University
West Lafayette, IN 47907
(765) 496-6809
phegley@purdue.edu

PRE-REQUISITES FOR VM 21500 SA MEDICAL NURSING CLINICAL MENTORSHIP I

Course Pre-requisites

VCS 14500	Principles of Anesthesia for Veterinary Technicians I
VCS 14600	Principles of Anesthesia for Veterinary Technicians II
VM 20600	Small Animal Medical Nursing Mentorship II

Contracts and Agreements

Because of legal, liability and AVMA accreditation issues, the following documents must be completed prior to beginning the Clinical Mentorship

1. Clinical Mentorship Site Facility Requirements Agreement
2. Clinical Mentorship Agreement
3. Clinical Mentorship Supervisor Agreement
4. Health Risk and Insurance Acknowledgment
5. Professional Liability Insurance Coverage
6. Agreement and Release of Liability
7. Technical Standards Acknowledgment

These forms are available on the VT-DLP web site for downloading, printout, and completion, or by phone request from the VT-DLP office (765-496-2873).

If more than one Clinical Mentorship course is taken, a separate Clinical Mentorship Site Facility Requirements Agreement, Clinical Mentorship Agreement, and Clinical Mentorship Supervisor Agreement must be completed for each course.

Failure to complete and return the listed documents and the payment for Student Professional Liability Insurance Coverage will prevent the student from enrolling in the Clinical Mentorship.

Insurance

Two types of insurance are recommended or required for the student working in a Clinical Mentorship.

Health Insurance is highly recommended to cover the medical expenses should the student become injured while on the job. It is the student's responsibility to procure such insurance.

Liability insurance is required to protect the student in the event of a suit filed against the student for acts he/she performed while in the Clinical Mentorship. Each VT-DLP student is required to purchase, for a nominal fee, Professional Liability Insurance through Purdue University. This is done by completing the

Professional Liability Insurance Coverage form and sending a check for the fee. The fee covers from the time of initiation of coverage until the subsequent May 31st.

Students will not be enrolled in Clinical Mentorships until the Professional Liability Insurance is paid, and the student is covered by the policy.

SELECTING THE CLINICAL MENTORSHIP SITE – FACILITY REQUIREMENTS

You must visit the Clinical Mentorship Site and determine if the following equipment is readily available to you for use during your Clinical Mentorship. You must complete and have the facility veterinarian sign the Clinical Mentorship Site Facility Requirements Agreement.

The veterinary care facility must be equipped:

With the following equipment:

- Anesthetic machine with an "out of circle" vaporizer
- Endotracheal tubes of various sizes with functioning cuffs
- Stylet for feline intubation (student should describe or show the stylet when cat is intubated)
- Rebreathing and Non - rebreathing systems
- 2 – Rebreathing bags (1L-5L) (500ml for Non Rebreathing system)
- Scavenge system (F-air canister is not acceptable)
- Clippers
- Stethoscope and esophageal stethoscope (for use during surgery)
- ECG or appropriate alternative cardiac rate or rhythm monitor

With the following pharmaceuticals or agents:

- Isoflurane
- Oxygen
- Lidocaine injectable/spray or gel for feline intubation
- Intravenous fluids
- Premedications: atropine, acepromazine, butorphanol, buprenorphine, morphine, hydromorphone, xylazine, medetomidine (require at least atropine plus one opioid and either acepromazine or xylazine/medetomidine)
- Induction agents: Pentothal, Propofol, Ketamine and Valium, Etomidate (require at least 2; Ketamine and Valium count as one agent)
- Emergency drugs – these will be defined in the project for emergency drugs

The following disposable items must be available

- Roll gauze for tying tube to jaw (NO TAPE!!)
- IV catheters
- Syringes
- Needles
- Cotton or other prep kits for prep of catheter site
- Aseptic solution for prep of catheter site
- Tape
- Towels
- Fluid administration set
- Eye lubricant
- Heparinized saline

- Anesthesia record (may use one provided or your own) Record must include the following:
 - Patient name
 - Date
 - Signalment
 - Weight
 - Procedure
 - Special precautions (if any) or patient conditions pertinent to anesthesia
 - TPR prior to premedication and preferably at rest (that morning)
 - Preanesthetics, induction agent and any other agents administered in the pre or peri anesthetic period with the amount given and the time
 - Heart rate, respiratory rate and gas concentration recorded every 5 minutes in chart form
 - IV fluid amount every 15-30 minutes (total at end of procedure)
 - Blood pressure readings and Pulse Ox readings recorded every 10 minutes (if using)
 - Post operative pain medication (if given), agent and amount
 - Time of extubation
 - Synopsis of patient recovery
 - TPR post extubation

Optional equipment

- Doppler with sphygmometer or other alternative blood pressure monitor
- Pulse oximetry
- Nitrous oxide
- Halothane
- Laryngoscope

SELECTION OF THE CLINICAL MENTORSHIP SUPERVISOR

The Clinical Mentorship Supervisor is the person who will sign your Logbook and assess your performance at the Clinical Mentorship site. This person must be a credentialed veterinary technician (graduated from an AVMA accredited program or met State requirements for credentialing as a veterinary technician) or a licensed veterinarian.

An individual who claims to be a “veterinary technician” but has not met the criteria for credentialing above is not eligible to be a mentorship supervisor.

The individual is not considered to be an employee of Purdue University when acting as your Clinical Mentorship supervisor.

The Clinical Mentorship Supervisor must complete the *Clinical Mentorship Supervisor Agreement*. You must return this agreement with the other agreements prior to beginning your Clinical Mentorship.

Should your Clinical Mentorship Supervisor change during the course of the Clinical Mentorship, you will need to have your new supervisor complete a *Clinical Mentorship Supervisor Agreement* and return it to the Purdue VT-DLP office. These forms are available on the VT-DLP web site for downloading and printing.

CRITERIA HANDBOOK AND LOG BOOK

This Criteria Handbook and Log Book contains the list of tasks that must be successfully completed in order to receive credit for this Clinical Mentorship. You are expected to have learned the basics of how, why, and when each procedure is to be done from the courses listed as pre-requisites for this Clinical Mentorship. This booklet contains the directions and forms that must be followed and completed in order to meet the standards set for successful completion of this Clinical mentorship.

Please read each component of each task carefully before doing the task to minimize the number of times you have to repeat the task. The components of each task are summarized:

Goal – Describes the ultimate outcome of the task you will perform.

Description – Lists the physical acts that you will perform, and under what conditions these acts will be completed.

Criteria – Lists *specific, observable, objective* behaviors that you must demonstrate for each task. Your ability to demonstrate *each* of these behaviors will be required in order to be considered as having successfully completed each task.

Number of Times Task Needs to be Successfully Performed – States the required number of times to repeat the tasks. The patient's name and the date each repetition of task was performed must be recorded by the Clinical Mentorship Supervisor.

Materials Submitted for Evaluation and Verification – These specific materials, which usually include some video or photographic materials, must be submitted to demonstrate that you actually performed the task as stated. Each evaluation states specifically what must be shown in the submitted materials.

The Purdue University course instructor for this Clinical Mentorship has the option to request further documentation if the submitted materials do not clearly illustrate the required task.

It is recommended that the video materials document all angles of the procedure. The purpose of the video and photographic material is to provide “concrete evidence” that you were able to perform the task to the standard required.

If you do not own a video camera, they can usually be borrowed or rented. Pre-planning the video procedures will help reduce the need to redo the video documentation. Feel free to explain what you are doing as you perform for the video documentation. Sometimes, voiceovers may need to be done to clearly explain what task is being performed.

Videotapes, pictures, the Criteria Handbook and Logbook and any other required documentation will not be returned. These items will be kept at Purdue as documentation of the student's performance for accreditation purposes.

This validation is essential to help the Purdue VT-DLP meet AVMA accreditation criteria. Therefore, it is essential that you follow the evaluation and validation requirements.

Summary Evaluation Forms – Each task has a form that must be completed and signed by the Clinical Mentorship Supervisor.

Supplementary Materials – Logs, written materials, photographs, or other forms/documentation may be required for specific tasks. Be sure to read the Materials Submitted for Evaluation section very carefully and return all documented evidence as prescribed.

COMPLETION OF THE CLINICAL MENTORSHIP

The Clinical Mentorships are designed to follow the semester format of Purdue University. However, you may complete the Clinical Mentorship and submit materials any time prior to the end of the semester.

If you are unable to complete the Clinical Mentorship by the end of the semester deadline, you must contact the course instructor for the Clinical Mentorship, the VT-DLP office (765) 496-6579, or Pam Phegley, BS, RVT (phegley@purdue.edu, 765-496-6809) to request an "Incomplete grade" for the semester. The Clinical Mentorship will be treated by the University as it would any other Incomplete graded course. See the VT-DLP Student Handbook for specific information on Incompletes.

When you have completed all of the tasks and the documentation, send the complete compilation of materials to:

Vet Tech Distance Learning
Clinical Mentorship VM 215 Evaluation
VAD, LYNN, Purdue University
625 Harrison Street
West Lafayette, IN 47907-2026

You will be contacted after the materials have been reviewed. The Purdue University instructor in charge has the option to require additional documentation if, in their judgment, the student has not performed or documented the task to the level set by the Criteria.

If additional documentation is deemed necessary by the course instructor or the Clinical Mentorship Coordinator, the student will be contacted and the additional required documentation explained.

Final approval of successful performance and completion of the Clinical Mentorship will be made by the Purdue University instructor in charge of the Clinical Mentorship based upon the documentation provided by the student.

Upon successful completion of the documentation, a grade for the course will be assigned by the course instructor based upon the Clinical Supervisor's evaluations and the documented performance of the tasks.

CLINICAL MENTORSHIP TASKS

INTRODUCTION TO ESSENTIAL TASKS AND CRITERIA

Before starting each task:

1. Read the Goal, Description, Criteria, and Materials to be submitted for Evaluation and Verification. Understand what is expected of you for each task.
2. Make sure you have whatever equipment you need to document the task. Pay particularly close attention to the details of what needs to be documented.
3. Make sure you obtain appropriate permissions where necessary. Please keep the facility's owner/manager aware of your activities. A continued good relation with the veterinarian in charge is key to having a positive Clinical Mentorship experience.
4. Label documentation so it is easy to find all components of the materials you submit for evaluation and validation at Purdue.
5. Once everything is completed, package all the paper, video, photographic or other required documentation and send it to the VT-DLP at the address provided in the *Completion of Clinical Mentorship* section above.

OBTAIN A HISTORY PRIOR TO ANESTHESIA

Goal: To obtain complete and accurate information from a client by asking specific questions about the pet prior to the patient receiving general anesthesia

Description: The student will question a client about the past and current condition of the animal that is to receive general anesthesia, and record the history on the attached History Sheet. As an alternative, the student may photocopy the recorded history from the clinical record if allowed to do so by the veterinarian. The Clinical Mentorship supervisor will verify the accuracy of the obtained history and observe the student performing the history so as to verify the criteria for this task.

Criteria: The student allowed the client to state the presenting problem before asking additional directed questions.

The student asked the questions clearly and used terminology the client understood so that the client was able to answer the question accurately.

The student asked specific questions regarding the following:

- When the patient last had food and water
- Did the patient have access to other sources of food and water
- Has the patient ever received anesthetic agents before (either sedatives or general anesthetics)
- If so, how did the patient recover from them
- Any reactions to medications
- How has the patient been acting lately

The student maintained good communication skills:

- good eye contact
- non-verbal body language that encouraged the client to continue to speak
- allowed the client to finish a statement without interrupting

The student asked questions in such a way that the question was not a leading question (e.g. "You did see diarrhea, didn't you?").

When/if a client was unable to understand a question, the student was able to formulate a different way of asking the same question and obtaining the needed information.

The student periodically repeated the information back to the client for confirmation that the student's interpretation of what the client said or meant is correct.

The student was able to direct the history taking dialogue to obtain the information in a timely manner (i.e. didn't allow the conversation to wander too far from the goal of getting a complete and accurate history).

The student was able to establish a working rapport with the client. The student conducted the history interview in a courteous and professional manner.

The student was able to gauge the amount of history needed based upon the critical status of the patient (e.g. if the case was an animal in critical status, only the pertinent history was obtained before emergency treatment was begun).

The student accurately recorded the history obtained from the client in sufficient detail to convey all the information needed by the veterinarian.

Number of Times Task Needs to be Successfully Performed: 3

Materials Submitted for Evaluation and Verification:

1. Summary Evaluation form for the history taking prior to anesthesia skill, signed by Clinical Mentorship supervisor
2. Either the original written record of the history for each patient or a photocopy from the clinical record of the written history signed by both the student and the Clinical Mentorship supervisor
3. One videotape either with a client animal or a simulation in which the student elicits and records a history. The written history corresponding to the video must be signed by the student and Clinical Mentorship supervisor and submitted with the tape. The videotaped history can be one of the mandatory three histories submitted.

Summary Evaluation Form for Obtaining a History Prior to General Anesthesia

Student Name: _____

Supervisor Name: _____ RVT, CVT, LVT
 DVM, VMD

#1 Patient Name: _____ Date History Taken #1: _____

#2 Patient Name: _____ Date History Taken #2: _____

#3 Patient Name: _____ Date History Taken #3: _____

Unsatisfactory Satisfactory Excellent

Allowed the client to state the presenting problem

Asked the questions clearly and used terminology the client understood

Asked questions pertinent to anesthesia:

- When the patient last had food and water
- Did patient have access to other food and water
- Has the patient ever received anesthetic agents before (either sedatives or general anesthetics)
- If so, how did the patient recover from them
- Any reactions to medications
- How has the patient been acting lately
- Has the patient ever had surgery or pertinent trauma in the past that might impact general anesthesia

The student maintained good communication skills:

- good eye contact
- non-verbal body language that encouraged the client to continue to speak
- allowed the client to finish a statement without interrupting

The student asked questions in such a way that the question was not a leading question (e.g. "You did see diarrhea, didn't you?").

	Unsatisfactory	Satisfactory	Excellent
When/if a client was unable to understand a question; the student was able to formulate a different way of asking the same question and obtaining the needed information.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The student periodically repeated the information back to the client for confirmation that the student's interpretation of what the client said or meant is correct.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The student was able to direct the history taking dialogue to obtain the information in a timely manner (i.e. didn't allow the conversation to wander too far from the goal of getting a complete and accurate history).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The student was able to establish a working rapport with the client. The student conducted the history interview in a courteous and professional manner.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The student was able to gauge the amount of history needed based upon the critical status of the patient (e.g. if the case was an animal in critical status, only the pertinent history was obtained before emergency treatment was begun).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The student accurately recorded the history obtained from the client in sufficient detail to convey all the information needed by the veterinarian.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Signature of the Clinical Mentorship Supervisor _____

PRE-ANESTHETIC PREPARATION OF THE ANESTHETIC MACHINE

Goal: To prepare an anesthetic machine for use on a patient receiving inhalant anesthesia.

Description: The student will prepare the anesthetic machine for use on a patient that is to receive inhalant anesthesia. This will be done prior to the case.

Criteria: The student checked the oxygen source to verify there was enough oxygen to complete the procedure.

The student turned the oxygen on and verified the oxygen pressure gauge was working and the flowmeter was functioning by turning on the flowmeter temporarily to watch the ball move to the desired oxygen flow.

The student checked the soda lime canister to ensure the granules were fresh according to the practice standard operating procedure.

The student checked the vaporizer to make sure there was inhalant agent in the vaporizer and that it was at least half full and the dial moved smoothly.

The student attached the proper breathing system and breathing bag for the patient being anesthetized.

The student traced the flow from the source, to the patient, from the patient and back to the scavenge system to ensure all connections were correctly assembled.

The student performed a low-pressure leak test to ensure all connections were secure and no leaking of gas would occur.

The student opened the pop-off valve to ensure it was not stuck or closed prior to anesthesia.

Number of Times Task Needs to be Successfully Performed

- 2 times with a rebreathing system
- 2 times with a non-rebreathing system

Materials Submitted for Evaluation and Verification:

1. Summary Evaluation form for the Pre-anesthetic Preparation of Anesthetic Machine skill, signed by Clinical Mentorship supervisor.
2. Two video taped submissions. One video of the student setting up and checking the machine with the rebreathing system and one

setting up and checking the machine with the non-rebreathing system. The student will close up on the gauges during checking so the instructor can verify no leaks were present. The student should also provide a narrative of what they are doing while videotaping.

3. Written SOP for the clinic for sodalime maintenance.

Summary Evaluation Form for Pre-Anesthetic Preparation of the Anesthetic Machine

Student Name: _____

Supervisor Name: _____ RVT, CVT, LVT
 DVM, VMD

#1 Date: _____ #3 Date: _____

#2 Date: _____ #4 Date: _____

	Unsatisfactory	Satisfactory	Excellent
The student checked the oxygen source to verify there was enough oxygen to complete the procedure.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The student turned the oxygen on and verified the oxygen pressure gauge was working and the flowmeter was functioning by turning on the flowmeter temporarily to watch the ball move to the desired oxygen flow.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The student checked the soda lime canister to ensure the granules were fresh according to the practice standard operating procedure.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The student checked the vaporizer to make sure there was inhalant agent in the vaporizer, it was at least half full and the dial moved smoothly.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The student attached the proper breathing system and breathing bag for the patient being anesthetized.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The student traced the flow from the source, to the patient, from the patient and back to the scavenge system to ensure all connections were correctly assembled.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The student performed a low-pressure leak test to ensure all connections were secure and no leaking of gas would occur.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The student opened the pop-off valve to ensure it was not stuck or closed prior to anesthesia.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Signature of Clinical Mentorship Supervisor: _____

PREPARATION OF SUPPLIES PRIOR TO GENERAL INHALANT ANESTHESIA

Goal: To prepare anesthetic supplies prior to general anesthesia.

Description: The student will prepare all supplies needed for general inhalant anesthesia to ensure induction and maintenance of anesthesia goes smoothly.

Criteria: The student chose at least 2 endotracheal tubes of appropriate size for the patient to be anesthetized, checked the cuffs for leaks, and placed them at the induction area.

If the case is a feline, the student prepared lidocaine spray/gel and a stylet to aid in intubation.

The student placed a piece of non-stretch gauze near the endotracheal tubes for use in tying the tube. The piece was of adequate length to tie around the tube.

The student placed a syringe near the endotracheal tubes for use in filling the cuff after intubation.

The student placed a syringe of heparinized saline at or near the induction site to use in verifying intravenous catheter patency.

The student prepared an intravenous catheter of appropriate size for the patient being anesthetized. While leaving the catheter in the package, the student opened the catheter, removed the cap, flushed the catheter with heparinized saline and placed at or near the induction area.

The student provided tape for securing the catheter to the leg at or near the induction area.

The student placed clippers and aseptic preparation materials at or near the induction area for clipping and prepping the intravenous catheter site.

The student provided ophthalmic lubricating ointment at or near the induction area to lubricate the eye after induction.

The student calculated oxygen flow rate prior to induction.

The student provided an oxygen mask near the induction area to provide oxygen or inhalant agent prior to intubation if needed.

The student had a stethoscope and other monitoring devices (depending on practice standard operating procedure) ready for use at the induction area and verified they were in working order.

The student located and made others aware of the location of the emergency supplies in case they are needed during the procedure.

The student provided towels, blankets and other methods for keeping the patient warm at the anesthesia area.

The student set up intravenous fluids with an administration set at the induction area for use during anesthesia.

The student prepared the anesthesia record and placed it at the area for induction.

The student prepared the anesthesia induction agent so it was ready to administer at time of induction.

Number of Times Task Needs to be Successfully Performed: 2 dog, 1 cat

Materials Submitted for Evaluation and Verification:

1. Summary Evaluation form for the Preparation of Supplies Prior to General Inhalant Anesthesia skill, signed by Clinical Mentorship supervisor.
2. One videotaped submission showing the student preparing the supplies. The videotape should highlight the area that will be used for induction and clearly show all of the supplies mentioned in the criteria. A narrative should be provided while videotaping. The video should include a close up on the checking of the endotracheal tube cuff.
3. Written SOP for the clinic for monitoring devices used during anesthesia.

Summary Evaluation Form for Preparation of Supplies Prior to General Inhalant Anesthesia

Student Name: _____

Supervisor Name: _____ RVT, CVT, LVT
 DVM, VMD

Case #1 Date: _____ Procedure: _____ Canine or Feline (circle one)

Case #2 Date: _____ Procedure: _____ Canine or Feline (circle one)

Case #3 Date: _____ Procedure: _____ Canine or Feline (circle one)

Unsatisfactory Satisfactory Excellent

The student chose at least 2 endotracheal tubes of appropriate size for the patient to be anesthetized, checked the cuffs for leaks, and placed at the induction area.

If the case is a feline, the student prepared lidocaine spray/gel and a stylet to aid in intubation.

The student placed a piece of non-stretch gauze near the endotracheal tubes for use in tying the tube to the jaw. The piece was of adequate length to tie around the tube and to the jaw.

The student placed a syringe near the endotracheal tubes for use in filling the cuff after intubation.

The student placed a syringe of heparinized saline at or near the induction site to use in verifying intravenous catheter patency.

The student prepared an intravenous catheter of appropriate size for the patient being anesthetized. While leaving the catheter in the package, the student opened the catheter, removed the cap, flushed the catheter with heparinized saline and placed at or near the induction area.

The student provided tape for securing the catheter to the leg at or near the induction area.

The student placed clippers and aseptic preparation materials at or near the induction area for clipping and prepping the intravenous catheter site.

Unsatisfactory Satisfactory Excellent

The student provided ophthalmic lubricating ointment at or near the induction area to lubricate the eye after induction.

The student calculated oxygen flow rate prior to induction.

The student provided an oxygen mask near the induction area to provide oxygen or inhalant agent prior to intubation if needed.

The student had a stethoscope and other monitoring devices (depending on practice standard operating procedure) ready for use at the induction area and verified they were in working order.

The student located and made others aware of the location of the emergency supplies in case they are needed during the procedure.

The student provided towels, blankets and other methods for keeping the patient warm at the anesthesia area.

The student set up intravenous fluids with an administration set at the induction area for use during anesthesia.

The student prepared the anesthesia record and placed it at the area for induction.

The student prepared the anesthesia induction agent so it was ready to administer at time of induction.

Signature of Clinical Mentorship Supervisor: _____

PREANESTHETIC PREPARATION OF THE PATIENT FOR ANESTHESIA

Goal: The student will evaluate the patient prior to administration of preanesthetic or induction agents to ensure the patient is prepared and in appropriate condition for anesthesia.

Description: The student will review the patient chart and pertinent lab work, review the physical exam, and review the procedure to be performed, prior to general anesthesia. This will also allow the student to prepare for potential emergencies or special patient considerations prior to general anesthesia.

Criteria: The student identified the patient's chart and reviewed it to ensure that the appropriate laboratory tests had been performed as defined by the practice standard operating procedure.

The veterinarian was consulted regarding results prior to premedication or induction of general anesthesia.

The student performed a physical exam prior to administering any anesthetic premedications. Any abnormalities were brought to the attention of the veterinarian.

The student reviewed the procedure to be performed and the patient's condition, and prepared according to the facility SOP for premedication, general anesthesia and maintenance.

The student calculated the dosages of preanesthetic agents and inductions agents as prescribed by the veterinarian, and had those doses checked by the mentor prior to administration.

The student administered the approved premedications to the patient at least 15-30 minutes prior to induction of general anesthesia.

Number of Times Task Needs to be Successfully Performed: 2 dog, 1 cat

Materials Submitted for Evaluation and Verification:

1. Summary Evaluation form for the Preanesthetic Preparation of the Patient for Anesthesia skill, signed by the Clinical Mentorship supervisor.
2. One videotaped submission showing the student evaluating the patient as defined in the criteria. The student will also submit a copy of the anesthetic record for the patient being videotaped. This record will include TPR, signalment, procedure and agents with doses being administered. If laboratory tests were ordered, those results should accompany the anesthetic record.

3. Facility SOP for laboratory tests prior to anesthesia
4. Facility SOP for premedications

NOTE: *The videotape submission will include premedication, intubation, maintenance and recovery. The tasks are written up separately for ease of explanation. In real time they happen very rapidly in sequence. For that reason, we are recommending that you select one dog and one cat to film the entire anesthetic episode. Not all of maintenance or recovery will need to be recorded. You should always use your criteria to guide the videotaping process. Each point of criteria will need to be on videotape. It is helpful to provide a narrative during the videotaping. This will help clarify issues when it is being evaluated at a later date.*

Summary evaluation form for Preanesthetic Preparation of the Patient for Anesthesia

Student Name: _____

Supervisor Name: _____ RVT, CVT, LVT
 DVM, VMD

Case #1 Date: _____ Procedure: _____ Canine or Feline (circle one)

Case #2 Date: _____ Procedure: _____ Canine or Feline (circle one)

Case #3 Date: _____ Procedure: _____ Canine or Feline (circle one)

Unsatisfactory Satisfactory Excellent

The student identified the patient's chart and reviewed it to ensure that the appropriate laboratory tests had been performed as defined by the practice standard operating procedure.

The veterinarian was consulted regarding results prior to premedication or induction of general anesthesia.

The student performed a physical exam prior to administering any anesthetic premedications or induction agents. Any abnormalities were brought to the attention of the veterinarian.

The student reviewed the procedure to be performed and the patient's condition, and prepared accordingly for premedication, general anesthesia and maintenance.

The student calculated the dosages of preanesthetic agents and inductions agents as prescribed by the veterinarian, and had those doses checked by the veterinarian prior to administration.

The student administered the approved premedications to the patient at least 15-30 minutes prior to induction of general anesthesia.

INDUCTION BY INJECTABLE AGENT (ENDING PRIOR TO INTUBATION)

Goal: To induce anesthesia in a patient using an injectable anesthetic agent to facilitate intubation.

Description: The student will use one of the approved induction agents to induce a state of general anesthesia facilitating intubation.

NOTE: This task description ends prior to intubation. Actual videotaping and performing this task will include intubation, which is listed as a separate task. It is recommended that you read both this task and the intubation task before performing the actual tasks.

Criteria: The student checked the syringe to verify the amount drawn up in the syringe matched the calculations.

The student removed any air bubbles in the syringe.

The student flushed the patient's catheter with heparinized saline to ensure its patency.

The student checked the work area one last time to make sure all materials were ready.

The student, with an assistant holding the patient, administered the induction agent according to practice standard protocol.

The student attempted to open the patient's mouth to determine if more induction agent was needed to intubate.

Number of Times Task Needs to be Successfully Performed: 3 dog, 2 cat

Materials Submitted for Evaluation and Verification:

1. Summary Evaluation form for the Induction by Injectable Prior to Intubation skill, signed by the Clinical Mentorship Supervisor.
2. Videotaped Submission of the following:
 - 1 dog induction
 - 1 cat induction

NOTE: This induction videotape will be a part of the anesthesia videotape including premedication, induction, intubation, maintenance and recovery.

**Summary Evaluation Form for Induction by Injectable Agent
(Ending Prior to Intubation)**

Student Name: _____

Supervisor Name: _____ RVT, CVT, LVT
 DVM, VMD

Case #1 Date: _____ Procedure: _____ Canine or Feline (circle one)

Case #2 Date: _____ Procedure: _____ Canine or Feline (circle one)

Case #3 Date: _____ Procedure: _____ Canine or Feline (circle one)

Case #4 Date: _____ Procedure: _____ Canine or Feline (circle one)

Case #5 Date: _____ Procedure: _____ Canine or Feline (circle one)

Unsatisfactory Satisfactory Excellent

The student checked the syringe to verify the amount drawn up in the syringe matched the calculations.

The student removed any air bubbles in the syringe.

The student flushed the patient's catheter with heparinized saline to ensure its patency.

The student checked the work area one last time to make sure all materials were ready.

The student, with an assistant holding the patient, administered the induction agent according to practice standard protocol.

The student instructed the assistant to hold the patients until it seemed adequately anesthetized.

The student attempted to open the patient's mouth to determine if more induction agent was needed to intubate.

Signature of Clinical Mentorship Supervisor: _____

INTUBATION OF A DOG

Goal: The student will intubate a dog without injury to the trachea or other oral structures.

Description: The student will intubate a dog after induction of general anesthesia and verify correct placement of the endotracheal tube.

Criteria: The student waited until the assistant opened the mouth and the dog did not resist opening of the mouth.

The student chose an appropriate endotracheal tube, and used the tube to push the tongue out to the side of the mouth so the assistant could grasp it with a gauze sponge and extend the tongue over the lower canine teeth. The assistant or student did NOT place their hands in the dog's mouth at any time.

The student visualized the opening of the trachea and placed the endotracheal tube in the trachea.

The student attached the breathing tubes, palpated at the thoracic inlet to feel the tip of the endotracheal tube and to verify that only one tubular structure existed.

The student used roll gauze to secure the endotracheal tube.

The student inflated the cuff until no leak was heard when inflating the lungs to a pressure of 20cm H₂O. A small leak should be heard when inflating the lungs past 20cm H₂O.

Number of Times Task Needs to be Successfully Performed: 3 dog

Materials Submitted for Evaluation and Verification:

1. Summary Evaluation form for the Intubation of a Dog skill, signed by the Clinical Mentorship Supervisor.
2. One videotape showing dog intubation. The videotape should contain all steps outlined in the criteria.

NOTE: This intubation videotape will be a part of the anesthesia videotape including premedication, induction, intubation, maintenance and recovery.

Summary Evaluation Form for Intubation of the Dog

Student Name: _____

Supervisor Name: _____ RVT, CVT, LVT
 DVM, VMD

Case #1 Date: _____ Procedure: _____

Case #2 Date: _____ Procedure: _____

Case #3 Date: _____ Procedure: _____

Case #4 Date: _____ Procedure: _____

Case #5 Date: _____ Procedure: _____

Unsatisfactory Satisfactory Excellent

The student waited until the assistant opened the mouth and the dog did not resist opening of the mouth.

The student chose an appropriate endotracheal tube, and used the tube to push the tongue out to the side of the mouth so the assistant could grasp it with a gauze sponge and extend the tongue over the lower canine teeth. The assistant or student did NOT place their hands in the dog's mouth at any time.

The student visualized the opening of the trachea and placed the endotracheal tube in the trachea.

The student attached the breathing tubes, palpated at the thoracic inlet to feel the tip of the endotracheal tube and to verify that only one tubular structure existed.

The student used roll gauze to tie the endotracheal tube to the top of the jaw.

The student inflated the cuff until no leak was heard when inflating the lungs to a pressure of 20cm H₂O. A small leak should be heard when inflating the lungs past 20cm H₂O.

Signature of Clinical Mentorship Supervisor: _____

INTUBATION OF A CAT

Goal: The student will intubate a cat without injury to the trachea or other oral structures.

Description: The student will intubate a cat after induction of general anesthesia and will verify correct placement.

Criteria: The student waited until the assistant opened the mouth and the cat did not resist opening of the mouth to apply lidocaine to the larynx.

The student chose an endotracheal tube, placed a stylet in the tube and used the tube to push the tongue out to the side of the mouth so the assistant could grasp it with a gauze sponge and extend the tongue over the lower canine teeth. The assistant or student did NOT place their hands in the mouth at any time.

The student visualized the opening of the trachea, placed the tube in the trachea without force, and pulled the stylet from the tube.

The assistant held the cat's mouth shut and the cat was laid on its side while the student attached the breathing tubes, palpated at the thoracic inlet to feel the tip of the endotracheal tube and to verify that only one tubular structure existed.

The student used roll gauze to tie the endotracheal tube behind the cat's head, and behind both ears.

The student inflated the cuff until no leak was heard when inflating the lungs to a pressure of 20cm H₂O. A small leak should be heard when inflating the lungs past 20cm H₂O.

Number of Times Task Needs to be Successfully Performed: 2 cat

Materials Submitted for Evaluation and Verification:

1. Summary Evaluation form for the Intubation of a Cat skill, signed by the Clinical Mentorship Supervisor.
2. One videotape showing cat intubation. The videotape should contain all steps outlined in the criteria.

NOTE: *This intubation videotape will be a part of the anesthesia videotape including premedication, induction, intubation, maintenance and recovery.*

Summary Evaluation Form for Intubation of the Cat

Student Name: _____

Supervisor Name: _____ RVT, CVT, LVT
 DVM, VMD

Case #1 Date: _____ Procedure: _____

Case #2 Date: _____ Procedure: _____

Case #3 Date: _____ Procedure: _____

Case #4 Date: _____ Procedure: _____

Case #5 Date: _____ Procedure: _____

Unsatisfactory Satisfactory Excellent

The student waited until the assistant opened the mouth and the cat did not resist opening of the mouth to apply lidocaine to the larynx.

The student chose an endotracheal tube, placed a stylet in the tube and used the tube to push the tongue out to the side of the mouth so the assistant could grasp it with a gauze sponge and extend the tongue over the lower canine teeth. The assistant or student did NOT place their hands in the mouth at any time.

The student visualized the opening of the trachea, placed the tube in the trachea without force, and pulled the stylet from the tube.

The student attached the breathing tubes, palpated at the thoracic inlet to feel the tip of the endotracheal tube and to verify that only one tubular structure existed.

The student used roll gauze (NOT TAPE) to tie the endotracheal tube behind the cat's head, and behind both ears.

The student inflated the cuff until no leak was heard when inflating the lungs to a pressure of 20cm H₂O. A small leak should be heard when inflating the lungs past 20cm H₂O.

Signature of Clinical Mentorship Supervisor: _____

MAINTENANCE AND MONITORING OF GENERAL ANESTHESIA

Goal: The student will maintain a state of general anesthesia while monitoring the patient's vital signs, reflexes and overall depth of anesthesia for a period of at least 30 minutes. Keep these parameters within normal limits for the particular breed/species, and to minimize patient discomfort during the procedure.

Description: Following induction and intubation, the student will monitor anesthetic gas concentration and oxygen flow rate, patient vital signs and reflexes, and maintain those values within normal limits. The anesthetic episode should last at least 30 minutes.

Criteria: The student set the oxygen flow rate according to the patient's weight and requirement based on the breathing system.

The student adjusted the vaporizer setting to 1.5-3% based on the patient's response to the induction agent.

The student verified that the patient was breathing and recorded a heart rate before proceeding further to ensure the patient was stable following induction and intubation.

The student placed an esophageal stethoscope into the esophagus (if monitoring during a surgical procedure) and secured it to the endotracheal tube (not mouth) in order to facilitate quick removal if an emergency arose.

The student attached the ECG (or appropriate alternative) according to the practice standard operating procedure.

The student attached intravenous fluids to the catheter and set the rate for surgical maintenance as ordered by the veterinarian.

The student manually squeezed the rebreathing bag every 1-2 minutes regardless of the patient's respiratory rate to 15-20 cm H₂O.

The student recorded values including heart rate, respiratory rate, anesthetic gas concentration and fluid volume administered (as well as any other parameters being monitored) on the anesthesia record every 5 minutes (every 30 minutes for fluids). The student brought abnormal readings to the attention of the veterinarian.

The student checked the patient's reflexes (palpebral, pedal, jawtone, eye position, depending on accessibility) to ensure the patient was neither too deep nor too light, and brought abnormal responses to the attention of the veterinarian.

The student observed the patient's respiratory function by observing the rebreathing bag to count rate and observing chest excursions to ensure adequate depth of each breath.

The student maintained the anesthetic gas concentration at the lowest level possible to achieve general anesthesia.

The student decreased the anesthetic concentration near the end of the procedure.

Number of Times Task Needs to be Successfully Performed: 2 cat 3 dog

Materials Submitted for Evaluation and Verification:

1. Summary Evaluation form for the Maintenance and Monitoring of General Anesthesia skill, signed by the Clinical Mentorship Supervisor.
2. Videotaped Submission of the following:
 - 1 dog maintenance and monitoring
 - 1 cat maintenance and monitoring
3. Clinic SOP for monitoring anesthetized patients

NOTE: *This maintenance videotape will be a part of the anesthesia videotape including premedication, induction, intubation, maintenance and recovery.*

Summary Evaluation Form for Maintenance and Monitoring of General Anesthesia

Student Name: _____

Supervisor Name: _____ RVT, CVT, LVT
 DVM, VMD

Case #1 Date: _____ Procedure: _____

Case #2 Date: _____ Procedure: _____

Case #3 Date: _____ Procedure: _____

Case #4 Date: _____ Procedure: _____

Case #5 Date: _____ Procedure: _____

Unsatisfactory Satisfactory Excellent

The student set the oxygen flow rate according to the patient's weight and requirement based on the breathing system.

The student adjusted the vaporizer setting to 1.5-3% based on the patient's response to the induction agent.

The student verified that the patient was breathing and recorded a heart rate before proceeding further to ensure the patient was stable following induction and intubation.

The student placed an esophageal stethoscope into the esophagus (if monitoring during a surgical procedure) and secured it to the endotracheal tube (not mouth) in order to facilitate quick removal if an emergency arose.

The student attached the ECG (or appropriate alternative) according to the practice standard operating procedure.

The student attached intravenous fluids to the catheter and set the rate for surgical maintenance as ordered by the veterinarian.

<p>The student manually squeezed the rebreathing bag every 1-2 minutes regardless of the patient's respiratory rate to 15-20 cm H₂O.</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<p>The student recorded values including heart rate, respiratory rate, anesthetic gas concentration and fluid volume administered (as well as any other parameters being monitored) on the anesthesia record every 5 minutes (every 30 minutes for fluids). The student brought abnormal readings to the attention of the veterinarian.</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<p>The student checked the patient's reflexes (palpebral, pedal, jawtone, eye position, depending on accessibility) to ensure the patient was neither too deep nor too light, and brought abnormal responses to the attention of the veterinarian.</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<p>The student observed the patient's respiratory function by observing the rebreathing bag to count rate and observing chest excursions to ensure adequate depth of each breath.</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<p>The student maintained the anesthetic gas concentration at the lowest level possible to achieve general anesthesia.</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<p>The student decreased the anesthetic concentration near the end of the procedure.</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Signature of Clinical Mentorship Supervisor: _____

RECOVERY FROM GENERAL ANESTHESIA

Goal: The student will monitor the recovery of a patient from general anesthesia.

Description: The student will monitor the recovery of a patient from general anesthesia following an anesthetic episode that lasts at least 30 minutes. The patient will be closely monitored until extubation and will be periodically monitored until it is able to sit or stand unsupported.

Criteria: The student turned off the inhalant anesthetic gas and administered oxygen for a period of 2-5 minutes to scavenge waste gases prior to disconnecting the breathing circuit.

The student inspected the oral cavity to insure it was free of secretions and/or objects that could impede respiration.

The student maintained the patient's head in a normal position.

The student deflated the endotracheal tube cuff and untied it from the patient to facilitate quick removal.

If placed, the student removed the esophageal stethoscope and other monitoring devices prior to the patient awakening from general anesthesia.

The student removed the endotracheal tube when the patient began to swallow (2-3 times) without stimulation.

The student observed the patient following extubation for signs of respiratory distress and/or cyanosis, and informed the veterinarian if abnormalities were noted. If abnormalities were noted, the student administered oxygen while awaiting the arrival of the veterinarian.

The student recorded heart rate, respiratory rate and temperature following extubation. Values were recorded every 5 minutes for the first 15 minutes following extubation. Abnormalities were brought to the attention of the veterinarian.

Summary Evaluation Form for Recovery from General Anesthesia

Student Name: _____

Supervisor Name: _____ RVT, CVT, LVT
 DVM, VMD

Case #1 Date: _____	<input type="checkbox"/> Canine	<input type="checkbox"/> Feline
Case #2 Date: _____	<input type="checkbox"/> Canine	<input type="checkbox"/> Feline
Case #3 Date: _____	<input type="checkbox"/> Canine	<input type="checkbox"/> Feline
Case #4 Date: _____	<input type="checkbox"/> Canine	<input type="checkbox"/> Feline
Case #5 Date: _____	<input type="checkbox"/> Canine	<input type="checkbox"/> Feline

Unsatisfactory Satisfactory Excellent

The student turned off the inhalant anesthetic gas and administered oxygen for a period of 2-5 minutes to scavenge waste gases prior to disconnecting the breathing circuit.

The student inspected the oral cavity to insure it was free of secretions and/or objects that could impede respiration.

The student maintained the patient's head in a normal position.

The student deflated the endotracheal tube cuff and untied it from the patient to facilitate quick removal.

If placed, the student removed the esophageal stethoscope and other monitoring devices prior to the patient awakening from general anesthesia.

The student removed the endotracheal tube when the patient began to swallow (2-3 times) without stimulation.

The student observed the patient following extubation for signs of respiratory distress and/or cyanosis, and informed the veterinarian if abnormalities were noted. If abnormalities were noted, the student administered oxygen while awaiting the arrival of the veterinarian. as ordered by the veterinarian.

The student recorded heart rate, respiratory rate and temperature following extubation. Values were recorded every 5 minutes for the first 15 minutes following extubation. Abnormalities were brought to the attention of the veterinarian.

The student used available means to elevate body temperature to normal. The student recorded the patient's temperature every 30 minutes to insure the patient did not become overheated. Heating methods were discontinued once the patient's temperature reached 100 degrees Fahrenheit.

The student placed the patient (if recumbent) in the opposite recumbency as it was during the procedure to assist in ventilating the previously "down" lung field.

If indicated, IV fluids were continued and the rate and catheter site monitored.

The patient was monitored for signs of pain and analgesics administered as needed on the orders of a DVM, and recorded in the patient record.

The patient was monitored closely for respiratory depression if narcotic analgesics were administered.

The student recorded recovery parameters and notes at the bottom of the anesthetic record to become a part of the patient's permanent record.

Signature of Clinical Mentorship Supervisor: _____

ANESTHESIA RECORD PROCEDURES

Goal: The student will record various parameters during general anesthesia on an anesthetic record. This is a legal document that will be a permanent part of the patient's record.

Description: The student will record various parameters outlined in the criteria during general anesthesia. This record will be part of the patient's permanent record.

Criteria: The anesthetic record included the following information:

- Patient name
- Date
- Signalment
- Weight
- Procedure
- Special precautions (if any) or patient conditions pertinent to anesthesia
- TPR prior to premedication (taken same day as procedure), preferably at rest
- Preanesthetics, induction agent and any other agents administered in the pre or peri anesthetic period, including the dose given, and the time
- Heart rate, respiratory rate and anesthetic gas concentration recorded every 5 minutes on the anesthesia record
- IV fluid volume every 15-30 minutes (total at end of procedure)
- Blood pressure readings and pulse oximetry values recorded every 10 minutes (if using)
- Notes pertaining to major anesthetic or surgical events
- Post operative pain medication (if given) agent and amount
- Time of beginning and end of anesthesia, the procedure, and extubation
- Synopsis of patient recovery
- TPR - post extubation

The student used black or blue ink.

The record was legible and able to be interpreted.

Number of Times Task Needs to be Successfully Performed: 2 cat 3 dog

Materials Submitted for Evaluation and Verification:

1. Summary Evaluation form for the Anesthesia Record Procedure skill, signed by the Clinical Mentorship Supervisor.
2. Submit the anesthesia record for the dog and the cat used in the videotape. The name of the patient will be announced on the video and should correspond to the anesthetic record.

Summary Evaluation Form for Maintenance and Monitoring of General Anesthesia

Student Name: _____

Supervisor Name: _____ RVT, CVT, LVT
 DVM, VMD

Case #1 Date: _____ Procedure: _____

Case #2 Date: _____ Procedure: _____

Case #3 Date: _____ Procedure: _____

Case #4 Date: _____ Procedure: _____

Case #5 Date: _____ Procedure: _____

The anesthetic record included the following information:

	Unsatisfactory	Satisfactory	Excellent
• Patient name	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Date	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Signalment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Weight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Procedure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Special precautions (if any) or patient conditions pertinent to anesthesia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• TPR prior to premedication (taken same day as procedure), preferably at rest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Preanesthetics, induction agent and any other agents administered in the pre or peri anesthetic period, including the dose given, and the time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Heart rate, respiratory rate and anesthetic gas concentration recorded every 5 minutes on the anesthesia record	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• IV fluid volume every 15-30 minutes (total at end of procedure)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Blood pressure readings and pulse oximetry values recorded every 10 minutes (if using)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Notes pertaining to major anesthetic or surgical events	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Post operative pain medication (if given) agent and amount	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Time of beginning and end of anesthesia, the procedure, and extubation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Synopsis of patient recovery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• TPR - post extubation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

The student used black or blue ink.

The record was legible and able to be interpreted.

Signature of Clinical Mentorship Supervisor: _____

Patient sticker

Date	Cage	ID	Premedication	
Weight	MMC	CRT	Agent	Time
Temp	Pulso	Respiration	Administered	Route
PCV	TP	Glucose	mg ml	Pre-op Effect
BUN	ASA	1 2 3 4 5 E	mg ml	<input type="checkbox"/> none <input type="checkbox"/> slight <input type="checkbox"/> moderate <input type="checkbox"/> profound <input type="checkbox"/> adverse
Procedure	Induction Agent		Administered	Route
Relevant Clinical Data	Agent		mg ml	Time
	Time		mg ml	Calculated
	Time		mg ml	Discarded

Clinician: _____
 Surgeon: _____
 Anesthetists: _____

Anesthesia Time: _____
 Surgery Time: _____
 Approved by: _____

Tube Size _____	00	15	20	25	30	35	40	45	50	55	60	Remarks:
Codes												
Anesthesia A-Ⓟ												
Surgery O-Ⓟ												
Radiology R-Ⓟ												
Cont Vest C-Ⓟ												
Et CO ₂ <input type="checkbox"/>												
SPO ₂ X <input type="checkbox"/>												
CVP <input type="checkbox"/>												
Heart rate <input type="checkbox"/>												
Resp Rate <input type="checkbox"/>												
Blood Pressure <input type="checkbox"/>												
Systolic <input type="checkbox"/>												
Diastolic <input type="checkbox"/>												
Mean <input type="checkbox"/>												
Monitoring												
<input type="checkbox"/> ECG												
<input type="checkbox"/> Temperature												
<input type="checkbox"/> NIBP												
<input type="checkbox"/> IBP												
<input type="checkbox"/> CVP												
<input type="checkbox"/> ET/CO ₂												
<input type="checkbox"/> SPO ₂												
System												
<input type="checkbox"/> Semi Closed												
<input type="checkbox"/> Non-rebreathing												
<input type="checkbox"/> Mechanical												
Body Position												
<input type="checkbox"/> Lateral R L												
<input type="checkbox"/> Sternal												
<input type="checkbox"/> Dorsal												
<input type="checkbox"/> Perineal Board												
Agent												
<input type="checkbox"/> Isoflurane												
<input type="checkbox"/> Halothane												
O ₂ _____ Liters/min												
% Gas												
Fluids												
Total												

VM 210 Project Tasks

1. Completion of One Non-Routine Anesthetic Episode

The student will anesthetize a patient for a non-routine anesthetic episode that will span at least 30 minutes. The goal of this task is for the student to gain experience in anesthetizing a patient that is higher risk and would be more challenging to anesthetize. Contact the mentorship supervisor if you have any questions on the appropriateness of a certain case.

Examples would be:

- Geriatric dog or cat receiving a dental prophylaxis or surgical procedure.
- Brachycephalic breed (i.e.- Bulldog, Boston Terrier) undergoing anesthesia.
- Dog or cat with kidney or liver disease undergoing a surgical procedure.

The student must provide the following information, written in their own words:

- Signalment
- History and Physical exam findings
- Results of any additional testing done prior to anesthesia (hematology, etc.) This may be photocopied and attached.
- Procedure to be performed and why patient is receiving this procedure. The student will also describe what aspects of the procedure may be particularly risky to the patient, and how the student will respond.
- Anesthetic plan (including drugs, monitoring and positioning)
- Synopsis of procedure (describe induction, maintenance and recovery)
- A copy of the anesthetic record
- Self-assessment of student performance, including aspects that went well/as planned, as well as aspects that need improvement or that the student would do differently, given another opportunity.

VM 210 Project Tasks Continued

2. Emergency Drugs Project

- a. Identify five emergency drugs that might be used during an anesthetic emergency and address the following for each:
 - Specific use / purpose of the drug (In what situation would it be used?)
 - Systemic effects of the drug
 - Contraindications / situations in which to avoid use of the drug

- b. What is your practice standard operating procedure regarding emergency drugs?
 - Is there a central location (i.e.: a tackle box, drawer, cabinet)?
 - Are the agents inventoried on a regular basis?
 - How often are the agents checked for outdates?
 - How could the current system be improved?